The United Republic of Tanzania

National Report on Follow-up to the World Summit for Children

Ministry of Community Development, Women's Affairs and Children

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CONTENTS

FOREWORD

This report provides an account of progress made in the implementation of World Declaration and Programme of Action by Tanzania for achieving the goals set at the World Summit for Children in 1990.

The World Summit for Children held in New York in September 1990 and attended by World leaders including the President of the United Republic of Tanzania set eight goals to be achieved by all member states of the United Nations. As a follow up to the World Summit for Children, the Government of Tanzania in collaboration with UNICEF and other development partners held a National Summit for Children in 1991. The National Summit for Tanzanian children set seven goals for Child Survival, Protection and Development together with implementation structures.

Tanzanian children, like those of other developing countries, have been facing serious challenges for survival and development. Such challenges include high infant and child mortality rates, high maternal mortality rates, malnutrition, limited access to clean and safe water, sanitary disposal problems and related consequences, enrolment and retention in schools, violence and the HIV/AIDS. It is in recognition of this situation that the Government of Tanzania in collaboration with its development partners undertook concerted efforts to address the challenges.

The government of Tanzania has instituted policies and strategies to address the challenges and created conducive environment for NGOs and CBOs to play their role in addressing the problems affecting children. Such policies include the Child Development Policy, the Youth Development Policy, the Community Development Policy, the Education and Training Policy and the Women and Gender Development Policy. Associated programmes and strategies being implemented include the Tanzania Development Vision 2025, the Poverty Reduction Strategy, the Child Survival, Protection and Development Programme, and other sector reforms.

In addition to the policies, strategies and programmes, the government of Tanzania has taken specific measures relevant to survival, protection and development of children in the country. Such measures include reviewing and enacting laws to protect children from societal harassment, torture, abuses of all types and denial of their basic human rights.

The Education Act 1978 and the Sexual Offences (Special Provisions Act) 1998, are some of the laws intended to specifically address these challenges. National campaigns of different types have also been carried out simultaneously in the period of this report. National campaigns for school enrolment, immunization against killer diseases, village child days were set on 16th June each year to monitor growth, protection and development of children in the country. In Addition, Special National Assembly Sessions on the Child have all been part of the implementation strategy aimed at improving the poor conditions of children in the country.

The major constraints to the implementation of the WSC have been the persistent situation of poverty. The government of Tanzania took measures to deal with this problem and the results led to the economic recovery programme and the HIPC arrangements within the Tanzania Assistance Strategy. The government also took measures to strengthen democracy, good governance and respect of law whereby every person including children are beneficiaries. With the infrastructure already established in terms of policies, laws, strategies and programmes, there is a bright future for Tanzanian children.

The Government of Tanzania would like to thank most sincerely the UN system and UNICEF in particular, development partners, government ministries, NGOs, CBOs for the financial and technical support which assisted in the implementation of activities that contributed to the progress to meet the goals set for the survival, protection and development of children in the country.

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TANZANIA

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List of Abbreviations

AIDS	-	Acquired Immuno Deficiency Syndrome
ARI	-	Acute Respiratory Infections
CNSPM	-	Children in Need of Special Protection Measures
CRC	-	Convention on the Rights of the Child
CSPD	-	Child Survival, Protection and Development Programme
DAC	-	The Day of the African Child
DPT	-	Diphtheria, Pertussis and Tetanus
EPI	-	Expanded Programme on Immunization
GER	-	Gross Enrolment Rate
GMP	-	Growth Monitoring and Promotion
GOT	-	Government of Tanzania
HIPC	-	Highly Indebted Poor Countries
HIV	-	Human Immuno Deficiency Virus
IDD	-	Iodine Deficiency Disorders
IMCI	-	Integrated Management of Childhood Illness
IMR	-	Infant Mortality Rate
MCH	-	Maternal and Child Health
MMR	-	Maternal Mortality Rate
MTEF	-	Medium Term Expenditure Framework
NACP	-	National AIDS Control Programme
NCHS	-	National Child Health Surveys
NER	-	Net Enrolment Rate
NGO	-	Non Governmental Organisation
NPA	-	National Programme of Action for Children (Tanzania)
NPES	-	National Poverty Eradication Strategy
NSC	-	National Summit for Children
ORT	-	Oral Rehydration Therapy
PHC	-	Public Health Committee
PPM	-	Parts per Million
PRSP	-	Poverty Reduction Strategy Paper
TDHS	-	Tanzania Demographic Health Survey
TRCHS	-	Tanzania Reproductive and Child Health Survey
U5MR	-	Under Five Mortality Rate
UPE	-	Universal Primary Education
UN	-	United Nations
UNICEF	-	United Nations Children's Fund
WES	-	Water and Environmental Sanitation
WHO	-	World Health Organisation
WSC	-	World Summit for Children
ZEMAP	-	Zanzibar Education Master Plan

A: INTRODUCTION AND BACKGROUND

The United Republic of Tanzania delegation to the World Summit For Children (WSC), held in September 1990 in New York was led by H.E. Ali Hassan Mwinyi, the President of the United Republic of Tanzania. A high-powered delegation representing government ministries and other institutions accompanied him. The objective of the summit was to assess the situation of the world's children and adopted the Declaration on Child Survival, Protection and Development and a Plan of Action to achieve the goals by the year 2000.

The WSC set the following goals to be achieved by all the nations.

WSC goal 1: Between 1990 and the year 2000, reduction of infant and under-five child mortality rate by one third or to 50 and 70 per 1,000 live births respectively, whichever is less.

WSC goal 2: Between 1990 and the year 2000, reduction of maternal mortality rate by half.

WSC goal 3: Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-five children by half[1].

WSC goal 4: Universal access to safe drinking water.

WSC goal 5: Universal access to sanitary means of excreta disposal.

WSC goal 6: Universal access to basic education, and achievement of primary education by at least 80 per cent of primary school-age children, through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls.

WSC goal 7: Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level, with emphasis on female literacy.

WSC goal 8: Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situation.

Apart from these 8 major goals there were 19 other goals. Most of these goals were only for estimation at global and regional level and not for measurement at national level. WSC also required all countries to provide additional information on the following:

- Monitoring children's rights
- Monitoring Integrated Management of childhood illnesses (IMCI) initiative and malaria
- Monitoring HIV/AIDS

[1] Malnutrition estimates and goals set (2 percent severe malnutrition and 22 percent moderate malnutrition) in the 1980's used the Harvard standards instead of the NCHS references. 80 percent of Harvard standards coincides with approximately a –2SD cut-off for the NCHS reference.

The statistical appendix to the report highlights the situation achieved in all the 27 goals of WSC and provide information on additional indicators for monitoring children's rights, Integrated Management for Child Illness (IMCI) initiative, malaria and HIV/AIDS.

As a follow up to the World Summit, Tanzania held a National Summit for Children, in Dar es Salaam in June 1991 where the seven major goals for Child Survival, Protection and Development were adopted and the implementation structures to achieve these goals were endorsed. The child protection measures were further strengthened when the national Parliament resolved to give children first priority in national plans and agreed to support measures that will lead to achieving the Goals for Children in Tanzania by the year 2000.

Following the National Summit for Children, programmes of action for achieving the goals for Tanzanian children by the Year 2000 were prepared. These programmes of action were adopted for implementation in 1991 in Zanzibar, and in 1993 on the Tanzanian Mainland. The Tanzania National Programme of Action (NPA) is an integrated synergistic programme designed to address the situation of children and women, through developing strategies for achieving the set targets. NPA decided to combine the goals on safe drinking water and sanitation and reduce the number of goals to seven. The preparation of the NPA involved a broad spectrum of officials from sectors of health, education, water, social welfare, agriculture, planning, finance, local government, community development, and related institutions. Apart from government officials, NGOs, academia, private sector and civil society were involved in the preparation of the NPA through a consultative process. Goals articulated by NPA were endorsed by the National Parliament at a special session held in Dar es Salaam on 7 June 1991. These goals were articulated as follows:

Goal 1:
Between 1990 and the year 2000, to reduce infant and under five mortality rates by one third or to 50 and 70 per 1,000 live births respectively, whichever is less. According to the 1978 census, the infant mortality rate was then 138 and 104 and U5MR was 249 and 179 in rural and urban areas respectively. This means that by the year 2000, infant mortality rate should be reduced to 50 and U5MR to 70.

Goal 2:
Between 1990 and the year 2000, to reduce maternal mortality by half. According to available statistics in 1991 shows that between 200 and 400 women die every year due to complications of pregnancy or child birth 100,000 live births. The objective was to reduce these rates to between 100 to 200.

Goal 3:
Between 1990 and the year 2000, to reduce moderate and severe malnutrition among children under five by half. According to available statistics, nearly 6 per cent of children under five are severely malnourished and 45 per cent have moderate malnutrition. Aim was to reduce these rates to 2 percent and 22 percent respectively.

Goal 4:
Universal access to safe drinking water and sanitary means of excreta disposal by the year 2000. According to statistics available in 1991, only 45 per cent and 65 per cent of the rural and urban population respectively have access to safe drinking water; and 62 per cent and 74 per cent of the rural and urban population respectively have sanitary means of excreta disposal.

Goal 5:
Universal access to basic education and enrolment of all school-age children (7 years old) by the year 2000. At least 80 per cent of these children should complete primary education by the age of 15 and should be able to read, write and be able to live independently. Although primary school enrolment rates are 70 per cent in total, according to available statistics in 1991, only 12 per cent of standard one enrolees are of the appropriate age, the rest are older than seven. Overall completion rates are 75 per cent.

Goal 6:
By the year 2000, to reduce adult illiteracy to at least half of the 1990 level, with special emphasis on female literacy. According to Ministry of Education and Culture's statistics for 1989 adult literacy rates were 93 for men and 88 for women. These rates should reach 96 and 94 for men and women respectively.

Goal 7:
Improved protection of children in especially difficult circumstances by the year 2000.

Tanzania also incorporated into NPA the Mid-Decade (1995) goals which were adopted in Dakar Senegal at the Organisation of African Unity (OAU), International Conference for Assistance to African Children held in November 1992.

The NPA provided an institutionalised mechanism under the Planning Commission in the President's Office to monitor progress made in the implementation of the NPA. A strategy for effective implementation of the NPA and for co-ordinating its activities with the Tanzania/UNICEF Programme of Co-operation on Child Survival, Protection and Development (CSPD) was also developed. Periodic annual and mid-term reviews on implementation of the NPA/CSPD have been undertaken. The United Republic of Tanzania submitted her periodic report on the Implementation of the Convention on the Rights of the Child in 1998 as required under article 44 of the Convention. The report is scheduled to be discussed mid – 2001 by the Committee on the Rights of the Child.

B: PROCESS ESTABLISHED FOR THE END DECADE REVIEW

The process for the End Decade Review started in 1998/99, with the Mid-term review of the Country Programme of Co-operation on CSPD, which took stock of achievements and constraints towards implementation of the original objectives. The review was done under the guidance of the Country Programme Steering Committee comprising of Permanent Secretaries of the relevant government ministries. A Technical Working Group on the Mainland and a Technical Committee on the Isles supported the Steering Committee in this task.

A multi-disciplinary approach was chosen in each theme because the 1998 CSPD annual review, which involved 55 districts on the Mainland and the whole of Zanzibar, had noted that one of the major problems emerging during the implementation of the programme was lack of co-ordination and integration of activities.

Since 1991, the Day of the African Child has been used to create awareness about children's rights and collect children's views on various issues affecting their lives. The Day of the African Child in 2000 was used to take stock of the implementation of the Summit Goals. A special session of the National Assembly was organised on 17 June 2000 to inform Members of Parliament on progress made in implementing the National Summit Goals, and other issues related with children's rights, notably HIV/AIDS.

Several studies have been carried out on various aspects related with children and women's issues. Findings of these studies were widely disseminated and discussed through workshops, round table discussions and through the mass media.

C. ACTION AT NATIONAL AND INTERNATIONAL LEVELS

1. The National Summit for Children (NSC)

The National Summit set up a bottom up approach in carrying out activities to achieve the set goals. In implementing the goals, households, the villages, wards and eventually the districts were to set their own goals on the basis of capacities and resources available at each level. Back-up support was to be co-ordinated at the national level in collaboration with the regional machinery. The National Co-ordinating Committee for Child Survival, Protection and Development chaired by the Planning Commission in the President's Office was charged with co-ordinating, planning and reviewing implementation.

In each village implementation and follow-up committees were set up. Members in these committees were drawn from each neighbourhood and it was intended that half of them were to be women. In practice however, in many Tanzanian communities women have the same opportunity as men to air their views. These committees were responsible for maintenance of village registers where births and deaths are recorded. Children under five are regularly weighed and these records are included in the village register. Results of weighing are analysed to determine nutrition status. Information collected on infant, child and maternal deaths, and results from weighing are discussed in a joint meeting of all villagers. Community capacity in identifying the problems, collecting and analysing data and making informed decisions was built through this process.

2. The National Programme of Action/Country Programme of Co-operation between The Government of Tanzania and UNICEF

Some of the priorities identified for NPA were incorporated in the 1992-1996 Country Programme of Co-operation between the Government of Tanzania and UNICEF, Child Survival Protection and Development (CSPD).

The implementation of the CSPD has been participatory in nature, involving key actors including government, NGOs, civil society, communities, village governments and mass media in creating awareness, and sensitisation. Advocacy materials were produced and widely disseminated using mass media, schools, NGOs, commemoration of the Day of the African Child, youth groups and other means.

Through CSPD programme, community-based management information systems were established with information on three key indicators: nutrition status and growth monitoring, monitoring enrolment in primary schools, immunisation to ensure children are protected against the six killer diseases. Statistics are aggregated by gender in some cases. Progress towards the goals was also facilitated through research and development, including studies on the girl child and on children in need of special protection measures.

3. Policy and Strategies.

Tanzania has taken several policy initiatives that will have direct and indirect effect on the implementation of the NPA. These initiatives provide the context within which the NPA is operating. Some of these initiatives are discussed below:

- **Tanzania Development Vision 2025**

  This is a national vision with economic and social objectives to be attained by the year 2025. It lays out the long-term development goals and perspectives, against which the National Poverty Eradication Strategy (NPES) was formulated.

  The Tanzania Development Vision 2025 has three principal objectives: - achieving quality and good life for all, good governance and the rule of law; and building a strong and resilient economy that can effectively withstand global competition.

  The vision sees the future of Tanzania to be a country at peace, tranquillity and national unity; a country with an educated population imbued with an ambition to develop; and an economy which is competitive and which ensures sustained growth for the benefits of all people.

- **Poverty Reduction Strategy:**

  At the core of the problems facing women and children in the country is abject poverty which affects the majority of Tanzanians. A study based on a national household survey carried out in 1991 found out that 51 percent of the population had incomes of less than an absolute poverty line of US $1 per day

per person, 42 percent had incomes of less than US $0.75 per day. The poverty profile suggests that poverty in Tanzania is very much a rural phenomenon. While 59 percent of the population live in rural areas, about 85percent of the below-US$1-a-day poor and 90 percent of the below-US$0.75-a-day poor live in rural areas. Income levels are strongly associated with other social indicators. Children of poor parents are more likely to die during infancy; they are more likely to be malnourished; they are less likely to be enrolled in school; and, if enrolled, more likely to perform poorly. Given the fact that poverty affects all the social indicators negatively and thus national development, the government has decided to put poverty reduction at the centre of its development efforts. The GOT published an Interim Poverty Reduction Strategy Paper (PRSP) in March 2000, and a more comprehensive PRSP was published in October 2000. The PRSP explicitly emphasises the importance of participatory planning at village and district level. Through this approach, human potential will be unleashed to help solve the numerous problems confronting people. The PRSP aims at facilitating the mainstreaming of a poverty and welfare monitoring system into the budget instruments, such as the Medium Term Expenditure Framework (MTEF). The PRSP aims at strengthening the prioritisation of actions within and across sectors targeting poverty. Two areas that have received particular attention are primary health and education.

Through the PRSP more resources will be allocated for fighting poverty. Before PRSP and Tanzania's qualification to the enhanced Highly Indebted Poor Countries (HIPC) initiatives, the nation was spending about 40percent of the public budget on debt servicing; more than allocations for education and health sectors combined.

- **Child Development Policy**

The Ministry of Community Development, Women's Affairs and Children was established in November 1990. A Child Development Policy was formulated and approved for implementation in 1996. The policy enshrines the basic principles of Convention on the Rights of the Child (CRC) namely non-discrimination, the best interests of the child, right to life, views of the child and indivisibility. A revision of the policy and its implementation framework has been initiated in order to address pertinent issues such as child participation rights, the challenge of HIV/AIDS, street children, child labour and related aspects of poverty and marital relationship. The implementation framework of the Child Development Policy contains guidelines addressed to different key actors which include the central government, local government, NGOs, mass media, international agencies, community, parents/ guardians, and children themselves in ensuring children rights for survival, protection, development, non-discrimination and participation.

- **Youth Development Policy**

The Government formulated the National Youth Development Policy in 1996. This is the key document guiding the formulation and implementation of programmes and projects by the government and all stakeholders involved in youth development. The policy is intended to help foster proper upbringing of

women and men, and for them to become responsible citizens and develop their full potentials in all aspects and promote their full involvement and participation for socio-economic development.

Future programmes of the youth development will be based on the Youth Empowerment Programme vision 2025. Hence, the National Youth Development Policy, which is under review, includes strategies and statements, which will facilitate the youth in their capacity building and empowerment.

- **Reform Programmes – Local Government Reform and Sector Development Reforms**

Local Government Reform (LGR) is intended to improve the quality and quantity of service delivery to the people. The Local Government Reform and the devolution of political, administrative and development responsibilities, including the authority to raise and use revenue, provides a major opportunity for facilitating and overseeing development in a comprehensive and holistic manner. This requires that the district and sub-district officials be sensitive to community priorities and respect their capacity to develop, own and co-ordinate their own plans, resources and partners.

The Local Government Reform is going hand in hand with other sector reforms such as Health, Education, Water, and Agriculture, all intended to improve provision and delivery of various services to the people. Educating and sensitising people on their roles as far as cost sharing is concerned is one of the activities being undertaken now.

D. SPECIFIC ACTIONS FOR CHILD SURVIVAL, PROTECTION AND DEVELOPMENT

This section, presents actions that the United Republic of Tanzania has taken on the seven goals identified by the World Summit for Children.

(a) Tanzania Mainland

The United Republic of Tanzania signed the World Declaration in September 1990. A special session of the mainland Parliament held on 7 June 1991 endorsed the seven major goals of WSC. As discussed in the previous section, Tanzania has put in place several policy initiatives that will help the country to achieve its commitment towards children of this nation.

Goal 1: Reduction of Infant Mortality Rate (IMR) and Under-Five Mortality Rate (U5MR)

Goals set for IMR and U5MR have not been achieved. Information on IMR and U5MR has been derived from three national household surveys that were conducted in Tanzania during the 1990s. These surveys show that IMR dropped from 92 per 1,000 live births in 1992 to 88 in 1996 only to rise again to 99 in

1999. Similar pattern was observed for U5MR, which dropped from 141 per 1,000 live births in 1992 to 137 in 1996 and rose to 147 in 1999.

Vaccination coverage for at least all antigens has dropped since early 90s and especially after 1996 for several reasons. Irregular supply of kerosene and lack of spare-parts for cold storage facilities meant that for some period of time refrigerators were not working and could not be used for storing vaccines. Vaccination programmes have been affected by global shortage of polio vaccine.

Several measures have been put in place to remedy the situation. Government has allocated funds to districts to enable them purchase kerosene regularly. In case of shortage of funds, district authorities have been asked to make funds available from other sources. In districts where the coverage of vaccination has not been high, efforts are made to re-establish outreach activities and health workers have been provided with bicycles to carry out this task. Special strategies such as accelerated measles control programme (1999 –2003) and polio eradication programme (1996 – 2001) have shown encouraging results. Nation wide active surveillance on acute flaccid paralysis has reported no cases of wild poliovirus. A new vaccine against Hepatitis B, has been introduced in the immunisation programme. This will reduce preventable infections and hence help to reduce IMR and U5MR.

Goal 2: Reduction in Maternal Mortality Rates:

The most recent reliable estimate of maternal mortality from a 1996 survey is that 529 women die in every 100,000 live births. The major direct causes of maternal deaths are unsafe abortion, anaemia, eclampsia, haemorrhage, obstructed labour and puerperal infections. The principle indirect causes are HIV/AIDS, malaria, viral hepatitis, pulmonary tuberculosis and tetanus. In addition harmful traditional practices, inadequate emergency referral system, shortage of service providers with life saving skills, basic equipment and supplies in health facilities contribute largely to maternal deaths.

The rate of HIV/AIDS is increasingly being reported in antenatal clinics. In 1997, the prevalence of HIV infection among pregnant women attending ante-natal clinics ranged from 7.3 to 44.4 per cent in rural areas and from 22.0 to 36.0 per cent in urban areas. Opportunistic infections are also common, while perinatal outcome is also poor with increased frequencies of abortion, ectopic pregnancies and other complications.

Data shows a drop in the care provided to pregnant women. Indicators of antenatal and postnatal care all show a downward trend. Antenatal care coverage has dropped from 62.2 percent in 1992 to 45.6 percent in 1999. Perhaps more worrying is the fact that more and more women, both in urban and rural areas are delivering outside health facilities. In 1992, 52.6 percent of all births were delivered in health facilities compared to 45.1 percent of births delivered in health facilities in 1999. Childbirth care dropped from 43.9 percent in 1992 to 31.1percent in 1999. Decreasing use of health facilities for delivery, pre-natal and post-natal care may be an indication of poor services offered by the health facilities or due to the cost of services provided. However, the government policy is to provide maternal health services free of charge throughout the country.

Goal 3: Reduction of Malnutrition among Children:

Tanzania set itself a target of reducing the severe and moderate malnutrition among under-fives by half. This was to be achieved through encouraging women to breast-feed their children exclusively for four to six months; and then to supplement child's diet with other foods while continuing to breast-feed. Data collected during the three National Demographic Health Surveys (NDHS) show that there has been no marked improvement in the nutritional levels of the children over the decade.

Data on children who are underweight, who suffer from stunting and wasting show no change over the decade. About a third of all children are moderately underweight and around 6 percent are severely underweight. Nearly half of the children are moderately stunted and nearly one fifth are severely stunted. Data by gender is mixed. There are more under-five girls who are moderately or severely underweight than there are boys. However, incidences of stunting and wasting are higher among boys than in girls. Generally, more children in rural areas are underweight, stunted or wasted than children in urban areas.

Tanzania has made progress in reducing micronutrient malnutrition. This has been especially significant in reduction of vitamin A and iodine deficiencies. A national survey, to map out the extent of vitamin A deficiency problem was carried out in 1997. It showed that 24.2 per cent of children between the ages of six months and six years were Vitamin A deficient. To overcome the problem, training of relevant service providers was carried out on diagnosis and management of vitamin A deficiency, as well as management of vitamin A capsules supplementation. Vitamin A tablets were made available in all government and non-government health facilities. Through radio programmes and other means public awareness campaigns were carried out to educate the public on the effects and control of vitamin A deficiency. Also the massive Vitamin A capsule supplementation was carried out through National Immunization Days.

The programme for the control of iodine deficiency disorders (IDD) started in 1985. It aimed at eliminating areas of severe IDD by the year 1993, and virtually eliminating IDD as a problem of public health significance by 2000. To achieve this iodinated oil capsules were distributed in 27 highly endemic districts as a short-term measure. A more permanent solution was to require universal iodination of cooking salt. Iodinated salt is now widely available and about 66 percent of salt is iodised in the country (TRCHS,1999). A survey carried out in 1999 shows that the prevalence of goitre has gone down from 67.8 per cent in 1980s to 23.5 per cent in 1999.

Efforts are currently underway to reduce the levels of anaemia in the country through iron supplementation and de-worming of U5 children in pilot districts. To encourage women to breast feed their children, between 1993 and 1996 nearly 2000 health workers were trained on lactation management.

Goal 4: Increased Supply of Safe Water and Improved Sanitation:

Adequate and safe water supply, and improved sanitation facility are widely recognised as being important determinants of the public health of any country. In Tanzania, however, there is a problem of long distances to water sources especially in rural areas, a major factor contributing to increasing women's workload. Also, there is a problem of adequate clean and safe water. The goal of universal coverage of clean water and sanitation facilities, if achieved, will therefore make a major contribution to improving the situation of women and children.

According to the goals set at the beginning of the decade, Tanzania Mainland had to achieve universal access to safe drinking water and sanitary excreta disposal by year 2000.

The 1991 National Water Policy focused on the involvement of the community in all aspects of the water projects, including operation and maintenance. One of the problems with the earlier schemes was that there was no community participation in the establishment of water schemes. However, several initiatives have been undertaken by the government to empower communities to identify their problems such as establishment of water funds and water committees. The policy also advocated an integrated approach where water and sanitation activities were to be integrated with activities of the sectors of health and community development. By 1999, 92.1 per cent of the urban population and 56.3 per cent of the rural population have access to safe water.

In urban areas, sanitation is closely tied to availability of water. In rural areas excreta disposal is through pit latrines. There has been a slight improvement in access to safe sanitation. Number of people who had access to safe sanitation rose from 83.4 per cent in 1991/92 in rural areas to 84.3 per cent in 1999. In urban areas nearly all have access to safe sanitation. However, figures estimating safe water and sanitation should in general be regarded with some caution, bearing in mind that within communities, degrees of access vary considerably. Also it is estimated that at any given time, up to 30percent of water schemes are out of service.

Goal 5: Improved Access to and Achievement in Basic Education:

Education is a basic human right of every child as well as a basic necessity for the social and economic development of the nation. Education has important benefits in improving productivity, raising income levels, lowering fertility rates, and improving health and nutrition. Therefore the importance of education for child survival, protection and development cannot be over emphasised. There are two issues that need to be discussed in provision of basic education: access and quality.

The policy on Education for Self-Reliance (ESR) set the framework for the national education following the Arusha Declaration in 1967. Through ESR, the government committed itself to providing basic education to every child in the country, with the purpose of ensuring gender equality in education. The government called for general mobilisation to accelerate the achievement of

Universal Primary Education (UPE). Earlier plans expected UPE to be reached in 1989. More than 90 percent of the children between the ages of 7 and 13 were enrolled in schools. The results of the national UPE campaign were impressive, especially in quantitative terms. In 1978, 878,321 pupils were enrolled in Standard One, an increase of 254 percent over the 248,000 Standard One pupils in 1974. The total primary school population rose from 1,228,886 in 1974 to a peak of 3,553,144 in 1983, an increase of 189percent. This striking achievement gained during this period was due to political determination and community mobilisation. However, it was not possible to sustain the high level enrolment.

As a follow up to the WSC, Tanzania reaffirmed its commitment to achieving universal access to basic education. This has not been achieved. Hardly any improvements have occurred in the Gross Enrolment Rate (GER) and Net Enrolment Rate (NER) in the last ten years. The GER and NER have remained around 75 percent and 56 percent throughout the decade. The difference between the GER and NER is mainly due to the implementation of previous/former government policy to enrol in school all children between 7 – 13 years. However in the new Education Policy enrolment is seven years. Twenty-five out of every hundred children who enrol in standard one do not complete seven years of primary education. Drop out is a major problem in mining and urban areas, where boys drop out of schools to supplement family income by doing petty trade. On performance in school, over 80 percent of students entering the Primary School Leaving Examination (PLSE) score less than 50 percent of the subject scores. Only 14 percent of children who complete primary school proceed to public secondary schools and the secondary enrolment rate is as low as 6 percent. However, the girls' performance is low compared to boys in which more than half of the girls sitting for the PLSE score less than 20 percent. This is due to gender disparities in the society.

Goal 6: Reduction of Adult Illiteracy:

Given the importance of literacy in the lives of individuals and their effect on socio-economic development, Tanzania set itself a goal of reducing illiteracy rate by half of the 1990 level. Special attention was to be paid to female illiteracy.

Tanzania intensified its efforts to eradicate illiteracy in the 70s and 80s. By 1986, Tanzania was able to reduce the illiteracy rate to 10 percent, one of the lowest in the developing countries. Since then the rates have been on the increase. By 1990, literacy test results showed that 16 percent of the population were illiterate. The task of halving the illiteracy rate has proved difficult. The number of illiterates has kept on increasing. Enrolment in literacy classes has dropped significantly. Between 1997 and 1999 there was a drop of 40 percent in the number of adults enrolled in literacy classes. The number of illiterate is further inflated by low levels of enrolment and high levels of dropout in primary schools. Current illiteracy rates are estimated to be around 30 percent. Around 36 percent female and 22 percent male are estimated to be illiterate.

Goal 7: Improved Protection of Children in Need Of Special Protection Measures (CNSPM)

Extended families have traditionally provided a safety net for children when difficulties arise. However, in the last ten years the combined impact of extreme economic hardship which lead to abject poverty, and the impact of HIV/AIDS and disintegration of the extended family system have damaged the social fabric. This has resulted in a drastic increase in the numbers of children in need of special protection measures.

In Tanzania the following categories of children are considered as in need of special protection measures:

- Children in institutions e.g. orphanages, approved schools, remand homes, children with disabilities living in institutions; prisons;
- Orphans;
- Abused and neglected children;
- Girls who are married and get pregnant before attaining physical maturity;
- Working children;
- Children living on the street;
- Child commercial sex workers; and
- Children with disabilities.

In terms of numbers, the category that is currently of great concern to the nation is that of orphans. According to the Tanzania Reproductive and Child Health Survey (TRCHS) carried out in 1999, there were 1.3m orphans, most of them as a result of losing one or both parents due to AIDS. The traditional coping mechanisms in such cases where extended families take over care of such children are increasingly under stress. We are seeing the emergence of child headed families where the eldest child takes over the responsibility of looking after younger siblings. Very old family members care for the majority of the orphans and they have limited access to basic social services. Orphans, who are HIV positive, heads of households and with terminally ill parents are the most vulnerable. Orphans often end up as children on street, child prostitutes or domestic workers. They are often vulnerable to sexual and physical abuse. Abuse and the sense of hopelessness that many orphans feel compound the trauma of losing their parents.

Efforts to provide institutional care for CNSPM are shared by the government and several NGOs, religious institutions and CBOs. As a first step, the government has strengthened the legal provisions as a step towards protecting these children.

(b) <u>Zanzibar</u>

The situation faced by women and children on the mainland is replicated to a large extent on the Isles as well. Heavy workload, poor nutrition, poor economic conditions, high illiteracy rates, high risk of contracting diseases such as malaria, as well as the HIV/AIDS pandemic all affect women and children in the Isles.

Women still provide 70 percent of the labour force for agriculture but their earning potential is constrained by small plots and limited access to credit and modern technology. Some women have turned to non traditional acitivities such as seaweed farming to supplement their income but recent downward trends in the world price have reduced enthusiasm for this endeavour. Low earning capacity and limited authority within the household are important factors, which reduce the capacity of women to provide quality care for their children.

Goal 1: Reduction of Infant Mortality:

The mortality rates as of 1992 were 120 for infants and 202 per 1000 live births for under five. Currently the IMR and under U5MR are estimated to be 83 and 114 respectively. The goal of reducing mortality rates to 50 and 70 respectively by year 2000 has not been achieved. This is due to the high prevalence of malaria, malnutrition and acute respiratory infection and diarrhoea.

With regard to combating childhood diseases through low-cost remedies and through strengthening primary health care and basic health services, the Integrated Management of Childhood Illness (IMCI) has been adopted by the Zanzibar government, with UNICEF supporting its introduction in three districts (North A, South and Micheweni districts). Capacity building exercises for communities at high risk for malaria have been done to establish strategies aimed at improving malaria prevention and control activities. Routine EPI services (also supported by UNICEF) have helped maintain immunisation rates at over 80 per cent. NIDs coverage in 1998 stood at 94.4 percent and 99.6 percent in the first and second round respectively.

Goal 2: Reduction in Maternal Mortality Rates:

The maternal mortality rate (MMR) which in 1991 was 314 per 100,000 live births has gone up to 377. The major causes of MMR are eclampsia, puerperal sepsis, obstructed labour, and antepartum haemorrhage. Increasing rates of HIV/AIDS cases in recent years have had a marked effect on MMR. HIV/AIDS prevalence among pregnant women jumped from 1.0 percent in 1994 to 3.7 percent in 1995. On the prevention and treatment of AIDS, District AIDS Committees (DAC) have been established together with community committees.

Goal 3: Reduction of Malnutrition among Children:

The 1992 levels for the moderate and severe malnutrition in under fives were 37 percent and 5 percent respectively. The current status is estimated at 25.8 percent for moderate and 7.0 percent for severe malnutrition respectively. The desired levels have not been reached due to several factors which include the low purchasing power of the community, diseases e.g. malaria, ARI and diarrhoea as well as food production and feeding practices. The burden of Protein Energy Malnutrition (PEM) is seen more in North Unguja and North Pemba regions.

To overcome malnutrition, several village committees have received CSPD integrated training so as to be able to address health and nutrition problems. This has resulted in the re-establishment of community based growth monitoring and promotion (GMP). Growth monitoring and promotion training have also been conducted with PHC staff.

Breast feeding topics were included in the training workshops in order to protect, promote and support breast-feeding activities.

Goal 4: Increased Supply of Safe Water and Improved Sanitation:

Water in Zanzibar is primarily obtained from ground water. In 1992, the access to safe water for Unguja Island was estimated at 65 percent while that for Pemba was 16 percent. Sanitary means of excreta disposal was 67 percent and 24 percent respectively. The current (2000) status of access to good quality water is estimated at 75 percent for the urban population and 50 percent for the rural population. In 1999 access to safe water has increased to 74 percent in Unguja and to 73 percent in Pemba. The Sanitary excreta disposal has increased from 67 percent to 73 percent in Unguja and 24 percent to 51.6 per cent in Pemba. These levels of coverage are a result of completion of small water projects built through community mobilisation.

Goal 5: Improved Access to Basic Education:

The GOZ reiterated its commitment to provide access to education to all its citizens. The adoption of resolutions of the World Conference on Education for All and the National Summit for Children resulted in the formulation of Zanzibar Education Policy in 1991 and its revision in 1995. An education sector review was carried out in 1995 and a ten-year Zanzibar Education Master Plan (ZEMAP) (1996 – 2006) was launched. In implementing the Master Plan, the government of Zanzibar committed to increasing the share of education budget from 14 percent to 20 percent of total expenditure.

Some of the goals of the World Conference on Education For All and the National Summit for Children were incorporated in the ZEMAP. The Master Plan envisaged attainment of a pre-school GER of 100 percent (for the 4-6 age group population) by the year 2006. Access to primary education was to be raised from the (1996) GER of 81.2 percent to 100 percent by the year 2006. In order to negate the effect of dropouts on the literacy rates, it was planned to involve 50 percent of dropouts of ages between 10 to 16 in non-formal and informal alternative education arrangements by the year 2001 and all of them (100 percent) by the year 2006.

The NER in primary education has increased from 50.9 percent in 1991 to 67 percent in 1997. At primary school level female/male ratio has been around 1.0 throughout the decade. In order to increase access to basic education, communities in many areas have started building classrooms to alleviate the shortage of space in schools. The recent move by the government to allow private provision of education is also expected to further increase access.

Major problems in the education sector still remain to be addressed. Throughout the 90s, education sector has remained under funded. Allocations to education in the budget have never exceeded 14 percent of total. Shortages of classrooms have limited the number of pupils enrolled in schools. The drop out in primary school is high, around 30 percent. The quality of education has remained poor, most of the school leavers lack necessary skills for employment or for self-employment.

In Zanzibar, child-care is traditionally provided at home by the family. Women are responsible for taking care of infants and young children. Pre-schools have in recent years been playing a more prominent role in providing care and education for young

children between the ages of four to six years. Currently there are 15 formal pre-school centres with an enrolment of 13,046 children. Koranic schools, which number around 1000, have an enrolment of over 200,000.

Goal 6: Reduction of Adult Illiteracy:

In 1986, the adult literacy was estimated to be 61.5 percent. Literacy among men is higher than in women and in Unguja compared to Pemba. Throughout the decade, efforts to reduce adult illiteracy have not been successful due to low attendance and high dropout from literacy classes. The literacy campaigns, which were very active in 1970s and early 1980s, have lost steam. Most of the traditional literacy programmes, which emphasised 3R's, were not well received by many of the learners. According to ZEMAP the adult literacy rate was to increase from 60 percent to 85 percent by the year 2006.

Data on the current situation of adult literacy in Zanzibar are not available, but it is assumed that the rate has not increased significantly from the 61.5 percent in 1986. In order to create more interest in literacy, the department of Adult Education has started demand- driven adult literacy programmes targeting specific clients such as fishermen, farmers and women's income-generating groups. However, the number of such programmes is still too small to generate a significant increase in the literacy rate.

Goal 7: Improved Protection of Children in Need Of Special Protection Measures (CNSPM)

In Zanzibar children included in CNSPM categories are children with disabilities; children with HIV/AIDS, orphans, children of children due to early marriage and high divorce rate; children in the labour market; and sexually abused children. Despite the efforts of the government and various NGOs, the problem remains critical due to economic changes and weak support from their respective families as well as communities. Efforts to support this group of children are made more difficult by lack of accurate data in each category.

E. LESSONS LEARNT

In summary, most of these statistics show that there has been little progress for children in the 1990s and some critical indicators have worsened. There are reasons for the little progress. In 1991, Tanzania adopted the WSC goals out of which further analysis show that national capacity, both in terms of financial and human resources could not adequately provide resources for smooth implementation of programmes to achieve these goals. The following section examines some of the factors influencing the achievements or non-achievement of the goals.

1. Political will:

Tanzania political will was demonstrated by Tanzania delegation to the WSC led by the President of the country. In 1991, a special session of the Parliament was held to endorse the WSC goals and set out modalities on how these goals would be achieved.

2. **HIV/AIDS:**

A key factor in explaining why progress has been reversed in several areas, such as infant, under-five and maternal mortality rates, is the growing HIV/AIDS pandemic. HIV/AIDS has over the decade evolved from being a health crisis to become a developmental crisis. One likely impact of the increasing HIV prevalence rate in Tanzania, which currently is estimated to be 10 percent, is a higher rate of child mortality. Still many babies are being infected with the virus at birth, and recent figures from National Aids Control Programme (NACP) show that 70,000-80,000 newly born were infected annually. It is also known that 80 percent of those infected at birth do not survive their second birthday and at the age of five very few will still be alive. Being infected with HIV through breast milk as well, children are indeed suffering in the most direct way from the HIV/AIDS pandemic.

3. **Poverty:**

At the core of Tanzania's problems is the basic poverty that is prevalent in the country. Initiatives taken to overcome or reduce poverty have not yet borne fruits. Policies such as PRSP and benefits to accrue as a result of HIPC initiatives will take time to filter down to the grassroot level. Tanzania has put in place policies, which should begin to affect positively the lives of women and children in the country soon. The Country, like many third world countries, is trapped in the cycle of debt. The recent initiatives taken at the macro level has qualified Tanzania for HIPC assistance.

4. **Prevalence of Disease:**

Another important factor affecting mortality rates is the consistently high rate of malaria and diarrhoea infections among children below five years. Increasing resistance of common malaria drugs to the parasite suggest that the treatment of malaria is becoming still less effective and it is estimated that up to 45 percent of all child deaths are attributable to malaria. Likewise the prevalence of diarrhoea is a threat to the health. Poor nutrition exacerbates the impact of disease.

5. **Declining Use of Facilities**:

Inspite of the fact that there are safe motherhood initiatives and free MCH services, it has been reported that in rural areas there are more women delivering at home where traditional birth attendants attend majority of deliveries instead of health facilities. This situation has arisen largely due to direct and indirect costs of using health facilities.

6. **Social Practices:**

Several social practices affect both children's and maternal mortality rates. Women's heavy workload during pregnancy, especially in rural settings affect both their health and that of their children. The culture that glorifies motherhood in terms of children borne encourages women to have many children with inadequate time between pregnancies. This prevents women from recovering and gaining strength. Fertility rates are over 5.8 and the rate of contraceptive acceptance is only 16 percent. The mean interval between births is less than two years. Conditions for mother and child are also affected by early marriages. Over one-third of women give birth before they are physically mature. Chronic under-nutrition throughout childhood contributes to young women having short stature, which puts them at

greater risk at childbirth. Women's poor health combined with heavy workload, even during pregnancy, result in high maternal deaths.

7. **Education:**

One area that is of major concern is that of education. Stagnant enrolment, high dropout rate, relevance of the education provided, are, all issues of concern. The resources for education are not sufficient for the requirements and internal inefficiency in the education system is a problem. In order to increase resources going to primary education, communities are encouraged to contribute towards running of the schools**.**

8. **Liberalization of the economy:**

Liberalization of the provision special social services has increased the number of schools as well as health facilities and many people have access to these facilities at a cost. This has eased congestion in public facilities.

9. **Cost Sharing:**

The cost sharing policy has created an opportunity to improve the quality of education and health services. However, due to poverty, there are some people who are unable to meet the costs. However, the government has instituted measures to allow them free access to essential health services such as mother and child, prenatal and delivery care, and for epidemic diseases such as cholera, tuberculosis, etc to pregnant mothers and children under five years.

F: FUTURE ACTIONS

1. Political Will:

It is necessary to match political will with concrete action. One important way of ensuring success is to put in place a monitoring and evaluation mechanism.

2. Co-operation:

Given the magnitude of the problems, it is through the concerted efforts of the Government, community, NGOs and bi-lateral and multi-lateral donors that the problems facing women and children can be addressed. Recent policy initiatives are aimed at devolving decision-making powers from central government to local levels. Reforms such as Local Government Reform aim to shift decision making to the district and village levels. As issues that concern women and children have their roots in the culture of the people concerned and in their economies, strategies adapted need to aim to make changes at the family, village (community) and district levels, as well as at national and international levels.

3. Actions at different Levels:

- **Family Level:**

Experience in Tanzania and in neighbouring countries has shown that there are effective traditional mechanisms and practices that can be strengthened to the advantage of children in general and vulnerable children in particular. Along side with traditional practices, child rights and developmental approaches should be adopted.

Most of the care of children happens at the household level, and the community has the crucial role to support the efforts of the family. Therefore efforts will be made to strengthen the capacity of families and communities to effect optimal child-care and to enhance the mother's caring capacity as a primary duty-bearer. One important challenge in this aspect is the nutrition of the mother. As shown earlier, many mothers are anaemic during pregnancy which not only affects the babies they give birth to, but seriously affects their ability to breast feed and care for their babies. Immediate improvement in nutrition of mothers and reduction in the their workload, especially during pregnancy depends to a large extent on the attitude of families towards women. As these differ among different ethnic groups, programmes that take into consideration local conditions will have to be developed. In this respect, the role of NGOs can be crucial - they can become the sensitising agents within the community.

- **Village Level:**

Integration of all aspects of childcare, that is health, nutrition, WES and early stimulation has the potential to bring about optimum child development, with implications for policies and programmes that address the child holistically. A multisectoral approach to early childhood development has been found to be the most appropriate way of achieving better results.

A community based strategy for early childhood survival, growth and development needs to be developed. Communication strategies that address the issues of care for women during pregnancy, child-care, care during illness, and hygiene need to be developed. Improvement of routine community-based monitoring and evaluation of maternal deaths should be given special attention, so that there is exhaustive analysis by community health workers and leaders of each maternal death that occurs in the village. This will lead to a better understanding of immediate underlying and basic causes of the death and more rapid action to improve the situation. Community-driven management and monitoring information systems must guide action at all levels.

Also there is need for promotion of positive cultural and social factors related to food intake, reduction of women's workload by introducing appropriate technologies and reduction of workload in home and community. Advocacy and support for increased rest for pregnant and breast feeding mothers should be enhanced.

Another area where communities could come together to solve their problems is water and education. Communities should be encouraged to establish a water fund, which could be used for rehabilitation of existing sources and for construction of new water projects. In the field of primary education there are several initiatives that tap community

resources. There is a pilot project which is funded by the World Bank to support government efforts in provision of basic education. The project provide financial support for community education fund by providing matching grants to communities to be used at the discretion of local communities. Many communities have been able to improve the school environment through this scheme. HIV/AIDS is another issue that needs an open debate at the village level.

- **National Level:**

Community based action cannot occur overnight. Communities need support at national level. The Local Government Reforms provide the framework within which communities can be nurtured and supported to plan their development programmes. This will also mean that resources be provided where they do not exist. These can be used more effectively provided that people have improved knowledge and understanding concerning their problems, and support from outside is available to them.

- **Empowerment:**

A key component of community-based development approaches is empowerment of communities and their institutions. This means building and strengthening organisational and management capacities at community, village and district levels. The goal should be to enable communities themselves to identify and analyse problems and take appropriate action to address them through application of an empowerment framework. Advocacy, training, management information system and support for resource mobilisation and management are means through which communities can achieve empowerment. The Local Government Reform will more systematically incorporate a participatory methodology of identifying opportunities and obstacles to development to strengthen community-based planning processes. The community should be economically empowered especially women by providing entrepreneurial potential, more role in income generation and employment opportunities.

- **Education:**

The government is responsible for facilitating the provision of basic education to all its people. Education and Training Policy (ETP) emphasises the government's role in providing the necessary infrastructure and the need for the communities to take more control over the management of their schools. The government has instituted the cost sharing policy.

- **Co-ordination:**

Tanzania appreciates the efforts from all concerned, the government, communities, NGOs, bi-lateral and multilateral donors. In the past this has often led to a multiplicity of projects and duplication of efforts. In the field of education and health there are efforts to co-ordinate activities of various donor and NGO supported projects to ensure maximum benefits for the efforts made.

- **Self-Reliance:**

Although, Tanzania realises the importance of donor support to various development programmes in the country, it is also aware that such assistance is neither permanent nor unconditional. The assistance provided should only be as supplementary to government efforts. Tanzania, while welcoming assistance, will need to build a more self-reliant approach to its development efforts.

- **Poverty Reduction:**

Efforts need to be concentrated on poverty reduction. Poverty has an effect on all aspects of women and children's lives. Poverty reduction efforts should concentrate on ensuring food security; provide social safety nets in cases of natural disasters such as famine and floods; and providing employment and income generating opportunities for youth and women.

- **Good Governance and Accountability**:

Ensuring appropriate use of power, whereby the rights of children are respected and protected. It is important that democratic processes are extended to children so that they can contribute to decision making on issues that concern them as well as they concern their families, communities and nation.