Situation Analysis
of Children in Tanzania
Acknowledgements

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Foreword

Tanzania's children have been the subject of several important reports during this past year: the Report to the United Nations Committee on the Rights of the Child; the National Report on the Follow-up to the World Summit for Children; and this Situation Analysis, which attempts to synthesise information about the condition of children in a manner which will be widely accessible for planners and activists at many levels. You will see from these reports that the situation of Tanzania's children is largely not a good one, and in some respects it has been declining.

This trend must be turned around, if we are to achieve the sustainable human development that we are aiming for in our Development Vision 2025. There is, however, an increasing realisation that this is not just the responsibility of the Government, or NGOs or international organisations, but the responsibility of each and every one of us. Everybody has a role to play, including children themselves.

We can no longer exclude children- 50 per cent of the population-from the development process. Not only because children have the right to be included, to have their opinions heard, but because their input is beneficial to the process. Listen to children and you will be surprised by their understanding of the issues, and the practical ways they suggest to deal with them.

According to the National Report on the Follow-up to the World Summit for Children (MCDWA.C., 2000) the situation of children in Tanzania indicated a decline due to the inability of attaining the required goals. However, developments at the macro-level are encouraging, and this gives us reason for optimism. The huge challenge is to bring these positive developments to the micro-level where they can impact positively on the situation of children.

We are, in Tanzania, determined to provide an environment conducive for children to grow up healthy, educated and in dignity. All stakeholders must remember to have the best interest of children at the centre of all development policies. And, we need to do this not just for the children of Tanzania, but with the children of Tanzania.

I count on your commitment to play your part.

Benjamin William Mkapa
PRESIDENT OF THE UNITED REPUBLIC OF TANZANIA

Dar es Salaam
8 January 2002
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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>AZT</td>
<td>Azidothymidine (chemical name) or Ziduvodine (generic name)</td>
</tr>
<tr>
<td>BCG</td>
<td>Vaccine for Tuberculosis, named after Bacillus Carmet Gengeu</td>
</tr>
<tr>
<td>BEDC</td>
<td>Basic Education Development Committee</td>
</tr>
<tr>
<td>BEST</td>
<td>Basic Education Statistics for Tanzania</td>
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<tr>
<td>BM C</td>
<td>Bugando Medical Centre</td>
</tr>
<tr>
<td>BOT</td>
<td>Bank of Tanzania</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>CCM</td>
<td>Chama cha Mapinduzi</td>
</tr>
<tr>
<td>CFS</td>
<td>Child Friendly School</td>
</tr>
<tr>
<td>CG</td>
<td>Consultative Group</td>
</tr>
<tr>
<td>CHSB</td>
<td>Community Health Services Board</td>
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<tr>
<td>CNSPM</td>
<td>Children in Need of Special Protection Measures</td>
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<tr>
<td>COBET</td>
<td>Complementary Basic Education in Tanzania</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSPD</td>
<td>Child Survival, Promotion and Development</td>
</tr>
<tr>
<td>CUF</td>
<td>Civic United Front</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
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<tr>
<td>DPT</td>
<td>Diphtheria Pertusis Tetanus</td>
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<tr>
<td>ECC/SGD</td>
<td>Early Childhood Care/Survival Growth and Development</td>
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<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>EFA</td>
<td>Education for All</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>ESDP</td>
<td>Education Sector Development Programme</td>
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<tr>
<td>ESRF</td>
<td>Economic and Social Research Foundation</td>
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<tr>
<td>FAWE</td>
<td>Forum for African Women Educationalists</td>
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<tr>
<td>FemAct</td>
<td>Feminist Action Coalition</td>
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<tr>
<td>GBI</td>
<td>Gender Budget Initiative</td>
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<tr>
<td>GER</td>
<td>Gross Enrolment Rate</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>Hb</td>
<td>Haemoglobin</td>
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<tr>
<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<td>HRHT</td>
<td>Human Resources for Health Team</td>
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<tr>
<td>HSR</td>
<td>Health Sector Review</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>IM CI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IM F</td>
<td>International Monetary Fund</td>
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<td>IM R</td>
<td>Infant Mortality Rate</td>
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<td>IPEC</td>
<td>International Programme on the Elimination of Child Labour</td>
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<tr>
<td>ITN</td>
<td>Insecticide Treated Nets</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
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<tr>
<td>KINET</td>
<td>Kilomberu Valley Insecticide Treated Nets Programme</td>
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<tr>
<td>KIWOH EDE</td>
<td>Kimanga Women’s Health and Development Organization</td>
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<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
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<tr>
<td>MCDWAC</td>
<td>Ministry of Community Development, Women Affairs and Children</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MNT</td>
<td>Maternal and Neonatal Tetanus</td>
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MOE  Ministry of Education, Zanzibar
MOEC  Ministry of Education and Culture
MOF  Ministry of Finance
MOH  Ministry of Health
MSD  Medical Stores Department
MTCT  Mother to Child Transmission
NACP  National AIDS Control Programme
NER  Net Enrolment Rate
NFE  Non-formal education
NGO  Non-Governmental Organisation
OC  Other Charges (non-salaried expenditures)
OPM  Oxford Policy Manual
ORT  Oral Rehydration Therapy
OSC  Orientation Secondary Class
PE  Personal Emoluments
PEDP  Primary Education Development Plan
PEM  Protein-Energy Malnutrition
PER  Public Expenditure Review
PHAST  Participatory Hygiene and Sanitation Transformation
PMCT  Prevention of Mother to Child Transmission
PO-RALG  President’s Office, Regional Administration and Local Government
PRSP  Poverty Reduction Strategy Paper
PSLE  Primary School Leaving Examinations
PTCT  Parent to Child Transmission
PTR  Pupil to teacher ratio
REPOA  Research on Poverty Alleviation
RFS  Rural Food Security
SP  Sulfadoxine Pyramethamine
STI  Sexually Transmitted Infections
TACAIDS  Tanzania Commission for AIDS
TADREG  Tanzania Development Research Group
TAS  Tanzania Assistance Strategy
TCDD  Tanzanian Coalition on Debt and Development
TDHS  Tanzania Demographic Health Study
TFNC  Tanzania Food and Nutrition Centre
TGNP  Tanzania Gender Networking Programme
TRC  Teachers Resource Centre
TRCHS  Tanzania Reproductive and Child Health Study
TSED  Tanzania Socio-Economic Database
Tshs  Tanzanian shilling
TTC  Teacher Training College
U5MR  Under-five Mortality Rate
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNESCO  United Nations Educational, Scientific and Cultural Organisation
UNHCR  United Nations High Commission for Refugees
UNICEF  United Nations Children’s Fund
URT  United Republic of Tanzania
USD  United States dollar
VCCT  Voluntary Confidential Counselling and Testing
VHW  Village Health Workers
VVF  Vesico-Vaginal Fistula
WFP  World Food Programme
WHO  World Health Organisation
WID  Women in Development
ZEMAP  Zanzibar Education Master Plan
ZPRP  Zanzibar Poverty Reduction Paper
Map of Tanzania
Introduction

A CHILD IN THE CITY
- More schools
- TV, newspapers, radio, computers
- Access to safe water
- Immunization - higher
- Malaria prevention - higher

A CHILD IN THE VILLAGE
- Worse schools
- Poor nutrition
- Less opportunity
- Service far away

Are we living in the same Tanzania?
Human rights and development

This report is informed by a human rights perspective to children's wellbeing and development. Its basic premise is that development and human rights are closely linked and mutually reinforcing. Human rights expresses the bold idea that all people - including children and young people - have claims to social, economic and political arrangements that secure them a life of freedom and dignity and protect them from deprivation and harm. Human development, in turn, is a process of enhancing human capabilities to enable each person to live a long, healthy life of value and respect (UNDP, 2000b).

Human rights add value to the development agenda. They draw attention to the imperative to respect, protect and fulfill the rights of all people, such that ensuring children's wellbeing is no longer a matter of charity or goodwill but obligation and accountability. In this light, children are no longer mere recipients of services but subjects of rights. The tradition of human rights also brings a deep history of collective organising for justice and social change - as well as practical legal tools and institutions such as laws, due process and an impartial judiciary - that are essential to sustainable development.

The rights perspective places special emphasis on those who are excluded, vulnerable or deprived, particularly when these are caused by discrimination. It directs attention to the need for access to information and political voice for all people - including children and young people, and especially the poor and marginalised - and to civil and political rights as being integral to the development process. In this sense human rights are not neutral. They stand for clear values and truthfulness; and they express solidarity with those who are oppressed and criticise those in positions of authority who abuse their powers (Santos Pais, 1999).

The human rights of children generate duties and responsibilities that must be honoured. The primary obligation lies with the State and its representatives, to provide the services and create the conditions that are necessary for the fulfillment of rights. But duties also lie at all levels of society, from the individual to the international levels. Perhaps the most important is the community level, where children live, and where most rights are fulfilled or violated. Thus engaging with communities in the development of community capacity to recognise, respect, fulfill and promote rights is vital. This includes strengthening the capacity both of rights-holders to articulate, organise and claim their rights, and of duty-bearers to listen and act responsibly in kind. It is in effect the creation of a dynamic environment for accountability.

Building capacity for accountability is not just a matter of training or skills-building. For a person to be held accountable, three other conditions must be satisfied. First, the person must accept the responsibility to carry out the duty. Second, she or he must have the authority to carry out the duty. Lack of authority means that the requisite power is vested in someone else, or that someone must facilitate such authority in the person who has accepted the responsibility. Third, the person must have access to and control of resources required for meeting the obligation. Programming for human rights requires action in all three areas (UNICEF, 2001h).

The Government and Parliament of Tanzania have expressed a clear commitment to human rights. The Constitution recognizes the fundamental rights and freedoms of all citizens. The country's Vision 2025 document places democracy, empowerment and popular participation at the heart of development (see chapter 1). The Government has also ratified several important human rights treaties, including the United Nations Convention on the Rights of the Child (CRC) and the Convention on the Elimination of
All Forms of Discrimination against Women (CEDAW). Recent Government policy decisions, including the process of local government reforms, aim to create greater space for public participation in governance and development.

The partnership between Tanzania and the United Nations (UN) is grounded in respect for human rights, a commitment to promote sustainable human development and a desire to create conditions for democratic public participation in the development process. The UN Development Assistance Framework (UNDAF) for Tanzania, whose development has been guided by Government decisions and policy positions, embodies this commitment. The UNDAF aims to achieve greater coordination, effectiveness and efficiency in the UN system. This is especially important in the support of local government reform/decentralisation processes and the associated sectoral development programs (URT and UN, 2001). This analysis of the situation of children complements the analytic work that informs the UNDAF process.

This analysis is also informed by the principles outlined in the guidelines on the operationalisation of human rights programming, developed by the UNICEF East and Southern Africa Regional Office (UNICEF, 2001h).

The situation of children in Tanzania

Tanzania has made important strides in recent years in maintaining relative stability and improving macroeconomic performance. The rate of inflation has been reduced from 34% to 6% between 1994 and 2000. Government revenues have increased and public expenditures have been better controlled. Debt relief has been secured through the Highly Indebted Poor Countries (HIPC) initiative, which is intended to make additional resources available for poverty reduction. The Government has articulated the country's key development priorities and strategies in the Poverty Reduction Strategy Paper (PRSP), which places special emphasis on improvements in education, health, water and good governance, areas that are crucial to child wellbeing. A brief overview and analysis of these issues is provided in Chapter 1.

The country's 'macro' developments are important achievements. But they have yet to be translated into concrete improvements in the lives of children. At the beginning of the twenty-first century and forty years after independence, the rights and wellbeing of children are far from being assured in Tanzania. As the Government's review of progress following the 1990 World Summit for Children and report to the Committee on the Rights of the Child make clear, Tanzania has not met the 2000 targets (MOCDWAC, 2000; URT, 1998), and is far from being on track to meet 2015 international development target and Vision 2025 goals. Instead, virtually every critical measure of child wellbeing stagnated or declined through the 1990s. In its discussion of the Tanzania report in June 2001, the Committee appreciated the economic constraints facing the Government, but noted that a number of critical measures to promote child rights could nonetheless be taken immediately, including in legal reform and improving juvenile justice.

The situation of young children of 0 to 6 years is discussed in depth in Chapter 2. Their situation continues to be precarious. The proportion of births delivered at health facilities and by skilled personnel declined through the 1990s, placing both the mother and child at great risk of illness, injury and death. Infant and child mortality rates also increased slightly, such that one in every six children fails to make it to their fifth birthday. Despite some important recent initiatives, the major childhood illnesses - including malaria, acute respiratory infections and diarrhoea - continue to kill, maim and debilitate millions each year. Stunting, which can have permanent negative effects that last well into adulthood, retards the growth of almost half of Tanzania's children. The
Children in their schooling years, aged 7 to 13 and in some cases older, likewise fare poorly. After recording impressive gains in primary school enrolment in the 1970s, less than one half of all children completed primary education at the end of the 1990s. The quality of schooling is extremely poor throughout the country. Dilapidated classrooms, shortages of toilets and water facilities, lack of books, ineffective teaching methods, and violence and intimidation, particularly against girls, are the norm. Many teachers lack the skills, support and motivation needed to help children learn. Given these circumstances, it is no surprise that learning achievement is so low, with less than one quarter passing the primary school leaving examinations (PSLE) in 2000. In 2001, the Government launched the Primary Education Development Plan (PEDP) to expand enrollment, improve quality and strengthen institutional and financial arrangements in basic education. The plan is an important indicator of Government commitment and resolve to improve education, but successful implementation will be the true mark of progress. At the same time, deeper questions of the meaning of education and how to educate children to thrive and become active, critical and creative citizens are yet to be addressed. Chapter 3 provides a detailed analysis of children in their primary schooling years.

Chapter 4 discusses the rights and wellbeing of adolescents and young people, whose situation is perhaps the most critical. Their circumstances and quality of life are not as well documented, in part because adolescents have less contact with Government institutions and because issues important to them are often difficult to measure. But for the same reasons there has traditionally been far greater attention to younger children and a paucity of programmes for adolescents, leaving them without the institutions and supports they need for development. This is especially significant in the context of growing evidence that many adolescents are gradually excluded from basic family and community assets, resources and other supports. Post-primary education, which could provide young people with the means to transform their situation, is still highly exclusive. Only 6 in every 100 Tanzanians of secondary school age have access to lower secondary education, and only 1 in every 100 goes to upper secondary school. Often, young people’s growing bodies and onset of sexual activity are not a blessing but a burden that adolescents find hard to deal with without support from sympathetic and knowledgeable adults.

Chapters 2-4 describe the situation of children and young people on Tanzania Mainland. Chapter 5 focuses on Zanzibar, and covers many of the same issues discussed above. The development challenge in Zanzibar is equally daunting, and the inequities between its constituent islands of Unguja and Pemba are especially stark. Progress towards realising children’s rights has been compromised by disputed elections and political conflict, and the consequent withdrawal of funding from some large donors. However, in late 2001 the two main political parties on the islands signed an agreement on the way forward, and this has provided moderate optimism for creating an enabling environment for social development.

All the chapters discuss HIV/AIDS, whose full impact on Tanzanian society is now apparent. By the end of 1999, an estimated 1.3 million Tanzanians were living with HIV, and 700,000 orphaned children were living in difficult circumstances. These data, which have been used throughout this report, may in fact be a significant undercount. Methods
used to estimate prevalence of HIV and orphanhood may miss counting some of the most affected groups because they are less likely to participate in household surveys or use services. Indeed, community surveys in six districts indicate that numbers of orphaned children are in some cases more than double the estimated national average. AIDS debilitates and kills thousands of teachers, health workers and other caretakers, the very people who are most needed to provide prevention education and care. Children are often hit the hardest, as parents fall ill and scarce resources are devoted to treatment, or expropriated by others after their parents' death. Young people are at particular risk, with 60% of all new HIV infections occurring among the 15-24 age group. Yet the coverage and quality of life-skills based sex education and services for young people are clearly inadequate. In recent years, the Government has made a firm, high-level commitment to dealing with HIV/AIDS. The ramifications of the disease - on basic services, on productive capacity and on the social fabric - are yet to be fully understood. Work is needed at all levels, especially in supporting community networks to cope with and respond to HIV/AIDS.

**Equity and governance**

While the challenges outlined above affect most children and adolescents in Tanzania, some are more disadvantaged than others. Rural-urban differentials are especially stark. On virtually every aspect, children in rural communities do less well than urban children. Children and young people in urban areas have higher rates of immunisation, nutrition, survival, bednet protection against malaria, health care, access to water and sanitation, primary and secondary education, examination scores, media access, and sexual and reproductive health services. Even within rural areas there are major relative differences, as can be seen in ward level comparisons where data are available. People in rural areas are disproportionately poor, and many of the rural-urban differentials may in fact be a marker of poverty. Precise information on wealth and income levels is not available, but an analysis of the 1996 Demographic and Health Survey (DHS) data and other evidence used in this report clearly shows that the poor do worse, and that many basic opportunities remain the preserve of the richer segments of society.

Gender disparities in Tanzania are also significant, but not in every aspect. Most indicators show boys and girls do equally well in their early years. Contrary to popular perception, female primary school enrolment is generally on par with males, save in some areas, and overall fewer girls dropout than boys. Enrolment differentials emerge at secondary school, and increase significantly further up the education pipeline. But the quality of schooling and community experience is clearly marked by gender discrimination from the earliest ages, with girls confronted with extra responsibilities, insulting stereotypes, sexual harassment and violence, and lack of equal opportunity on many fronts. In particular, female participation in decision-making is often compromised by discriminatory attitudes and practices. These circumstances disadvantage girls such that they are less able to protect themselves and promote their own interests, and thus also less able to live a life of safety, freedom and dignity.

Children and young people with disabilities are probably the most disadvantaged group in Tanzania, often hidden and excluded from life's basic opportunities, though precise demographic data on the extent of the problem are not available. Children from pastoralist and refugee communities do less well too, particularly in relation to education. Other groups of young people, such as child laborers, orphaned children, street children and children in prison are often especially vulnerable to stigma and discrimination.

In short, Tanzania is far from being an equal society. The deep level of disparity and inequity across the country is a major theme of this report. Being a child in Tanzania can
mean different things, depending on family income, parent's level of education, rural-urban location, sex, disability or other factors.

The other major theme of this report is governance. While technical aspects are important for effective programme planning and implementation, the human rights perspective focuses attention on the extent to which social and political arrangements enable people to express themselves and participate meaningfully in decision-making. Tanzania has an elaborate structure of participatory decision-making down to the village and urban neighbourhood levels. In practice, however, the extent of public participation is extremely limited, lopsided and of poor quality. In most cases ordinary people are unable to access local councils and committees, which tend to be either dormant or dominated by few individuals. Young people have even less access, and are increasingly marginalised and excluded from resources, assets and opportunities they need to secure a decent life.

The allocations and flows of public funds provide good indicators of how public benefits are distributed across the country, and of the institutional arrangements in place to ensure they are put to good use. This report therefore pays considerable attention to financial issues, particularly in relation to the priority education, health and water sectors. It includes new analysis of the allocation of non-salary disbursements to local councils in these sectors. Recent Government decisions to broaden involvement in the public expenditure review (PER) process and publish disbursement data in local newspapers has enabled this analysis and created greater opportunity for scrutinising use of public funds.

Children and young people make up more than half the population of Tanzania. This report argues that their inclusion at the centre of the development agenda and human rights process is necessary for Tanzania to achieve sustainable human development and a vibrant, open and democratic society. Creating the conditions in which children are respected and cared for, where they learn, grow and thrive, and where they become confident, creative and critical citizens is essential for the fulfillment of their rights, and essential for the country's vitality. Tanzania can afford no less.
Chapter 1

The Development Context

Tanzania Annual Rate of Inflation

IT IS COMING DOWN!


YES!

STILL WONDERING HOW DO I GET WHAT I NEED...
Conditions for children in Tanzania did not improve during the 1990s. Nonetheless, the Government and other observers maintain that overall developments in Tanzania have been positive, and that the country is now in a better position to move towards sustainable reduction in human poverty. They point to the important changes that have taken place at the ‘macro’ level, or in the broader political and socio-economic context of the country. This chapter examines key developments in this context, and discusses some of the critical issues and assumptions involved.

Tanzania’s Constitutional framework provides for the Union Government of the United Republic of Tanzania, comprised of the mainland and the islands of Zanzibar. The Government of Zanzibar has jurisdiction over many aspects of development on the isles, including education, health and other services of importance for children. The Constitution provides for elections every five years, and several political parties have contested the past two elections, in 1995 and 2000. Chama cha Mapinduzi (CCM) remains the overall dominant party and has won the elections on both occasions.

Tanzania’s Development Vision 2025 and Vision 2020 for Zanzibar articulate the agenda for the country’s development. High rates of economic growth have been envisioned, and a better educated, healthy population. Targets have been set, including targets for educational achievements and reductions in child and maternal mortality. Emphasis is put on stronger, accountable and transparent systems of governance, with greater public participation in democratic governance.

### Vision 2025

**The Targets**

- **High Quality Livelihood**
  A high quality livelihood for all Tanzanians is expected to be attained through strategies which ensure the realisation of the following goals:
  - Food self-sufficiency and food security
  - Universal primary education, the eradication of illiteracy and the attainment of a level of tertiary education and training that is commensurate with a critical mass of high quality human resources required to effectively respond and master the development challenges at all levels
  - Gender equality and empowerment of women in all socio-economic and political relations and cultures
  - Access to primary health care for all
  - Access to quality reproductive health services for all individuals of appropriate ages
  - Reduction of infant and maternal mortality rates by three-quarters of current levels
  - Universal access to safe water
  - Life expectancy comparable to the level attained by typical middle income countries
  - Absence of abject poverty

- **Good Governance and the Rule of Law**
  It is desired that the Tanzanian society should be characterised by:
  - Desirable moral and cultural uprightness
  - Strong adherence to and respect for the rule of law
  - Absence of corruption and other vices
  - A learning society which is confident, learns from its own development experience and that of others and owns and determines its own development agenda

- **A Strong and Competitive Economy**
  The economy is expected to have the following characteristics
  - A diversified and semi-industrialised economy with a substantial industrial sector comparable to typical middle-income countries
  - Macroeconomic stability manifested by a low inflation economy and basic macroeconomic balances
  - A growth rate of 8% per annum or more
  - An adequate level of physical infrastructure needed to cope with the requirements of the Vision in all sectors
  - An active and competitive player in the regional and world markets, with the capacity to articulate and promote national interests and to adjust quickly to regional and global market shifts
  - Fast growth will be pursued while effectively reversing current adverse trends in the loss and degradation of environmental resources (such as forests, fisheries, fresh water, climate, soils, biodiversity) and in the accumulation of hazardous substances.

**Driving Forces**

- A developmental mindset imbued with confidence, commitment and empowering cultural values
- Competence and a spirit of competitiveness
- Good governance and the rule of law.

**Implementing the Vision**

- Developmental mindset and competitiveness
- Democratisation and popular participation
- Monitoring, evaluation and review
The past few years have seen the Government put priority on stabilising the macro economy and undertaking a number of reforms of the public sector. These changes have been guided by the view that government should facilitate and regulate development, but not engage itself in direct productive activities.

Central aims of the Government’s reform processes are to improve the provision of social services and to decentralise and devolve functions to democratic local authorities. These developments can be constructive for the fulfilment of the rights of women and children, although implementation remains problematic due to inadequate resources, as well as limited opportunity for meaningful popular participation. Concerns are also widespread that Government resources are not managed in a transparent and cost-effective manner.

There has been considerable success in stabilising critical aspects of the economy. Inflation rates have been reduced from 34% in 1994 to 6% in 2001. This means that households are not confronted by escalating prices for basic commodities. Government policy aims to continue to reduce inflation so that it matches that of Tanzania’s major trading partners.

Real growth of the gross domestic product (GDP) has increased from 1.4% in 1994 to around 5% in 2000, but this is still well below the rate needed to generate significant reductions in poverty. The economy continues to be dominated by agriculture, and data on household incomes consistently show farming households to be poorer than those in urban areas. Preliminary data from the 2000/2001 household budget survey, conducted by the National Bureau of Statistics (NBS), show little change in poverty since the last comprehensive survey was undertaken in 1991/92. A more complete analysis of these data is expected in early 2002.

The deep and pervasive poverty in Tanzania affects and is affected by the devastation wrought by HIV/AIDS. Twelve percent of pregnant women are estimated to be infected with HIV (NACP, 1999). Life expectancy is projected to fall from 56 to 47 years. The most productive age group in the population is being lost, leaving behind increasing numbers of orphaned children. People's lives, livelihoods and human rights are under serious threat, and the coping strategies of many families and communities are being exhausted (see box).

The vulnerability of poor households is frequently exacerbated too by the vagaries of the weather. In recent years, El Nino and La Nina weather phenomena have led to

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Figure 1.1
Annual Rate of Inflation, 1994-2000

Source: BOT, 2000
widespread drought in some areas and flooding in others, and this has severely affected infrastructure and agricultural production. The condition of rural roads is poor, leading to high costs in marketing produce and in providing inputs for farming. The costs of improving and maintaining rural roads are estimated to exceed by far the likely possibilities for financing through official government and aid sources, though this is now being given greater priority in Government budget allocations.

Successful marketing of produce depends also on networks of marketing organisations able to generate good prices for producers. Tanzania’s crop marketing boards have not been effective, and Tanzania still exports primary products, whose prices are largely determined by international buyers. Many of these prices have been falling in recent years, notably for coffee, and they are frequently subject to wide fluctuations. For example, in the 2000-2001 cashew-marketing season prices offered to farmers fell from about Tshs. 800 to under Tshs. 200 per kilo. Such sudden dramatic falls in prices for farmers have a devastating impact on their families’ livelihoods and the local economies of their communities. Even at Tshs. 800 per kilo, Tanzanian cashew farmers earn a very small proportion of the price of processed cashews paid by consumers in Europe and North America.

The rate of inflation has been lowered in part through reducing Government budget deficits, achieved by strict control on spending through the operation of a cash budget system. As a result, most Government obligations, apart from the wage bill and debt service, have been severely restricted in the last five years, including allocations for

HIV/AIDS is now so widespread in Tanzania that it is fair to say that there is hardly a single person who is not affected in one way or another. People’s lives, livelihoods and human rights are under serious threat and the very fabric of the lives of many individuals, families and communities is in danger of being torn apart. In such a situation, the current response is inadequate both in scale and relevance. Urgent action is needed to ensure that the human rights of all are protected as a key to combating HIV/AIDS effectively.

The spread of HIV/AIDS is seriously threatening many rights:

- Children whose parents are ill or die of AIDS may lack appropriate care and may find their rights to health, education, participation and inheritance severely compromised.
- Children whose parents are ill or die of AIDS are more vulnerable to all forms of abuse and exploitation - emotional, intellectual, physical and sexual.
- Children whose parents die of AIDS are rarely consulted on the arrangements for their care and their future; siblings are often separated and property taken.
- AIDS-affected adults and children are frequently stigmatised and treated as pariahs in society.
- HIV infection of the mother threatens the rights of her unborn baby and makes breastfeeding, which is the foundation of good nutrition, a risky undertaking.
- The spread of AIDS has served to reinforce gender disparities and prejudices. Women are still frequently blamed for the spread of the disease and while women are likely to look after an ailing spouse, the opposite is frequently not the case.
- The costs of the pandemic at all levels, from household to national level, are putting a great strain on already insufficient resources and making the provision of quality social services even more difficult.

The denial, or non-fulfillment of rights is a major contributing factor to the spread of HIV/AIDS:

- Denial of the right to appropriate information puts many people, especially adolescents and young people, at risk. It is also a threat to many unborn babies as many mothers still have inadequate information about the risks of transmission.
- The removal of girls from school to look after their younger siblings or get married endangers the girls since they are left with no qualifications or skills that will enable them to make a living for themselves. This increases their chance of being pushed into situations and activities which put them at risk of being exploited and infected with HIV.
- For many girls aged 9 to 19 transactional - usually unprotected - sex is a fundamental socio-economic coping strategy. This, together with their powerlessness in sexual relations puts them at serious and continual risk of infection.
- Lack of adequate parental care (such as in the case of orphaned children) can lead to exploitation, which soon pushes children into a vicious cycle that increases their risk of contracting HIV.
essential supplies for primary education and health services. Government allocations of development funds for regions and local authorities have been minimal, leading to even greater dependence on external financing for development. Over 80% of the overall development budget - over 40% of the total budget - is externally financed. Domestic revenues as a percentage of GDP remain low at around 12%.

Until Tanzania is able to achieve the targets of the Visions, there will continue to be a need for concessional sources of development assistance. In 1999 the Government started the development of the Tanzania Assistance Strategy (TAS) to rationalise the use of development assistance in the country and make it more effective. A draft of the TAS document was discussed at the Consultative Group (CG) meeting in Dar es Salaam in May 2000. The document summarised the priorities for development, and articulated the Government's desire for assistance to be provided in ways which minimise transactions costs - including wasteful, parallel systems of administration and reporting, duplication of efforts and fragmented projects. It reflects the Government's strong preference for financing through budget support and assistance through sector wide programme approaches. The draft TAS also notes the need to monitor performance, not only of the Government's progress towards stronger management of development assistance, but also of development agencies' performance in providing assistance according to country's priorities, in ways which reduce transactions costs and strengthen Tanzanian capacities.

Because of heavy requirements for debt service, the Government has put priority on achieving debt relief through the enhanced Highly Indebted Poor Countries (HIPC) initiative. Tanzania has been paying about USD 200 million annually in debt servicing - far below its obligations, which have been closer to USD 600 million. Based on Tanzania's own Visions and Poverty Eradication Strategy, a Poverty Reduction Strategy Paper (PRSP) was submitted to the international financial institutions in mid-September 2000 (URT, 2000b). A progress report, submitted in September 2001, is expected to lead to confirmation of the full amount of HIPC relief from the International Monetary Fund (IMF) and World Bank in late 2001. Even with this relief, however, debt service will continue to take up a substantial amount of public funding, amounting to about USD 50 million annually for the next few years (Mbelle, 2001:14), 17% of projected total Government expenditures in 2001/2002 (URT, 2001a).

The PRSP recognises the pervasive nature of poverty in Tanzania, and its rural predominance and multiple facets, including income, social assets and vulnerabilities. There is strong emphasis in the PRSP on maintaining the macroeconomic stability that Tanzania has achieved in the late 1990s, and on strategies to achieve higher rates of economic growth. The PRSP also includes targets for educational achievement and mortality reductions within a three-year perspective, with specific activities to achieve these targets. Additional financing for these activities will be provided through the Government budget, from HIPC debt relief, as well as from budget support provided by bilateral agencies. HIPC relief at completion point is expected to amount to about USD 200 million annually.
Increased budget allocations have been provided to priority sectors, with a focus on primary levels of basic services, including basic education, primary health care, agriculture research and extension, rural roads, water, HIV/AIDS and justice. The constraints of the cash budget system have also been reduced, allowing for quarterly disbursements for priority activities. For 2001/02, the Government has significantly increased allocations for non-salary costs in primary education. These allocations had been the equivalent of about USD 1 per pupil per year. The plan is to increase this to USD 10, and to channel funds to schools in a manner that strengthens local governance of education (MOEC, 2001c).

Public sector reforms generally emphasise a programmatic approach. This has gone furthest in the health sector development programme, in the local government reform programme and in the recent primary education development programme. Joint funding arrangements involve several partners, who also participate in joint reviews of progress and plans for the subsequent year. A common concern of the sectoral reform processes and in the development of the PRSP, however, is that the interests of the central sectoral ministries have tended to dominate. Technical aspects of education and health services have been under-resourced for many years, and the allocation of additional resources through the Government budget is welcome. But the involvement of local authorities, some of the cross-sectoral ministries concerned with aspects of community development and social welfare, and civil society more broadly has been inadequate.

From the perspective of children's wellbeing, this is critical. A more fundamental assessment of the constraints to fulfilling children's rights is needed, with corresponding conclusions about changes required in the strategies and management of public resources. Many of the constraints directly affect families', communities' and local authorities' capacities to provide the care and services that would benefit children and young people. Changes are needed in gendered divisions of work and decision-making so that women can exercise greater influence over the allocation and control of resources, so that both men and women might spend more time caring for their children. Increased allocations for primary health care, and greater attention to preventive and promotive health are required too, including, for example, increased access to insecticide treated nets to reduce the toll of malaria, improved hygiene practices and use of oral rehydration therapy to reduce diarrhoeal diseases. Basic education needs to be revitalised, including greater opportunity for early childhood development, improved access and strengthened quality of primary and secondary education in schools that are safe, rights-respecting and child-friendly. Adolescents and young people need recognition, respect and support, to learn and grow, secure meaningful livelihoods and contribute meaningfully to their communities, so that they have hope for their future. Overall, more attention needs to be paid to effective social security for those whose vulnerability exceeds the capacity of their families and communities to cope.

More will be said about development from this perspective in later sections of this report. Here it is important to emphasise that it is not only the technical content of the macro frameworks that has implications for the fulfilment of children's human rights. The processes through which their priorities are developed, resourced and monitored are also very important.

The Local Government Reform Process is attempting to develop more participatory planning and budgeting processes that can take better account of community priorities. The Government has started to publicly report the amounts of financing for education, health and other critical services that are transferred to local authorities. This information aims to improve the transparency of public management at local levels. The Public Expenditure Review (PER) and PRSP processes have begun to provide
The Development Context

by Marjorie Mbilinyi

In 1996, in response to grassroots concern about the drastic decline in quality of services, a growing number of gender activist organisations in Tanzania began to realize the need to lobby for more government resources for education and health. Children, young people and women were particularly affected. What was the point of lobbying for gender equity in basic public social services that were rapidly disintegrating because of structural adjustment arrangements and the heavy debt burden were draining away national resources?

The result was the creation of the Gender Budget Initiative (GBI) organized by Feminist Activists (FemAct), a coalition of over 10 activist organizations led, in this case, by the Tanzania Gender Networking Programmeme (TGNP). The GBI was developed to broaden women's participation in policy-making and management of public resources, to analyze the impact of macro-economic policies and the budgeting process on women, youth and poor men in particular, and to advocate for a more people-oriented budget.

FemAct began a process of study to learn about the structure of policy formulation with respect to national and district budgets. The research was a critique not only of budget-making processes, but also of specific sectoral policies. Feedback workshops were held on a regular basis with relevant actors in government and civil society, so that immediate action could be taken.

The process of carrying out the research and disseminating its findings has been as important as the actual 'findings' themselves. Through participating in GBI workshops members of Parliament, government officials, members of civil society organizations and others raised their critical awareness of democratic issues with respect to policy formulation. Questions discussed include: Who makes the major decisions concerning allocation of resources? Which stakeholders have access to adequate information so as to be able to monitor expenditures? Who benefits from these allocations?

The research found that structural adjustment programmes had created a gender unfriendly macro-economic environment that prioritised efficiency over equity along gender, class, urban-rural and other lines. The budgeting process itself was found to be undemocratic and male dominated, excluding most citizens from decision-making. Austerity measures and budget cuts reduced the resources available for social services, and led to retrenchment of many women as well as men in public social services. Cost recovery measures along with budget cuts and privatization measures reduced poor children’s access to basic education and health, and increased the gap between the rich and the poor. The context of globalisation in the post-cold war world had also changed the terms of development assistance, from

More inclusive and participatory processes are more likely to reflect the priorities of the poor, of rural communities, of families struggling to care for their children, and of young people who could be a tremendous resource for the country's development. Such processes are also much more likely to strengthen the linkage between macroeconomic management and human development, and generate lasting progress towards the goals and targets of Tanzania's Visions and international partners' development assistance.

Conclusion

Because of the need for firmer control of government spending and the critical importance of external aid in the public budget, the Government in 1995 put priority on stabilising the macro economy. Significant gains have been made in this regard, but these have yet to translate into real benefits for poor families and their children, especially in rural areas. Public strategies and budgets are now becoming focussed more clearly on poverty reducing measures, and providing more resources for fulfilling children’s rights. With greater transparency and public participation in governance, and more participatory management processes, these resources could make significant positive changes in the lives of Tanzania's children.

Essay: Making Budgets People-Oriented

by Marjorie Mbilinyi

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'aid' programmes to an emphasis on trade and commerce. There was more open conditionality, including the demand to accept private investment from donor countries. Finally, top-down models of budgeting continued to be used, abetting corruption and wastage, and thwarted transparency and accountability at all levels.

Building on this analysis, GBI programmes have had several achievements. They have raised gender awareness and gender analysis skills among government officials in the Ministry of Finance, the Planning Commission, the participating sectoral ministries and members of Parliament. The government has now adopted its own gender budget initiative with separate donor funding, and contracted TGNP to work with government officials to mainstream gender into six sectoral budgets. The public expenditure review (PER) and Poverty Reduction Strategy Paper (PRSP) processes have also been opened up for gender input. Overall, gender has been mainstreamed into government decision-making processes to a considerable degree.

GBI has also contributed to the strengthening of the FemAct coalition, and built capacity in analytical, advocacy, communications and persuasion skills. Of special significance is the increased knowledge among participating NGOs about the structures of power that are reflected in government policy-making, planning and budget-making. Greater understanding has also been achieved about the linkage between macro and sectoral policies, and the negative impact macroeconomic reforms can have on the poor, and women in particular.

Underlying these achievements, however, are real problems about the ultimate outcome and meaning of GBI. Integrating gender analysis into existing policies and government structures of power may represent a return to discredited ‘women in development’ (WID) approaches. The GBI coalition may become part of a process that legitimises unregulated globalisation and economic reforms that fail to adequately safeguard the rights of all citizens. In this way ‘gender mainstreaming’ can end up adjusting feminist goals to fit the institutional interests of government ministries and international bodies.

An analysis of specific GBI recommendations made in the sectoral reports demonstrates this claim. None of them prioritize the need for a radical change in macroeconomic policy, from the present liberalisation and privatisation policies towards a focused pro-poor development strategy. While the negative impact of macroeconomic reforms on gender issues has been well documented, the basic assumptions and structure of the reform process remain unchallenged. Nor is there a strategy for the democratisation of government along participatory lines. The rhetoric of ‘partnership’ appears to have sidelined controversies and ignored conflicting interests between different ‘stakeholders’, as well as their different levels of power.

TGNP and FemAct coalition partners are aware of these limitations and contradictions. They also see the need for greater economic literacy, of strengthening skills in analysis of macro-micro economic reforms. Recognition of contradictions is a necessary and healthy process in learning from practice, so long as the lessons are used to improve future steps.

Ultimately, the key issue here may be the extent to which GBI partners are grounded at the grassroots and part of a strong, poor people’s social movement. Pressure from below can help ensure the GBI is sufficiently engaged with making macroeconomic policies and decision-making structures work for the poor.

Citizens have a right to participate in policy and budget decision-making. The question is, which policies? Which citizens? Who is excluded? How should they participate? And what difference will it make? It is clear that economic policies and decision-making processes have a tremendous impact on social wellbeing. The struggle to democratise economic policy-making is therefore also the struggle to realise the rights of all children in Tanzania.

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Chapter 2
The Early Childhood Years
Every child has a right to the best possible start in life. In the first five to six years - when most brain development happens and children learn to sense, walk, think, play and communicate - they desire and need abundant care, love and interaction. The early years are also the most opportune period to lay the foundation for a happy, healthy and long life, and to nurture the values and practices to last a lifetime. For these reasons the choices made and actions taken on behalf of children during this critical period affect not only how the child develops but also how a country progresses (UNICEF, 2001b).

Children do not grow up in isolation but in communities, and healthy communities will be better prepared to ensure the development of their children. In this regard the rights and wellbeing of women, who are often the primary caregivers of young children, are inextricably linked to the rights and wellbeing of children. Within this context social friendship and interaction, and access to health, nutrition, water and sanitation services are vital to early childhood development.

From the earliest years after independence in 1961, Tanzania made a clear commitment to community-based human development, including primary health care. In the first two decades the country invested heavily in programmes to enhance the quality of life of its people, and made important advances on a number of fronts. In the 1980s and 1990s, however, economic stagnation and the pressure to reduce the government deficit adversely affected public services. This led to a deterioration of facilities, poor morale among staff and reduced quality of care.

Consequently, and because of the impact of the HIV/AIDS epidemic, the health of children has worsened, and more young children die today than a decade ago. On most health measures, Tanzania has failed to achieve the goals for 2000 it set for itself following the World Summit for Children (MOCDWAC, 2000) and is far from being on track to achieve internationally agreed development goals for 2015 (UN, 2000b or Vision 2025 targets).

This chapter examines some of the major aspects of early childhood in Tanzania for which there are available data. These include maternal health and nutrition; child health, illness and mortality; malnutrition; HIV/AIDS; and water and sanitation. Attention is also given to the quality and financing of basic health services. Issues related to formally organised early childhood education are not covered, due to lack of data and because less than 2.5% of children aged 3-5 years are estimated to be attending such programmes (TRCHS 1999 : 16). The chapter ends with a discussion on the policy environment, with particular emphasis on issues of governance and public participation in the health sector.

2.1 Maternal and Child Health

Healthy women and mothers

Women’s health status is critical to their own wellbeing, and to that of their children. Even though women are the main caregivers and food producers at household level, and are often disproportionately overloaded with work, they have limited or no control over assets and resources. In contrast, fathers typically contribute little of their time to caring for children and doing household duties. This situation is well known in Tanzania, and often discussed, but there appears to be little change in practice.

The 2001 Health Sector Review (HSR) technical report notes important advances in policy and programme planning. Policies and guidelines on safe motherhood, an essential package for reproductive and child health, and life-skills curricula have been
developed (MOH, 2001c:12). These are important aspects of improved delivery of health services and essential to improving women's health, and could be expected to improve actual health outcomes in Tanzania to date.

Of the factors affecting women's health, good nutrition is among the most important. The most critical factor affecting women's nutrition is their workload. Women - especially rural women in Tanzania - consistently work hard, long hours. Their energy intake is not commensurate with their work output. Vitamin A deficiency and anaemia are among the major nutritional problems affecting women, particularly those who are pregnant and lactating. Adequate vitamin A intake improves overall health and survival. A national vitamin A survey conducted in 1998 indicated that 69% of lactating women had breast milk retinol levels, a good indicator of vitamin A status, well below the WHO recommended value (TFNC, 1998).

Anaemia in association with iron deficiency in pregnant women is linked with increased maternal morbidity and mortality (Tatala et al., 1998). Anaemia in pregnancy is also associated with low birth-weight-babies (Kramer, 1987). A community-based study in ten districts in Tanzania revealed significant prevalence of anaemia (haemoglobin levels of less than 11.0g/dl), with wide variations between districts. Among pregnant women investigated, anaemia levels ranged from 14% in Singida Rural district to 80% in Lindi Rural district (TFNC, 1998).

The maternal mortality ratio (MMR) in Tanzania is, like in most countries, difficult to determine given the absence of complete and accurate demographic data. Estimates generated from hospital records indicate that there are 200-400 deaths for every 100,000 births. The 1996 Tanzania Demographic and Health Survey (TDHS), that covers a more representative base as compared to the hospital data, estimated the MMR at 529. Trends over the last decade are difficult to assess, but at current rates the goal of 133 for 2015 will not be achieved.

The proportion of births attended by skilled personnel and in health facilities provides a good indicator of maternal care. Data collected in the 1990s indicate a decline in proportion of births delivered in a health facility in Tanzania, from 53% in 1992 to 44% in 1999. Similarly, the proportion of births delivered by skilled personnel has declined from 44% in 1992 to an estimated 36% in 1999 (figure 2.1). The falling number of deliveries performed in health facilities may be a consequence of
undermined confidence in the health system, brought about by the introduction of user fees, inadequate facilities and equipment, shortage of trained personnel, and poor quality of care (MOH, 2001c:13). In addition, a weak referral system limits availability of essential and emergency obstetric care, which has a direct bearing on maternal mortality and morbidity.

The percentage of women receiving antenatal care and delivering with skilled personnel varies considerably across income levels and urban/rural residence. In addition, educated women are more likely to give birth in hospitals and health centres than those with lesser years of schooling (TRCHS 1999:100, figures 2.2, 2.3, and table 2.1). Despite widespread attention to maternal mortality, maternal morbidity has been
largely ignored. Accurate estimates for maternal morbidity rates are unavailable in Tanzania, as in most countries. However following international trends, the number of women affected by maternal morbidity may be hundreds of times more than those who die in childbirth (Family Health International, 1996:96). Extrapolating from the crude birth rate in the 1996 TDHS, approximately 355,000 women in Tanzania are estimated to experience acute obstetric complications annually and about 177,500 suffer from life-threatening complications (Kwast and Vickery, 1998:1).

Septic abortions, a leading cause of maternal mortality in Tanzania and elsewhere, are high especially among adolescent girls (MOH, 2001c:13). Nonetheless, post-abortion care is not adequately provided in government hospitals, and manual vacuum aspiration kits are not available in the Medical Stores Department, nor included in the national essential equipment list (MOH, 2001c:13).

Various cultural practices promote early marriage and childbearing. Among women aged 20-39 years at the time of the 1999 TRCHS, approximately one-quarter had given birth for the first time between 15 to 17 years. Early pregnancies often result in increased complications for the pregnant girl, with high rates of abortion, mortality and morbidity including fistulae and secondary infertility (see box).

### Table 2.1 Antenatal Care Visits and Delivery Attendance by Income Quintile, 1996

<table>
<thead>
<tr>
<th>Quintiles</th>
<th>Poorest</th>
<th>Second</th>
<th>Middle</th>
<th>Fourth</th>
<th>Richest</th>
<th>Population average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care visit (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to a medical trained person</td>
<td>82.4</td>
<td>89.7</td>
<td>87.6</td>
<td>92.7</td>
<td>96.0</td>
<td>89.3</td>
</tr>
<tr>
<td>to a doctor</td>
<td>4.8</td>
<td>4.7</td>
<td>5.2</td>
<td>7.1</td>
<td>12.7</td>
<td>6.7</td>
</tr>
<tr>
<td>to a nurse or trained midwife</td>
<td>77.6</td>
<td>85.1</td>
<td>82.4</td>
<td>85.6</td>
<td>83.3</td>
<td>82.6</td>
</tr>
<tr>
<td>2 + visits</td>
<td>87.5</td>
<td>92.8</td>
<td>92.8</td>
<td>93.4</td>
<td>94.1</td>
<td>91.9</td>
</tr>
<tr>
<td>Delivery attendance (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>by medically trained person</td>
<td>26.7</td>
<td>40.4</td>
<td>41.2</td>
<td>51.8</td>
<td>80.9</td>
<td>46.7</td>
</tr>
<tr>
<td>by a doctor</td>
<td>3.0</td>
<td>5.2</td>
<td>5.3</td>
<td>5.3</td>
<td>11.1</td>
<td>5.7</td>
</tr>
<tr>
<td>by a nurse or trained midwife</td>
<td>23.7</td>
<td>35.2</td>
<td>35.9</td>
<td>46.6</td>
<td>69.8</td>
<td>40.9</td>
</tr>
<tr>
<td>% in public facility</td>
<td>24.7</td>
<td>37.0</td>
<td>38.6</td>
<td>48.7</td>
<td>74.0</td>
<td>43.2</td>
</tr>
<tr>
<td>% in a private facility</td>
<td>2.3</td>
<td>2.9</td>
<td>3.3</td>
<td>3.7</td>
<td>4.7</td>
<td>3.4</td>
</tr>
<tr>
<td>% at home</td>
<td>68.0</td>
<td>55.0</td>
<td>54.0</td>
<td>44.9</td>
<td>18.9</td>
<td>49.5</td>
</tr>
</tbody>
</table>

Source: Gwatkin, et al, 2000

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Vesico-Vaginal Fistula in Mwanza: Sato’s Story

Sato’s grandmother couldn’t believe her eyes. “I thought you died!” she cried.

When 19-year-old Sato was taken to Bugando Medical Centre (BMC) in Mwanza from her tiny village, no one expected to see her again. Sato had been living with vesico-vaginal fistula (VVF), a condition that caused her to leak urine uncontrollably after childbirth. A district medical officer diagnosed her problem, and after hearing radio announcements about a special clinic at BMC, he drove her over two hours of dirt and potholed roads to bring her to the hospital.

Sato arrived at BMC leaning on a stick to help her walk, since during childbirth she sustained severe nerve damage in her legs. She wore a sheet and had a piece of plastic wrapped around her waist to sit on. She was welcomed at BMC, and examined. This was not an easy task, since after three stillborn births, a caesarean section and the fistula, Sato was terrified.

Sato was encouraged to overcome her fear of surgery by compassionate nurses and doctors at the hospital. The surgery went well and it was a joyous day when she was fully recuperated, dry and healed. Nearly three-quarters of the patients at BMC who have fistula repairs have a complete recovery. Since Sato had never left her village before coming to BMC, she was accompanied by staff of the hospital on her return home. There, she was met by grandmother’s exuberant greeting. The word spread, and neighbours came to welcome her back. Sato - like all fistula patients - received some final advice: when it is time to deliver a baby again, go to a hospital for assistance!

Excerpted from Maryknoll Magazine, November 1999
Healthy infants and children

Growth and development in the first two years of life influence how later childhood and adolescence unfolds. Investments in the early years of life have significant implications not only for personal health outcomes, but also for ensuring a strong and vibrant citizenry in the long term.

Given the near total dependency of young children on their parents and other responsible adults, they are particularly vulnerable, especially in situations of abject poverty, civil conflict, violence and other emergencies. The onset of the HIV/AIDS pandemic in particular has posed significant new challenges to the wellbeing and rights of infants and children. Building the capacity of caretakers and children themselves to fulfil children’s best interests is critical. Among other aspects, this includes taking explicit measures to promote the direct participation and involvement of young children, with due regard to their evolving capacities.

Tanzania is not on track to meet the 2015 target of reducing under-five mortality by two thirds (figure 2.4). Data derived from population censuses and national demographic and health surveys indicate that child mortality rates dropped significantly in the period 1960 - 1985 (UNICEF estimates, figure 2.5). However, since the late 1980’s the infant mortality rate has increased from 100 to 104 per 1,000 live births, and the under-five mortality rate increased from 160 to 165 per 1,000 live births in the same period. This means that in year 2000 one in six children died before they reach the age of five years. HIV/AIDS is likely to have contributed significantly to the upward trend in the child mortality rates, though its precise impact is yet to be established.

As with other health indicators, infant and under-five mortality vary greatly by income levels. Analysis of demographic survey data from 1996 shows that children in the richest quintile are significantly less likely to die in infancy and early childhood as compared to the national average, though mortality rates are generally high for all income groups (table 2.2).

Overall, Tanzanian mortality levels and trends are largely determined by what happens in the rural areas, where most of the population resides. Urban mortality rates are
The Early Childhood Years

Figure 2.5
Infant and Under-five Mortality, 1960-2000
Source: UNICEF, 2001f

generally lower than rural rates. Mortality rates are also linked to the mother’s age, as significantly more deaths occur to children of mothers who gave birth at a younger age (TRCHS 1999:88; figures 2.6 and 2.7).

A 1998 survey of childhood deaths reports that more than 8 out of every 10 children died at home, and 6 of them without any contact with formal health services. A study in three districts shows that the leading immediate causes of under-five mortality include malnutrition, AIDS, pneumonia, acute febrile illness including malaria, perinatal mortality, anaemia, and acute diarrhoeal disease (MOH, 1999a:4).

Table 2.2
Infant Mortality Rate (IMR) and Under-five Mortality Rate (U5MR) by Income Quintile, 1996
Source: Gwatkin, et al, 2000

<table>
<thead>
<tr>
<th>Quintiles</th>
<th>Poorest</th>
<th>Second</th>
<th>Middle</th>
<th>Fourth</th>
<th>Richest</th>
<th>Population average</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR:</td>
<td>87.3</td>
<td>118.0</td>
<td>95.6</td>
<td>102.1</td>
<td>64.8</td>
<td>94.1</td>
</tr>
<tr>
<td>U5MR:</td>
<td>140.1</td>
<td>179.8</td>
<td>148.0</td>
<td>152.8</td>
<td>97.5</td>
<td>144.8</td>
</tr>
</tbody>
</table>

Figure 2.6
Infant and Under-five Mortality. The Rural-Urban Disparity, 1999
Source: TRCHS 1999
Situation Analysis of Children in Tanzania

Childhood illnesses

A major public health intervention to address childhood illness has been the development of the Integrated Management of Childhood Illness (IMCI) programme. IMCI promotes inter-sectoral collaboration and community-based strategies for activities that were traditionally implemented through separate vertical programmes, including immunisation, oral rehydration therapy, hygiene and sanitation promotion, malaria prevention and prompt and effective treatment of malaria.

IMCI has been adopted and included in the Essential District Health Intervention Package in Tanzania. Its key components include improving skills of health workers, family and community practices and health system support. Coverage of IMCI increased in the 1990s. As of 2000 IMCI was being implemented in 33 districts in Tanzania, and another 56 districts had received orientation to begin the programme. Preliminary results from an evaluation of IMCI confirmed high baseline levels of malnutrition, morbidity and mortality in Tanzania. They also showed that IMCI had

Figure 2.7
Infant and Under-five Mortality by Age of Mother at Birth, 1999
Source: TRCHS 1999

Figure 2.8
Immunisation in the Nineties
Sources: TDHS 1992; TDHS 1996; TRCHS 1999
improved performance levels and led to better health services, but that there was an urgent need to strengthen household, family and community practices and involvement. The 2001 HSR also noted weaknesses in health system support for IMCI, including referral mechanisms, access to drugs and community ownership, and that it is not reflected in some district plans.

Through the 1990s important progress was made or sustained in reducing childhood illness, but overall the situation remained daunting. Particular successes and challenges in combating childhood illness in Tanzania include the following:

Immunisation: Immunisation coverage in Tanzania is relatively better in comparison to neighbouring countries, and has remained generally high over the last decade. Overall, about 70% of children were fully immunised in the 1990s, suggesting there is scope for improvement, especially to overcome large disparities between urban and rural areas (figures 2.8 and 2.9).

The Expanded Programme on Immunisation (EPI) co-ordinates national efforts to sustain and further expand the coverage of immunisation in Tanzania. Data from 1999 indicates national EPI coverage of 75%. However, there are large variations between districts. For example, Kiteto, Kinondoni, Ilala and Kahama districts have coverage rates below 50% whereas M eatu, Wanga and Msungwi all have immunisation rates above 95%. Overall, approximately 50 districts achieved EPI coverage of 80% or above; 50 districts achieved 60-80%; and 15 districts had coverage below 60% (MOH, 1999b).

Immunisation coverage reported in demographic surveys mirrors income distribution, following the trends for ante-natal clinic (ANC) visits and delivery attendance. For the richest quintile the proportion of children fully immunised stands at 83% whereas in the poorest quintile only 57% of children received all recommended antigens (Gwatkin, et al, 2000:3, table 2.3).

<table>
<thead>
<tr>
<th>Immunisation Coverage (%)</th>
<th>Quintiles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poorest</td>
<td>Second</td>
</tr>
<tr>
<td>Measles</td>
<td>66.9</td>
<td>79.9</td>
</tr>
<tr>
<td>Dpt3</td>
<td>74.6</td>
<td>84.6</td>
</tr>
<tr>
<td>All</td>
<td>57.3</td>
<td>68.8</td>
</tr>
<tr>
<td>None</td>
<td>6.9</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Source: Gwatkin, et al, 2000
Situation Analysis of Children in Tanzania

Recorded cases of polio, neonatal tetanus and measles have decreased sharply in Tanzania since 1991 (MOH, 2001c), though the EPI Annual Meeting in 2001 recorded a concern with an increase of measles outbreak among children aged 5 to 15 years (MOH, 2001b). Measles vaccination and vitamin A supplementation (one annual dose) have been conducted in over 80 districts, achieving coverage of above 90%. Supplemental immunisation for polio eradication was conducted in 2000 targeting 44 border districts, with coverage of 100%. Other successes include the absence of wild poliovirus since 1996, as well as the introduction of maternal and neonatal tetanus (MNT) elimination and hepatitis B vaccination programmes.

Despite these relative successes, the EPI Annual Meeting in 2001 noted persistent operational problems that hamper greater coverage. These include the shortage of kerosene and poor use of funds for kerosene, shortages of cold chain equipment and vaccine (especially OPV and DPT), and lack of adequate support for outreach services and supervision.

Malaria: Malaria has a serious impact on children and adults alike. Tanzania is estimated to have 14-18 million malaria cases annually, more than half of which are said to occur among children. Malaria causes 20 to 45% of all deaths among children under-five years, or about 70,000 to 80,000 deaths each year (TRCHS 1999:108, MOH/WHO, 2001). Its economic toll, estimated to consume 3.4% of GDP, is also enormous (MOH and WHO, 2001). Thus malaria deepens poverty, and also hits hardest among the poor.

The Government has drafted a five-year National Malaria Medium Term Strategic Plan (MOH and WHO, 2001). A new drug policy for malaria, reflecting a changeover from chloroquine to Sulfadoxine Pyrimethamine (SP) for first line treatment, has been developed and implemented in 2001. However, access to SP remains a challenge and initial implementation efforts have been hampered by the reportedly poor quality of SP drugs on the market. The Ministry of Health has also reportedly confirmed that SP may have serious side effects for people with immune deficiency, such as malnourished children and people with HIV/AIDS (Daily News, November 10, 2001). These difficulties will need to be resolved soon to earn public confidence in the new policy.

Recently, insecticide treated nets (ITNs) have proven to be one of the most effective means to control malaria. More than 40 field trials in Africa in the past two decades have shown that ITNs reduced overall child mortality by 20% and malaria episodes by 50%,
and substantially improved childhood anaemia. Calculations made by the Ifakara based
Kilombero Valley Insecticide Treated Nets (KINET) project estimate that 30,000 child
deaths and 5 million clinical episodes could be prevented annually in Tanzania (IHRDC
and STI, 2001:2). The KINET programme’s own research demonstrated major
improvements in their project area (see box).

Using Treated Nets to Control Malaria in the Kilombero Valley

KINET was a large-scale social marketing programme for
insecticide treated nets (ITNs) for malaria control in two
rural districts (Kilombero and Ulanga) in Southern
Tanzania. The project involved formative and market
research, establishing a public-private distribution system,
and a comprehensive information, education and
communication campaign. Much of the work was done by
local health and community development staff.

A total of 65,111 nets and 24,393 treatments were sold by
the project between May 1997 and June 2000. By
mid-1999, 63% of children under five years in Kilombero
and 31% in Ulanga were sleeping under (treated or
untreated nets), and overall 18% of such children were
sleeping under treated nets. Coverage was higher in areas
that had longer access to ITNs.

The impact of ITNs was assessed using a demographic
surveillance system in a population of 60,000. Treated nets
were associated with 27% improvement in child
survival in children aged 1 month to 4 years. The incidence
of malaria illness was reduced significantly. Children under
2 years who used ITNs had 12% less anaemia and
malaria as compared to those who did not use nets, and
pregnant women who used ITNs had 12% less anaemia
than those who did not use treated nets. There was no
evidence that mosquitoes became resistant to the
insecticide during the project period.

Source: IHRDC/STI, 2001

Tanzania has been in the forefront of ITN development since the 1980s. The country was
the first in Africa to withdraw taxes on netting material, which helped increase local
production and affordability. As a result, the use of ITNs is growing across the country.
But access is not even, and urban/rural differences are significant. In addition, many nets
on the market are still untreated. In 1999, whereas 48% of urban households reported
that all their children under five years slept under nets the night before the survey, the
comparable figure for rural areas was only 13%. The use of ITNs in both urban and
rural areas was the same, but very low. Only about 10% of households in both areas
reported ever having used treated nets (TRCHS 1999:110).

Poor women in particular are likely to have less access. In the KINET program, for
instance, women who had their own cash income were 40% more likely to use ITNs than
those who had no cash income (IHRDC and STI, 2001:21).

Diarrhoea: Diarrhoea is one of the major causes of child morbidity and mortality in
Tanzania. The problem becomes more acute in children six months and older, when they
begin to crawl and eat supplementary foods. According to the 1999 TRCHS, children
6-11 months are most likely to have had diarrhoea in the preceding two weeks, followed
by children in the 12-23 month group. Both boys and girls are affected, but boys
slightly more so.

Among families surveyed in the 1999 TRCHS, approximately two thirds of children with
diarrhoea were taken to a health facility for treatment, just over half were given oral
rehydration therapy (ORT) solution, an effective means of treating the dehydration
resulting from diarrhoea, and nearly one third were given more than the usual amount
of fluids. Differences in treatment by background characteristics such as birth order and
mother’s education were very small (table 2.4).

Acute respiratory infection (ARI): Like diarrhoea, ARI is among the leading causes of
morbidity and mortality among young children in the country, with pneumonia being the
most serious. Since 1992, recorded cases of ARI have increased in Tanzania from about
Improving the nutritional status of children is regarded as the best and most effective strategy for reducing the severity of acute ARI, since well-nourished children are better able to withstand ARI and recover more quickly (TRCHS 1999:107).

In the two weeks preceding the 1999 TRCHS, 14% of children surveyed were reported to have had a cough and rapid breathing. Prevalence was highest among children 6-11 months, and declined gradually to 8% for children 4-5 years. Among those suffering from ARI, 68% were taken to a health facility or provider (TRCHS 1999). There does not appear to be a significant variation in ARI prevalence due to child's sex, birth order, residence or by mother's level of education. Among children with ARI, a greater percentage living in urban areas were taken to a health facility or provider than those living in rural areas.

Nutrition

Malnutrition continues to be a major cause of high infant and under-five mortality in Tanzania. According to the World Health Organisation (WHO), malnutrition is the underlying cause for more than half of all child mortality (Murray and Lopez, 1996). The main types of malnutrition include protein energy malnutrition (PEM) and micro-nutrient deficiencies. Results from the demographic surveys in the 1990s show that overall PEM (weight for age) has remained stagnant at around 30%, suggesting that nearly one in every three Tanzanian children is malnourished. Stunting rates have increased, and nearly half of all children are either moderately or severely stunted (TDHS 1992; TDHS 1996; TRCHS 1999).
Low Birth Weight (LBW): Babies born with low weights (below 2500 grams) are of particular concern. Birth weight is a critical health and nutrition outcome for young children. Research has shown that children born with LBW have a greater risk of continued under-nutrition and mortality in the first year of life, and continue to be at a disadvantage for the rest of their lives (Barker and Osmond, 1986; Barker, et al., 1989).

Given the large variation of LBW across regions, and the fact that the available data are based on reporting from hospital sites, the true prevalence of LBW in Tanzania may be higher than is recorded. It is estimated that approximately 150,000 to 200,000 children in Tanzania are born with LBW each year.

Foetal malnutrition suggests maternal deprivation. Shorter mothers tend to have smaller babies, thus perpetuating the intergenerational cycle of deprivation and malnutrition. Further, many of the cognitive and psychosocial effects of early malnutrition are irreversible. This provides a strong case for early intervention, starting perhaps even before birth.

Work in the refugee camps in Western Tanzania (managed by UNHCR, UNICEF, WFP and IRC) shows that it is possible to reduce LBW incidence quite dramatically from over 50% to less than 10% over a very short time frame, through a package of services that include malaria vector control, ITNs and presumptive malaria treatment, improved ANC, folic acid supplementation, and STD screening and treatment (UNICEF, WFP and UNHCR, 2000; UNICEF, 2001c).

Child malnutrition: There are three standard indices of physical growth that describe the nutritional status of children: stunting (height-for-age), wasting (weight-for-height) and underweight (weight-for-age). In 1999 assessments of nutrition indicated that 44% of children under five years were stunted, 17% severely so. Five percent of children under five are wasted, and 29% are underweight (TRCHS 1999:122). The situation is considerably better now compared to the 1970s and early 1980s, in large part because of important progress made in the 1980s. A National Nutrition Status Survey conducted by the Tanzania Food and Nutrition Centre (TFNC) in 1986/87 estimated the

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Figure 2.12 Child Malnutrition in the Nineties

Sources:
TDHS 1992; TDHS 1996; TRCHS 1999
prevalence of moderate PEM (weight-for-age) to be 39.6%, down from earlier rates that were as high as 50% (Kavishe, 1990). Since then, however, the situation has generally stagnated through the 1990s, with no improvement since the 1992 TDHS (figure 2.12).

There is a significant difference in malnutrition rates between rural and urban populations, particularly in the stunting and underweight categories. A child in a rural area is on average twice as likely to be stunted as an urban child (figure 2.13). In contrast, the difference between the sexes is only slight across all three indices for malnutrition (figure 2.14).

Iodine deficiency is estimated to affect nearly one quarter of the country’s population (MOH, 2001c:14) and has been linked to health problems including goitre, stunting, mental retardation and cretinism. The use of iodised salt is an effective means to reduce iodine deficiency, and iodisation programmes have expanded in the last decade. However there are large differences between urban and rural areas, with 86% of urban and 60% of rural regions using iodised salt respectively (TRCHS 1999:20).

Vitamin A deficiency - which has an enormous effect on children’s capacity to fight disease, is estimated to affect about 24% of children under five years of age (MOH, 2001c:14)
Routine vitamin A supplementation has been low over the past decade, covering only 55% of the targeted children. The coverage for second and third doses, which are given to children at the age of 15 and 21 months, has been even lower. Data from sentinel surveillance surveys in 2001 indicate coverage of between 9% and 35% of children the age of 21 months.

In contrast, vitamin A supplementation coverage through sub-national measles campaign for children aged 6 months to 5 years in 1999 (30 districts) and 2000 (52 districts) was 94% and 99% respectively. This shows that campaigns can bring good results. With effect from 2001 Tanzania has opted to conduct vitamin A supplementation through the Day of the African Child and World AIDS Day each year. The 2001 campaign was conducted in all 114 districts, of which more than half achieved coverage of over 80%, though differences across districts were significant. The lowest performing districts, Handeni and Singida Urban, only achieved coverage of 37% (TFNC, 2001).

Communities are increasingly sensitive to malnutrition issues, and 4,100 villages are included in programmes for growth-monitoring. Some have developed action plans to assist where growth is faltering. About half of all district councils are implementing community-based nutrition programmes. Three regions of the country are categorised with very high rates of underweight children (above 40%), and seven additional regions have high rates of underweight children (31-40%) (MOH, 2001c:14).

Household practices related to infant and child feeding have an important bearing on the nutritional status of young children. In Tanzania, breastfeeding is universal, with approximately 97% of mothers initiating breastfeeding and often continuing into the child’s second year of life. However, exclusive breastfeeding up to 4-6 months is rarely practiced. Data from demographic surveys in the late 1990s indicate that about 40% of infants were exclusively breastfed from 0-3 months, and only about one-tenth from 4-6 months (figures 2.15 and 2.16). A 1999 IMCI survey of key family practices in seven districts supports these data, and in addition notes that there is a delay in the initiation of breast milk, poor use of colostrum, and poor quality, inadequate quantity and low frequency of feeding. The problem is aggravated by inadequate support given to mothers by the family and community for effective breastfeeding and child feeding (TRCHS 1999:118).

Growth monitoring, which is essential to management of childhood illness, is commonly practised in Tanzania. But its promotion is very weak, and overall effectiveness has declined over the last two decades. Village health workers (VHWs), who were in forefront of growth monitoring promotion during the heydays of Tanzania's primary health care program, have not generally received training or support in recent years.

![Figure 2.15](source: TRCHS 1999)
By the end of 1999, 1.3 million adults and children in Tanzania were estimated to be infected with HIV and about 140,000 died from AIDS in the same year (Measure et al., 2001:1). As noted before, methodological problems may miss out groups who are disproportionately affected, and thus the actual numbers may be significantly higher. As adults die of AIDS, many children are left orphaned, making the implementation of their rights more difficult. While further discussion of HIV/AIDS is contained in the chapter on adolescent years, issues specific to infants and young children are presented here.

Children orphaned: The death of parents from AIDS can have a devastating impact on their remaining children. Orphaned children are often left to the surviving next of kin, mostly grandmothers, or with older siblings, usually girls, in child headed households. In many cases community support systems are too strained to offer adequate protection, and the children’s access to nutrition, care, schooling and other vital resources is put at risk. Demographic surveys over the 1990s show that the number of children orphaned has grown significantly. The number of children under 15 who have lost both parents is estimated to have more than doubled between 1991 and 1999 (figure 2.17). Estimates based on population projections show that in 1999 about 960,000 children under 15 years had no father, 525,000 had no mother and 165,000 had lost both parents (Measure, et. al., 2001:37).

Prevention of mother to child transmission (MTCT) of HIV/AIDS: In Tanzania, general knowledge about HIV/AIDS is high, but specific knowledge about MTCT is very low. Children can become infected from their mothers in three ways: during pregnancy, during labour and delivery, and through breastmilk. In the absence of preventive measures, the risk of a woman with HIV passing on the virus to her child ranges from 25% to 35% in developing countries such as Tanzania. It is estimated that two-thirds of the infections occur during labour, birth and pregnancy. In societies where breastfeeding is common, transmission through breastmilk is responsible for about one-third of all transmissions (WHO, 2000).

Recent data from Coutsondis et al. (2001) suggests, however, that the risk of mother-to-child transmission of HIV increases with additional months of breastfeeding, as follows: 0-6 months - 5%; 0-12 months - 9%; 0-24 months - 14%. Further, these
estimates are based on mixed feeding regimens. When breastfeeding is exclusive, the risks are likely to be lower (Coutsondis et al., 1999).

A pilot project on the prevention of MTCT in Tanzania was launched in 1999 and has been implemented in five large urban hospitals. The purpose of the pilot project is to demonstrate the feasibility of integrating the prevention of MTCT to routine maternal child health (MCH) services. The project offers several key interventions to prevent MTCT. These include voluntary confidential counselling and HIV testing (VCCT), counselling on infant feeding options, care and treatment with anti-retroviral drugs (AZT and Nevirapine) and follow up for 18 months (UNICEF, 2001g).

As of July 2001, of the approximately 17,000 ANC clients who were seen by the project, 35% have used free VCCT services. Of these, 85% opted for testing, out of the 5,050 ANC clients tested 13% were tested positive for HIV. All clients with HIV were

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Key Challenges in the Pilot PMTCT Programme

Care and support for women with HIV: Follow up and referral mechanisms need strengthening, including through better collaboration between the health care system and NGOs to improve access to support and care for women with HIV.

Stigma and discrimination: Many people living with HIV/AIDS are stigmatised in their families and communities. The situation is especially bad for widowed women or children who are frequently ill. Reports indicate men often blame their wives for the infection, use violence or abandon them altogether. For these reasons many women with HIV are afraid to reveal their status, and keep it to themselves for as long as possible, thus increasing the risk of transmission to their babies.

Male involvement: Male involvement in VCCT has been very limited. In part this may be due to the fact that MCH clinics are seen as places for women and not welcoming to men. Explicit measures will need to be taken to create an inviting environment for men.

Quality of counselling: Counsellors often lack motivation because they are expected to perform their counselling duties in addition to their normal work routine without extra compensation. If extra compensation is offered to counsellors, it would significantly increase costs, thereby reducing the potential for scaling up plus sustainability of the MTCT response.

Infant feeding options: HIV positive women are counselled on infant feeding options, and informed about the relative risks associated with breastfeeding and replacement-feeding options.

Source: NACP and UNICEF, 2001
offered a short course ARV treatment (AZT) during the last 4 weeks of pregnancy and 1 dose of Nevirapine during labour (NACP and UNICEF, 2001). Constraints facing women, including lack of time and privacy, and social stigma have a significant influence on the decision whether or not to start treatment. Other challenges are also considerable (see box). However, the introduction of the new ARV drug Nevirapine, that needs to be taken only once at the onset of labour, may increase the number of women accessing treatment. Plans to scale-up the programme starting in 2002 are underway.

2.2 The Quality of Services

Water and sanitation

Poor access to water and inadequate sanitation are major obstacles to children and women achieving good health outcomes. Limited access to safe water demands that women and children spend large amounts of time and effort fetching water, leaving less energy and time for profitable activities, schooling, caring for young children and rest. The energy used in travelling long distances with heavy loads also increases malnutrition. Moreover, girls and women fetching water risk sexual abuse and harassment along the way.

In 1999 about 65.7% of households in Tanzania were estimated to have access to safe water. Urban-rural disparities were enormous. Ninety two percent of urban households had access to safe water, as compared to only 56% of rural households (TRCHS 1999:19) (figure 2.18). In practice, even those with access experienced intermittent supply of water, breakdowns, droughts, and poor water quality. Moreover, these household surveys do not account for the quality of sources and facilities.

Distance to water and time taken to fetch it is a major factor. In general, in 1999 people in rural areas spent twice as much time as Dar es Salaam residents collecting water (3.1 as compared to 1.5 hours daily respectively). Residents in urban areas other than Dar es Salaam spent an average of 2.5 hours per day doing the same (WB, 1999:165).

Figure 2.18
Use of Safe Drinking Water and Sanitation, 1999

Source: TRCHS 1999
A similar picture is reflected in the availability and reliability of sanitation facilities. Over 92% of urban households and 82% of rural households are reported to have latrines (TRCHS 1999:19). However, effectiveness in the use of latrines in rural areas is estimated at only 30%. Hand-washing was found to be common across Tanzania before and after eating, but much lower after defecation and after attending a child who had defecated. This may be due to positive reinforcement in the public act of sharing a meal as compared to the private act of defecating.

The past few years have seen the development of new approaches to community water supply and local governance related to water. The Government has adopted strategies to facilitate safe water provision in urban and rural areas, including private sector participation, cost-sharing schemes and community participation. The success of these strategies will depend on the capacity of low-income households to afford water, of communities to plan and manage water infrastructure, and of local government to coordinate access to the safe water sources. The introduction of Participatory Hygiene and Sanitation Transformation (PHAST) and other participatory methodologies at the village level has succeeded in promoting hand washing and use of latrines at the household level and in primary schools.

Health services

The Government and the voluntary sector manage about equal numbers of hospital facilities in Tanzania. However, Government health centres and dispensaries account for most of the care provided at local levels (MOH, 1997a:8-9). Nonetheless, as with the provision of other basic services, there is a large variation across the country in the number of health facilities available per population (table 2.5).

Ensuring wide access to basic, affordable, quality health services in an environment undergoing reforms is a major challenge in Tanzania. As noted in Chapter 1, there is a serious need to translate policy changes into improved and sustained health outcomes, with specific attention to equity issues. The enormous task ahead is aptly summarised in the Public Expenditure Review:

"The challenges for the public health sector in Tanzania in the twenty first century are extensive - rising demand for health care services in the wake of escalating costs, coupled with the HIV/AIDS pandemic, the prevalence of chronic and persisting communicable diseases, worsening inequities in access of services, demoralised health staff and emerging drug resistance to some diseases. The magnitude and gravity of the deteriorating quality of health services are compounded by widespread poverty, poor priority setting, lack of skilled and trained staff, mismanagement and inadequate resources in the health sector." (MOH, 2001c:7).

Overall, the primary health care system has ceased to function for many Tanzanians, whose basic right to health continues to be seriously jeopardised. Consequently, public satisfaction with the availability and quality of health services is extremely low. One study from the mid 1990s found drug availability to be a major problem, with 64% of the respondents characterising it as "poor" or "very poor", followed by location of health facilities, which 45% found to be unacceptably far away (WB, 1999:115). Rural residents are doubly affected, because the quality of services in their areas is relatively worse, and they are forced to incur high costs to travel to better equipped hospitals located in urban areas (WB, 1999: 114).

Strengthening the skills, motivation and effectiveness of health workers is essential to improving service delivery. In 1996 the Ministry of Health initiated a five-year Human
situation analysis of children in tanzania

resources for health (hrh) plan to address these concerns. while many activities have been implemented, serious challenges remain, including:

- salaries in real terms have decreased from 1995/6 to 1998/99; some salary grades have fallen as much as 35%.
- a comprehensive plan for rationalisation of staff, including adequate distribution of personnel in rural and less desirable areas, is still needed.
- the elimination of the ‘bonding’ policy obligating publicly funded health care graduates to public sector work needs to be re-examined, because many are unwilling to work in poor areas, reinforcing disparities.
- the procedures for and ramifications of the transfer of health staff to local authorities below the district level needs to be clarified to relieve uncertainty among health personnel (moht, 2001c:2-7).

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2.3 financing health

the 2001 public expenditure review (per) for health provides cautious optimism about proposed health expenditures through to 2004. total budgetary expenditure on health increased from 0.8% of gdp in 1999/00 to 1.3% in 2000/01. this positive trend is further reinforced in the 2001/02 budget as resources for priority activities in the health sector are expected to account for approximately 1.8% of gdp (urt, 2001). for 2001/02, domestic revenue is projected to cover 63% of total expenditure, and external support, including savings from hipc debt relief, the remaining 37%.

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Health funds are not allocated in a manner that promotes equity and reduces the burden of ill health among the poor. For example, half of the 1997/98 Government health budget was allocated to hospitals (MOH, 2001a:25) even though health centres and dispensaries are the main choice for outpatient care among the poorest. Seventy percent of the overall 1997/98 budget was allocated to salaries, leaving less than 30% for 'other charges' or 'OC' (non-personal emoluments, notably drugs), of which only 60% was released in 1996/97 (MOH, 2001a:40).

Within the country, the geographical distribution of funds does not appear to be on the basis of need or activity levels either (MOH, 2001a:25). An analysis of OC disbursements to districts published by the Ministry of Finance reveals enormous disparities. On a per capita basis, the average OC disbursement for health was Tshs 249, but ranged from Tshs 59 for Kinondoni to Tshs 1,587 for Pangani, a 27-fold difference (figure 2.19). Similarly, the average per capita OC disbursement for water was Tshs 64, but ranged from Tshs 5 for Geita to Tshs 648 for Mafia, a 130-fold difference. Fifteen urban districts received no OC funds for water at all (figure 2.20).

The districts with very low populations and/or remote locations, such as Mafia and Pangani, are probably allocated higher per capita amounts to cover fixed administrative and transport costs. In contrast urban districts such as Kinondoni, Temeke and Mwanza Urban are allocated lower per capita amounts reportedly because of their greater capacity to generate own funds. Nevertheless, there does not appear to be an adequate explanation or justifiable pattern to explain the extremely large disparities between districts. Neither have the criteria on which allocations are made been publicly available to enable further scrutiny.

Moreover, these data may not provide the full picture for what is actually made available for critical public services at the district level. There are wide disparities between budgets/allocations and actual expenditure at the district level. The 2001 Pro-Poor Expenditure Tracking Study found "significant re-allocations of funds" and "indications some of this re-allocation is being misappropriated", made possible by weak monitoring and reporting mechanisms (REPOA and ESRF, 2001:iii). The study also noted that a

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**Figure 2.19**

Health OC Disbursement per Population July 2000-May 2001

significant amount of disbursements were unaccounted for, and that delays between disbursement and receipt of funds from MOH to local authorities ranged from 9-43 days (REPOA and ESRF, 2001:13).

The equitability of user fee schemes in health is still in question. While the 2001 PER makes reference to an evaluation of hospital fees which concluded that fees did not seem to have affected attendance at public hospitals, the 2001 HSR refers to contradicting evidence. Some studies (Hussein and Mujinja, 1997) note a decrease in attendance rates in many of the government facilities (which may also be due to the non-availability of drugs). Importantly, policies on waivers and exemptions have been applied variably across institutions (MOH, 2001a:11). This may result from the absence of incentives among health facilities to provide exemptions, since they are not compensated for providing services free of charge (MOH, 2001c:26).

2.4 The Policy Environment

The policy environment underlying delivery of health services has a serious impact on the quality, quantity, access and affordability of health care in the country, and ultimately on the health and well-being of children and adults, women and men. The PRSP sets specific targets for improvements in health, including reducing child and maternal mortality and expanding immunisation and access to safe water (URT, 2000b:24-25). A range of other specific policy and programme changes have been instituted in the 1990s to improve the availability and quality of health services, including an overarching process of health sector reform. In addition to the implementation of the reform, the Government developed the first National Population Policy in 1992, and a National Reproductive and Child Health Policy in 1998.

In the past few years, the Government has begun to implement health sector reform as part of the overarching process of public sector reform in the country. The reforms are focussed on three main goals:
1. to increase the efficiency and sustainability of the sector by improving health financing mechanisms, promoting alternative modes of service delivery, and enhancing the voice and participation of the clients in the health system.

2. to rationalise resource use and allocations based on public health priorities and cost effectiveness criteria, and intensify the impacts on the burden of disease through high-impact, cost-effective public health interventions.

3. to strengthen the institutional capacity to support a decentralised public health system that emphasises increased responsibilities and resources for local agencies to manage public health programmes and for facilities to manage themselves.

An important component of the reforms is the decentralisation of health management to the district level, including responsibility for much of the financing of health services. MOH has begun to integrate vertical programmes and services in order to provide more comprehensive care, and move away from separate, parallel programmes funded and often heavily influenced by donors.

Major bilateral funders in Tanzania have decided to pool a portion of their funds to health activities in a ‘basket fund’ that provides USD 0.5 per capita for health services to each council undergoing reforms. There are explicit measures for distributing these funds directly to the district (or council) level. The Basket Fund Guidelines for the use of these funds have been developed and implemented in 37 initial ‘reforming’ districts.

There are a number of challenges to successful implementation of the reforms, and ultimately, the attainment of better health care for Tanzanians. A major concern is that while local authorities will increasingly need to develop health plans, decide budgets and allocate funds, their capacity to do so is weak. A number of other key challenges have been identified as needing priority action (see box).

The new policy environment provides an opportunity to strengthen community participation and broad accountability in planning, implementation and monitoring basic social services, including health. However, in the early years of the reforms communities had not yet been meaningfully involved in these stages. Rather, community involvement appears ad-hoc, externally managed and dependent on donor resources (MOH, 2001c:4). The Health Sector Review further notes:

"Council planning does not include mechanisms for council leaders to report publicly at all levels on the allocation/use of funds. Communities are not involved in on-going planning procedures and the term 'participation' is sometimes interpreted by policy-makers and communities themselves as paying user fees. There is very limited involvement of women and marginalised groups in decision making bodies and processes, and users do not participate in committees that review functioning of facilities and performance of health workers at all levels" (MOH, 2001c)

However, local authorities appear to be more involved in developing health plans than in the past. Guidelines for the establishment of Community Health Services Boards (CHSBs) and Health Facility Committees have been finalised, which in principle will provide a role for community members in decision-making and oversight. One area of contention is whether selection provisions will be changed to enable election of representatives by community members themselves, so as to enable CHSBs to be more representative of and accountable to their constituencies.

The move towards sector-wide and basket funding approaches have raised important questions about the role of NGOs, including faith-based health service providers. NGOs
Implementing Health Sector Reforms: Key Challenges

- Vertical programmes still dominate at the national and local government levels with separate accounts, supplies, reporting requirements and capacity building exercises. This makes it difficult to obtain an overview of actual activities and expenditures. At the same time, integration of vertical programmes should be done carefully so as to cause minimal disruption and not lose past gains.

- Details of the reform process are unclear to many local authorities and the general public, and collaboration between key ministries is inadequate.

- Explicit mechanisms for public reporting of the allocation and actual use of health funds are yet to be adequately developed.

- There are delays in transferring basket funds to districts, in part because local authorities have little information about or capacity to access the funds.

- Requirements placed on local authorities to plan for the USD 0.5 per capita basket fund allocation often override the development of comprehensive health plans.

- The basket fund allocation of USD 0.5 per capita does not adequately account for need or equity issues, including district specific poverty, burden of disease and actual utilisation of health services.

Source: MOH, 2001c

have contributed significantly to providing health services, including by managing a large number of district-designated hospitals and innovative health projects. More recently, some NGOs have begun to play an effective watchdog and advocacy role as well, which can bring in valuable independent input to the sector-wide approach, and help ensure adequate checks and balances. Despite this, however, support by external development partners to NGOs is projected to decline from Tshs 14.3 billion in 2000/01 to Tshs 4 billion in 2003/4 (MOH, 2001a:48). Whether this change is a reporting lag or an actual decline in resource commitments needs to be better understood.

"...NGOs and faith-based institutions often serve the poorer and more marginalised populations, provide essential health services complimenting government care, give examples to government of effective programming and bring community perspectives to bear in policy setting. Nonetheless, under the basket arrangement, these institutions (including voluntary agencies and district designated hospitals) are in some cases unable to access donor funds either from the donors themselves or through council health plans. While NGOs and councils should be encouraged to strengthen collaboration, continued funding must be available to civil society or else Tanzania may lose many vital and successful programmes". (MOH, 2001c:Appendices)

One way in which service delivery can be improved is by strengthening community capacity to demand better care and transparency. Field visits and reports consistently find the ways in which government staff (in all sectors) interact with members of the community to be problematic. The following experience from an agricultural review is illustrative.

"No village visited has an active agricultural extension agent stationed in it. Community residents expressed displeasure with the lack of proficient agricultural service in the villages, describing agents as "incompetent", "lazy", or "ignorant" of state of the art agricultural technology of use to farmers. Although theoretically an extension agent has been posted in half of all Shinyanga villages, in reality they are based in ward offices, and due to the size of the region and the poor quality of its roads, apparently rarely travel to remote sites" (CARE, 1995:27).
What is Gender and Why is it Important?

**What is gender?**
Being male or female is a biological fact. Gender refers to socially constructed roles based on one’s sex (“fetching water is women’s work”) as opposed to biologically determined roles (“men do not become pregnant and give birth”). Gender is also about the structure and terms of relationships between men and women and boys and girls, and how they influence life circumstances, choices and opportunities. In relation to HIV/AIDS, for example, gender becomes important in understanding why adolescent girls are disproportionately affected as compared to adolescent boys, and why women are blamed for spreading the disease.

**Why is gender important?**
Gender discrimination is common in all societies, including Tanzania. The specific forms, manifestations and extents of discrimination - and their causes - vary between different communities, but in most cases gender discrimination makes women less safe, reduces their quality of life, and diminishes their options for advancement. Gender based violence, for example, can cause enormous physical and psychological injury and even death of many women. For this reason attention to gender discrimination is often focused on the situation of women. However, this need not necessarily lead to the exclusion of men. In fact a gender perspective can reveal how men too can be negatively affected by the social construction of their identity, roles and expectations, including the ways in which they are socialised to relate with other men, women and children.

**What is a gender perspective?**
Taking a gender perspective goes beyond expressing a concern for women and girls, or simply including them. It involves examining how social, cultural, economic and political factors determine the roles and responsibilities of men and women differentially. A gender perspective involves asking the questions, “Who benefits, and who loses?” In relation to education, for example, a gender perspective can help one understand why girls’ performance achievements are so much lower than boys in Tanzania, and why their enrolment decreases significantly at higher secondary and university levels.

**What is gender mainstreaming?**
Gender mainstreaming means ensuring that gender issues are not only dealt with marginally, but that they become a core consideration in the central activities of any society or organisation. The UN Economic and Social Council provides a useful definition: “Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality” (http://www.undp.org/gender/capacity/gm_intro.html, accessed 15.11.2001). Thus while developing and monitoring the strategy for poverty eradication in Tanzania, gender mainstreaming can help identify discriminatory structural and cultural aspects that prevent full equality. At the same time, however, there is a need to ensure that the mainstreaming approach does not lead to the specific concerns of women or men being ‘diluted’ or ‘lost’ in the process.

MOH is aware of these problems and recently established the Community Initiative Framework to enable community members and government officials to work together in a more appropriate and effective partnership. A framework for the initiative has been agreed, and a pilot project plan for support to the council health management teams has been developed.

### 2.5 Conclusion

There were important new developments in early childhood programmes during the 1990s, including the introduction of ITNs and PMTCT services. Some interventions, such as immunisation, were maintained at relatively high levels. But overall, the situation of young children in Tanzania did not improve in the last decade. Many critical indicators - including infant and child mortality, malnutrition and access to safe water - remained stagnant or actually declined. The major childhood illnesses such as malaria, diarrhoea and acute respiratory infections continued to affect millions of children. Basic social services vital to the health and development of young children have been under-funded, access to them is limited, and their quality appears to have deteriorated even further. A telling indicator of the lack of public confidence in Government services is that most children die at home, many without seeing any health worker.
Consequently, Tanzania has not achieved the 2000 targets it set for itself following the 1990 World Summit for Children, and is far from being on track to meet 2015 international development goals or Vision 2025 targets. The basic right of all children to survival, protection and development continues to be threatened for far too many children in the country. Of particular concern are deepening disparities, with the children of the rural poor being especially disadvantaged.

These circumstances are troubling in the context of considerable success in Tanzania during the 1970s and early 1980s, which experienced a major expansion in primary health care. During this period important improvements were made in lowering infant and child mortality, and improving nutrition, immunisations, and access to water and sanitation. Attention to community-based approaches, including effective recruitment, training and support to village health workers (VHWs), was an important factor in the success of the programme. The relative success of immunisation programmes in the 1990s is likely to be due, in part, to the high level of community awareness and local demand. The recent health sector reforms provide an opportunity to make up lost ground and build on past successes. But far greater attention will need to be paid to revivising community-based programmes, which so far appear to have been only marginally addressed in the reforms.

The impact of user fees and cost sharing mechanisms needs better understanding and further independent analysis. While opinions on their adoption remain divided, there is clear evidence that many of the poor and other marginalised groups are unable to afford basic services, and that exemption safeguards are not functioning effectively. Ensuring equitable access to basic services for all needs to be a paramount Government policy objective if the rights of children are to be realised in Tanzania.

The full impact of the HIV/AIDS pandemic became apparent in the 1990s. By the end of 1999, 1.3 million Tanzanians were estimated to be living with HIV and 700,000 children orphaned by AIDS were estimated to still alive (Measure et al, 2001). Other surveys indicate that actual numbers may be higher. Over half of all beds in many hospitals across the country are occupied by people with HIV-related illness. AIDS debilitates and kills thousands of teachers, health workers and other caretakers, the very people who are most needed to provide prevention education and care. Children are often hit the hardest, as parents fall ill and scarce resources are devoted to treatment, or expropriated by others after their parents’ death. In recent years Tanzania has made a firm, high-level commitment to dealing with HIV/AIDS. But the ramifications of the disease - on basic services, on productive capacity and on the social fabric - are yet to be fully understood. In this regard supporting community networks to cope with and respond to HIV/AIDS will be vital.

Finally, while technical improvements and ongoing support are necessary to improve early childhood in Tanzania, democratic governance lies at the heart of the challenge. Strengthening governance institutions at all levels will be critical to translating public demands for a better life into concrete, realisable actions. This means, for example, enabling citizens to use local government councils, and water and health committees to channel their ideas and concerns, and hold leaders accountable (Bangser, 2000). It involves promoting broad transparency of information and processes, including over the allocation and use of public funds. Local government reforms initiated recently are consistent with this view. The critical task ahead is to implement the reforms at district and community levels in a manner that creates real space for public participation.