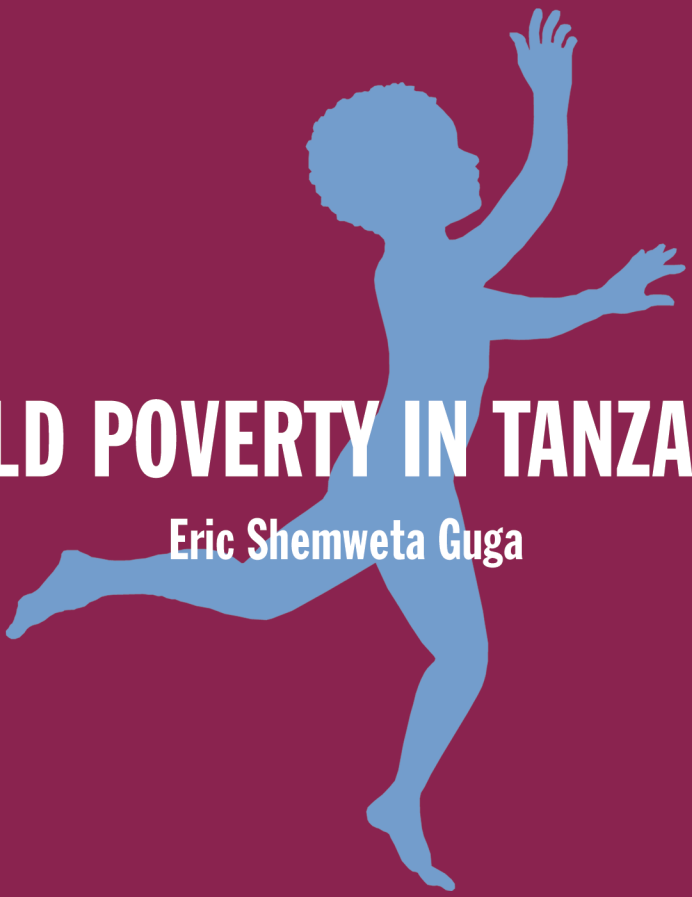


CHILD POVERTY IN TANZANIA

Eric Shemweta Guga

The African Child Policy Forum

Table of Contents

Preface 1

The situation of children in Tanzania: the facts 2

Introduction 4

Methodology 5

I. What do we know about poverty among children in Tanzania? 6

1.1 Nature and extent of child poverty 6
1.2 Children and non-income poverty 9
1.3 Health 11
1.4 Social vulnerability 12
1.5 The underlying factors 14

II. What is being done to address the problem? 17

2.1 Financing child poverty initiatives 17
2.2 Institutional framework 19
2.3 Monitoring and evaluation environment 24
2.4 Targeting the most vulnerable children 25
2.5 Sustaining the most vulnerable children response – national commitment 27
2.6 Policies and initiatives in support of the most vulnerable children 28

III. What are the opportunities for action? 29

List of Tables

Table 1: Poverty lines – TShs for 28 days per adult equivalent 6
Table 2: Income poverty indicators, baseline and targets 7
Table 3: New Standard I enrolees (2002-2006) 9

List of Maps

Map 1: Percent of population below the basic needs poverty line by district, 2001 8

List of Figures

Figure 1: Percent of approved budget released by components for FY 2005/06 10

Preface

Children account for a large proportion of the income-poor and the severely deprived worldwide. At least 600 million children under the age of 18 are surviving on less than US $1 a day around the world; 40 per cent of these children live in developing countries. Every second a child in developing countries is deprived of even the minimum opportunities in life.

Growing up poor means being disadvantaged from before birth; it means shorter lives; it racks up social and economic costs for societies; and it wastes precious human potential. All this adds up to a hugely credible moral case for tackling child poverty. At the same time, social and economic changes challenge African societies to improve living standards for all children, whilst ensuring that inequality does not lock poorer children out of opportunities.

Despite the widespread incidence of child poverty in the continent, most of the data available is anecdotal, outdated and often of questionable quality. Where survey data is used, this often means household data, compressing differences within households. Child poverty is overlooked in serious research undertakings, as children often have no voice. There is an incorrect assumption that children respond in the same way as adults to development interventions, or that policies formulated by adults will always act in the best interests of children.

Data and information influence policy, so good quality information is indispensable to policy development, as is good access to relevant evidence about successful interventions. Better statistical data and more effective analysis is the first step towards influencing policy and changing it for the better. Conducting studies to build the knowledge base on the issue and disseminating the results as widely as possible are pivotal in the policy advocacy arena. The African Child Policy Forum therefore initiated desk-based studies on child poverty and policy experiences in selected African countries. The findings of the studies were intended to inform the Third Policy Conference on the African Child, organised under the theme of child poverty and held from May 12-13, 2008 at the UN Conference Center in Addis Ababa. This publication is one of those commissioned studies, and we take pleasure in making it now available for a wider audience.

Assefa Bequele (PhD)
Executive Director
The African Child Policy Forum (ACPF)

The situation of children in Tanzania: factsheet		
Indicator	Year	Value
General		
Population (millions)	2006	37.9
Child Population (millions)	2006	20.2
Share of children in population	2006	53%
GDP per capita	2005	US $3.25
Child labour	1999-2006	36%
Birth registration		
Births registered before five years of age	1999-2006	8%
Health & nutrition		
Deliveries attended by skilled health worker	2005	43%
Infant mortality per 1,000 live births	2005	76
Children underweight (moderate & severe)	2000-2006	22%
Children with ARTI[1] taken to a health facility	2000-2006	59%
Immunised against measles (aged 12-23 months)	2005	91%
Share of population with access to improved drinking water	2004	62%
Share of population with access to adequate sanitation facilities	2004	47%
Share of government expenditure on health	2004	8.5%
Education		
Net primary enrolment - girls	2004	85%
Net primary enrolment - boys	2004	87%
Secondary school enrolment (gross)	2004	..
Ratio of orphans to non orphans attending school	2000-2006	102
Pupil teacher ratio (primary)	2004	58

Source: Africa Development Indicators (2007), UNICEF (2007) , World Development Indicators (2007), DHS (2006), PRB (2006), MDG (2005), WSS Info (2004) and WHO (2004)

[1] Acute Respiratory Tract Infections (i.e. pneumonia)

Introduction

Tanzania is among the poorest countries in the world, ranking 159th in the Human Development Index in 2005. It is characterised by especially high and persistent rural poverty,[2] with the additional burden caused by the HIV epidemic worsening the level and spread of poverty. There is evidence of continued improvement in economic indicators. There has also been some progress in some social indicators, such as child malnutrition, education and under-five mortality. Enrolment rates in primary education continue to be high, and there are reported reductions of drop-out rates and improvements in examination results. There have been recent reductions in rates of infant and under-five mortality, as well as in child malnutrition. However, improvements in economic indicators have not been large and wide-spread enough achieve the targets for poverty reduction among rural households. Moreover, progress has been unconscionably slow in a number of dimensions of well-being. More equitable allocations of resources, including trained staff, are needed to ensure that the poor and those in rural areas also benefit from these successes.

Children, which account for 53 percent of the total population, are the most vulnerable group to the shocks and stresses of poverty such as poor living conditions, malnutrition and ill-health. In spite of the sizable share of the population that children account for and their disproportionate vulnerability, existing data fails to provide information regarding the situation and trends in child development. Data generated by, and hence plans prepared by government bodies, are aggregates that do not provide age-segregated information on the situation of children.

This study intends to help fill this gap by providing detailed analysis of poverty that focuses on child poverty and goes beyond aggregated indicators of income poverty and inequality. The ultimate goal is to provide an analytic and information baseline for policies and strategies that can help bring about significant and lasting reductions in child poverty.

[2] 2006 rate: US$ 1=Tshs 1,200

Methodology

The analysis in this report mainly relies on three datasets: the Household Budget Survey (HBS), Tanzania Demographic Health Survey (TDHS) and the 2002 House and Population Census (HPC). These sources provide a coherent and complete foundation for a comparative analysis of child poverty. This has been supplemented by information from the analysis available in the series of Poverty and Human Development Reports of the MKUKUTA. Additional information on contextual issues and variables has been obtained from a review of the literature.

Poverty rates are measured using head-count ratios, applying the widely used poverty line of US$ 1 per day per person. Using this poverty line, we classify children as poor when they live in a household that lives on less than US$ 1 per capita. Indicators of income inequality are computed using the above-mentioned datasets.

Much has been done to relate the indicators of poverty and inequality with other aggregate variables. However, the comparisons have been severely limited due the low-frequency availability of household level income-expenditure data.

I. What do we know about poverty among children in Tanzania?

1.1 Nature and extent of child poverty

According to the Poverty and Human Development Report (PHDR) produced by the Research and Analysis Technical Working Group (RATWG) of the MKUKUTA Monitoring System, 36% of Tanzanians were living below the basic needs poverty line of US $1 per adult equivalent per day during the year 2000/01.[3] The Household Budget Survey of 2001 indicates this to be specific TShs 7,253 for 28 days per Adult Equivalent which is about TShs 259 per day per adult equivalent (Table 1). Similar situation exist in food poverty line where the Household Budget Survey in 2000/2001 indicates average of TShs 5,295 for 28 days per Adult Equivalent, which is about 189 per day. The proportion of household who consume no more than one meal per day has increased from 1.1 per cent in 2001 to 1.9 per cent in 2005.[4]

Table 1: Poverty lines – TShs for 28 days per adult equivalent

Poverty lines	1991/92	2000/01
Food poverty line	2,083	5,295
Basic needs poverty line	2,777	7,253

Source: 2000/ 01 Household Budget Survey, NBS

Between 200 and 2008, the growth rate of GDP ranged between 5.1 percent (2001) and 6.7 per cent (2004/2005) and the growth rate of agricultural GDP ranged between 4.0 percent (2003) and 6.0 percent (2006). The share of agriculture in the economy declined slightly, partly due to changes in economic policies and strategies. Nevertheless, agriculture is still the major source of income for about 80 percent of the population that lives in the rural area. Industry is mainly limited to processing agricultural products and light consumer goods.

[3] RATWG 2002, 2003 (P&HDR (2002/03), quoting Household Budget Survey 2000/01
[4] THBS (2001) TDHS 2005 in RATWG (2007)

Income inequality has increased tremendously, particularly in urban areas where inequalities are already high. As a result, the extent to which the growth has reduced poverty is questionable and may be affected by international and rural-urban terms of trade.[5] More recent poverty estimates using economic survey data suggest that in 2007 about 21% of Tanzanians were living below the basic needs poverty line.[6] There was an increase in the number of individuals living in poverty (11.4 million in 2000/01 compared to 9.5 million in 1991/92). Rural-urban migration is expected to increase with rising income stress in the rural areas and increasing labour demands in urban areas. The consequence of this is rising number of children living on the street and different forms of child labour in urban areas.[7]

Table 2: Income poverty indicators, baseline and targets

Indicator	Baseline		Trend						Targets	
	Estimate	Year	2001	2002	2003	2004	2005	2006	PRS 2003	MKUKUTA 2010
% of the population below the basic needs poverty line	36.0	2000-2001	x	x	x	x	x	x	30.0	19.0
% of the population below the food poverty line	19.0	2000-2001	x	x	x	x	x	x	15.0	10.0
GDP growth rate (%)	4.9	2000	5.7	6.2	5.7	6.7	6.7	6.2	6.0	6-8
Agricultural growth rate (%)	3.4	2000	5.5	5.0	4.0	6.0	5.1	4.1	5.0	10.0
Inflation rate (%)	5.9	2000	5.2	4.5	3.5	4.1	5.0	7.3	4.0	4.0
% of working age population not currently employed	13.0	2000-2001	12.9 (ILFS)	x	x	17.0 (TDHS)	x	11.7 (ILFS)		7.0

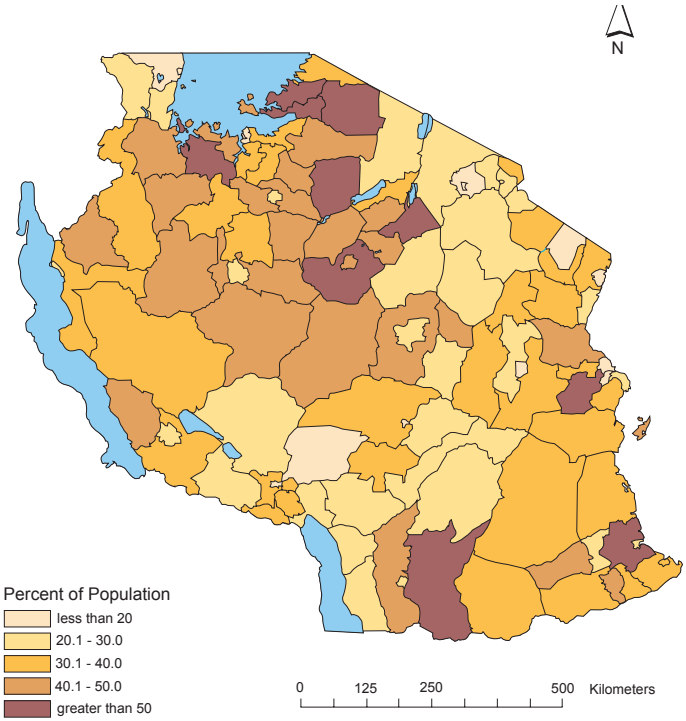
Sources: Adopted from National Bureau of Statistics (2002); Economic Surveys, various, p2 in Poverty and Human Development Report 2005

Despite the encouraging trends in GDP growth since 1993,[8] 'the perceptions of the majority of Tanzanians across all income groups, including the least poor, are that their living standards have been stagnant

[5] RAWG (2005)
[6] RAWG 2007)
[7] ILFS (2008)
[8] An assessment of the rate of growth reveals a sharp increase between 1993 and 1996, followed by a steady but lower rate of growth for the period 1997 through 2002; between 2004 and 2006 the econ omy continued to grow but at an even slower rate

or declining.'[9] The overpowering public perception is that only a small minority of Tanzanians are benefiting from reform and economic growth and more people appear to be worse off now than three years ago which signifies inequality in the society.[10] The major challenge therefore is how to best ensure that this increase in GDP benefits the majority population equally rural and urban and be able to address the development challenges on equal and equity bases.

Map 1: Percent of population below the basic needs poverty line, by District 2001



Source: PHDR (2005)

[9] Mamdani and Omondi (2008) p10; extract from 'Social Protection of Vulnerable Children in Tanzania Mainland: Evidence, Limits and Challenges. A Socio-Economic Policy Case Study in Tanzania' for JLICA, Learning Group 4 [forthcoming]

[10] REPOA Views of the People (2007) [forthcoming] A total of 7,879 people aged from 7 to 90 years from ten regions of mainland Tanzania participated

1.2 Children and non-income poverty

Education

Arguably, primary education has experienced the largest changes in Tanzania in the last decade in terms of scale, scope and budget. Under the Primary Education Development Plan 2002-2006 (PEDP),[11] massive investments were made in the sector across the country: the number of teachers increased by 50%, and over 41,000 new classrooms were built. Mandatory primary school fees and contributions were abolished. The overall budget for basic education more than doubled in five years (in nominal terms), allowing resources disbursed to the school level to increase more than five-fold from less than US$ 1 per pupil to over US$ 5 per pupil per annum. Following these reforms, an additional two million children were enrolled in primary school by 2006.[12]

National educational indicators reveal largely positive trends at all levels. As a result of the reforms, particularly abolishing school fees and contributions, official enrolments reached over 7 million in 2006, an increase of over 2 million pupils, as can be seen from the table below. While these figures need to be adjusted for increasing numbers of 'repeaters' (a worrying development), the increase is still significant.

Table 3: New Standard I Enrolees (2002-2006)

Year	Target enrolment	Actual enrolment	Repeaters	New enrolment	% above or below target
2002	1,500,000	1,632,141	36,498	1,595,643	+6.38
2003	1,600,000	1,481,354	117,514	1,363,840	-14.76
2004	1,640,969	1,368,315	131,358	1,236,957	-24.62
2005	1,040,880	1,376,467	125,512	1,250,955	+20.18
2006	1,065,843	1,316,727	145,933	1,170,794	+9.85
Total	6,847,692	7,166,852	556,815	6,618,189	-3.35

Source: Basic Education Statistics in Tanzania (2006)

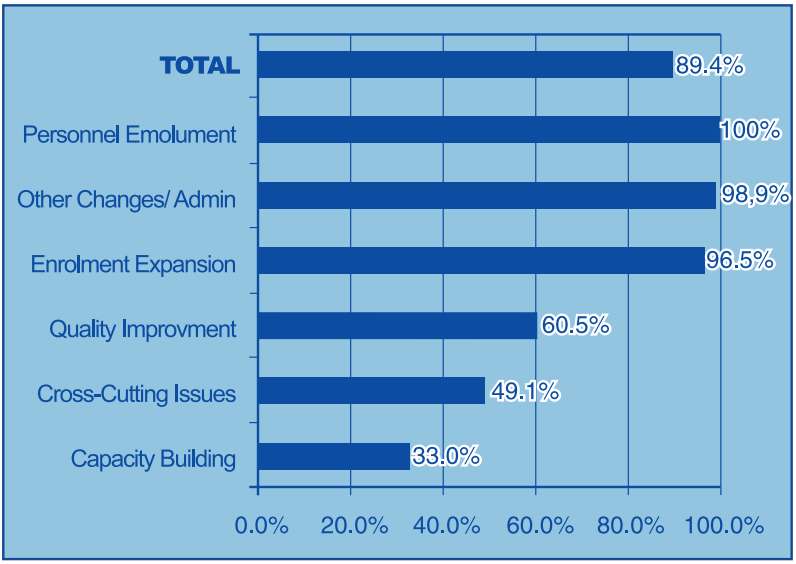
[11] United Republic of Tanzania, Education Sector Development Programme Primary Education Development Plan Dar es Salaam (July 2001)

[12] HakiElimu What has been Achieved in Primary Education? Key Findings from Government Reviews Dar es Salaam (October 2007)

Overall net enrolment increased from 67% in 2001 to 96% in 2006.[13] Gender parity has also been achieved in primary school enrolment in Tanzania.

In spite of the above-mentioned progress, implementation of the PEDP was fraught with several problems. The full US$ 10 per pupil that was promised under the plans has not been disbursed. Actual disbursements were closer to US$ 6, and appear to be falling in recent years. Lack of adequate funds has been cited as a reason, but this explanation does not square with the fact that the education budget has increased significantly each year, and in fact has risen much higher in the last two years where disbursement appears to be lowest.[14] There have also been problems of prioritization in the use of budgets. It would have made sense to prioritize capitation grant spending over other less critical expenditures such as

Figure 1: Percent of approved budget released by components for FY 2005/06



Source: Adapted from URT: PEDP Progress Report, 2006, 38 in HakiElimu 'What has been achieved in primary education? Key findings from government reviews' (October 2007)

[13] URT, MKUKUTA & RAWG Status Report 2006 REPOA (December 2006)

[14] HakiElimu Education Budget Briefs Number 07.1E Following the money for education (June 2007) see www.hakielimu.org

further construction or the payment of allowances. Instead, the opposite seems to have been done. The chart below is illustrative. The result of these problems has been an imbalance in quantity vis-à-vis quality in education services.

1.3 Health

Regarding health, Demographic and Health Survey (DHS) estimates from 2004/05 and 1999 suggest that Tanzania has made great strides in improving child health. There have been significant reductions in infant and under-five mortality rates. Infant mortality dropped from 99 per 1,000 live births to just 68. Under-five mortality dropped from 147 to 112 per 1,000 live births. The 2004/05 estimates also suggest significant improvements in all measures of malnutrition among under-fives compared to 1999 and 1996, though levels still stood high with 38% of children moderately or severely stunted and 22% underweight. Again, disparities prevail - according to the 2005 Poverty and Human Development Report (PHDR), child malnutrition (low height for age), increased by 8% amongst the poorest households but fell by 20% amongst the least poor households between 1991 and 1999. Malnutrition in Tanzania was indirectly responsible for more than a quarter of under-five deaths – even at its much reduced rate in 2004/05.

Despite remarkable improvements over the years since the advent of health sector reforms in the early 1990s, the health system is generally weak and is unable to handle effectively the disease burden in the context of the HIV/AIDS epidemic which is exerting more demand on an already over stretched system.[15] Access to health care is still inadequate, and the quality of care delivered is sub-standard for various reasons, including an enormous shortages of skilled workforce across all main cadres at all levels of the system, insufficient medical equipment and supplies, and a shortage of medicines,[16] The referral system is compromised by lack of emergency transport and communication systems.

The additional burden caused by the HIV epidemic striking adults in the prime of their lives deprives families and communities of their most

[15] MH&SW (2007)
[16] NBS (2006)

productive citizens, impoverishes households and further compromises the ability of households and communities to provide care for children. Population-based 2003/04 HIV/AIDS estimates show that 7% of Tanzanian adults between the ages of 15 and 49 years are living with HIV.[17] Prevalence among women is higher (8%) than among men (6%). There are urban/rural and geographic disparities. HIV infection among urban adults is double that of their rural counterparts – 10.9% versus 5.3%. Some geographical areas[18] have higher prevalence rates and therefore higher rates of orphanhood than others. But these high adult HIV prevalence districts are not necessarily the ones with the highest rates of child mortality or with the highest prevalence of poverty. Infection rates among adults range from 3.4% in the poorest quintile to 10.5% in the least poor quintile.

1.4 Social vulnerability

HIV/AIDS has aggravated the problem of orphanhood. Roughly 10% of all children below the age of eighteen years, roughly 2 million children, have lost one or both parents (i.e. they are considered to be orphans). Around 8% of children under 18 have lost their biological fathers, 4% have lost their mothers, and 1% cent have lost both parents. Furthermore, 18% of the children live with their mothers and not their fathers, 5% with their fathers not their mothers, and 15% live with neither parent (i.e. they are considered to be fostered). Altogether, orphans and vulnerable children (OVC)[19] accounted for 16% of the child population.

The HIV/AIDS pandemic is having an enormous impact in some communities in Tanzania. Some households and communities fare better than others, depending on a range of factors to do with their own endowments and the wider social and economic situation in which they find themselves,[20] but in a context of widespread poverty, stigma, chronic impoverishing forces and shocks may push the vulnerable to a deeper level of poverty.

[17] TACAIDS, NBS, and ORC Macro Tanzania HIV/AIDS Indicator Survey 2003/04 (March 2005)

[18] For example, almost a quarter of all children had been orphaned in Makete district in Iringa Region

[19] In the THIS survey, vulnerable children were defined as children with one or both parents very sick for at least 3 months in the 12 months priori to the survey or children living in a household with no adult between the ages of 18 and 59 years

[20] De Waal et al (2004)

Children are the most vulnerable to the multiple effects of poverty and HIV/AIDS, particularly in rural areas.[21] Of the total 18 million children under the age of 18, 79 per cent are rural and given the extent of poverty in the country, substantial numbers are living in desperate conditions. Estimates of children living in extremely difficult circumstances, with poor or minimal access to protection, education, health care, nutrition, shelter, property and legal rights range from between 5.3% to around 12% of all children under 18 years of age i.e. about 1 to 2.2 million children.[22] Projected estimates also suggest that there were over 6.6 million poor children in 2006, about 5.8 million in rural areas and 0.8 million in urban areas.[23] Many of the most vulnerable are forced into harmful child labour and/or sexually exploited for cash or to obtain 'protection' and as a result may be withdrawn from school. According to the 2000/01 Labour Force Survey (ILFS), around a fifth of all children aged 5-17 years were in the labour force and not attending school in 2000/01.[24] The latest estimates from the ILFS 2006 show that 21.1% of working children are employed as child labourers.[25] All these children are considered to be the most vulnerable.

Many of the poorest children are not orphans – according to estimates in Mhamba et al (2007), about half of the destitute are not orphans. Estimates from DHS 2004/05 indicate that 89.9% of 10-14 year olds who had lost one or both parents attended school, and other analyses reported in the PHDR 2005 also indicated no significant difference in primary school attendance between children who had been orphaned and those who had not. However, analysis which applies poverty mapping techniques to the census data indicates that orphaned children are poorer than children who are not orphaned, and that the difference between the two groups is larger in Dar es Salaam than in other parts of the country.[26] According to the Kagera orphanhood cohort study, maternal orphans were

[21] Leach V (2008) [forthcoming]

[22] Based on the estimate number of MVCs in the 19 districts where DSW was initially implementing the community based MVC programme, Lindeboom et al (2007)

[23] The estimates were obtained using official NBS population projections and the different vulnerability prevalence rates reported in the 2002 Population and Housing Census, Lindeboom et al (2007)

[24] URT (2002)

[25] Quoted in P&HDR 2007 (RAWG 2007). Child labour is considered as work performed by children less than 18 years of age which is exploitative, hazardous or inappropriate for their age, and which is detri mental to their schooling, mental, spiritual and moral development. Most children usually assist with household chores and child work in this context is usually considered to be socially desirable

[26] Lindeboom et al (February 2006)

more likely to be stunted and lose years of education, in particular those who had been orphaned at a younger age and who had not yet started school.[27] Paternal orphans, on the other hand, were less affected. Findings of a research undertaken in Mwanza by the National Institute for Medical Research (NIMR), Mwanza Centre, suggest that across most indicators, orphans appear to be more vulnerable than children living in nuclear families. Foster children are relatively less vulnerable to disadvantages than orphans, but they show evidence of reduced wellbeing across most indicators compared to children in nuclear families.

1.5 The underlying factors

Urban incomes have risen, and so has inequality. Agricultural GDP estimates suggest rising income at an average growth rate of 4.7% between 2000 and 2006. Despite this, little is known on how this translates into increased rural household income, especially for the poorer households.[28] About 75 to 80 percent of Tanzania's population lives in the rural areas and depends on underdeveloped smallholder primary agriculture production.[29] Major constraints include low level of access to inputs for production and for loans/credit to the majority of rural farmers, poor state of roads, periodic droughts, floods and environmental degradation. Unpredictable and unreliable rains are a major source of shocks in areas dependent on rain-fed agriculture.

The budget for education in Tanzania has increased dramatically in recent years, from about TShs 300 billion in 2000/01 to TShs 670 billion in 2005/06 and almost TShs 1.1 trillion in 2007/08.[30] Education constitutes the largest single budget line, and takes up about one quarter of the entire budget. This has been made possible in part through increased donor support, including World Bank credit, sector basket funds and budget support.

Weakness in the health system has direct impact on the delivery of maternal and newborn services. The maternal mortality rate (the ratio of women who die during childbirth) remains very high and shows no

[27] Beegle, De Weerdt & Dercon (2005)

[28] IRAWG (2007) in Mamdani and Omondi (2008) [forthcoming]

[29] INational House and Population Census, calculated from the projections (2002)

[30] IHakiElimu, education budget briefs number 07.1E, Following the money for education (June 2007) see www.hakielimu.org

improvement since the previous survey in 1996, with 578 women dying from conditions related to pregnancy, delivery, and related complications, for every 100,000 live babies born.[31] This implies that roughly one woman can be expected to die every hour from maternal causes in Tanzania. This is an indication not only of poor reproductive health, but also of women's low status, gender inequalities in decision-making processes and access to resources at household level, and poor access to basic health services. Regardless of high antenatal care attendance, with 94% of pregnant women attending at least once, only 47% of births occur at health facilities, and only 43.3% of these births are attended by skilled attendants (using the WHO definition of "skilled attendance").[32] There is a major gap in skilled attendance at delivery between urban areas (79%), and rural areas (34.5). Altogether, despite significant achievements, health conditions vary widely in Tanzania. There are enormous geographic disparities and people living in rural areas and those in poverty remain disadvantaged both in terms of service uptake and outcomes.

The cost of services is of concern, both to users and to those who do not use services. Major barriers perceived by rural poor women to access delivery health services include costs of care (official and unofficial), long distance to a health facility, lack of transport, and unfriendly services. The framework of cost sharing arrangements in Tanzania in the area of health provides for exemptions for some individuals falling under certain specified categories particularly pregnant women, under fives, the elderly, those suffering from some chronic diseases such as tuberculosis and diabetes, and the very poor. But many poor and vulnerable people fail to receive exemptions.[33] According to Views of the People (2007), only 10% of the elderly who sought treatment during the three months preceding the survey had received free treatment, and nearly half (48%) of all elderly people were not even aware that they were entitled to free medical treatment in government facilities. In addition, approximately one-fifth of respondents (18%) reported that they had been refused treatment in a

[31] ITDHS 2004/05 measured maternal deaths over the 10 year period preceding the survey

[32] The 2004/05 TDHS estimated skilled birth attendance for births that occurred in the five years pre ceding the survey. Further analysis of the TDHS data on 12-month intervals confirms that there has been no increase in the proportion of facility-based births within this five-year time frame. There are therefore no grounds for optimism that the rate of skilled attendance has improved either RAWG 2007)

[33] SC (2005); WDP (2003)

government health facility because they could not afford to pay for services. A further 13% declared they had been refused through lack of proof of their age. Systems of local governance are improving, but still lack capacity to deliver services appropriately. This problem is compounded by lack of transparency, abuse of power, financial mismanagement, corruption, lack of knowledge about rights and recent reforms, and lack of appropriate mechanisms to voice concerns. Low levels of citizens' participation in the decisions that determine their rights and entitlement to services entrenches social exclusion.[34]

There are many challenges with respect to resource requirements for a scaled up response, and measures that need to be taken towards a more coordinated, effective and sustained response. This section tries to summaries some of the key challenges and what measures are in place.

[34] Rakesh (2007)

II. What is being done to address the problem?

2.1 Financing child poverty initiatives

In most cases, the HIV/AIDS pandemic gave rise to the need to respond to the increasingly vulnerable children who are both orphaned and not orphaned by HIV/AIDS related deaths.[35] With support from Family Health International (FHI) and UNICEF, the Government has prepared a fully costed national plan of action (2006-2010) for a national response to orphans and vulnerable children.[36] The issue is not only how much, but how and what to cost.

In part, the national plan has adopted estimates from a recent expenditure gap analysis undertaken by REPOA.[37] This analysis is not intended to be a prescription for a programme, but rather an estimate of what it would cost to include the poorest and most vulnerable – the minimum costs – and then whether it could be "afforded."

Using data from the population census, REPOA's analysis projects the number of MVC in Tanzania Mainland to be 930,000 in 2006, which is roughly five per cent of the total child population. The most vulnerable children – the poorest – live in households with expenditures 30% below the poverty level and food is their biggest problem. They are orphaned and disabled children living in very poor living conditions – not necessarily all AIDS orphans since some may live in less poor households, and nor does it include a majority of all the children who are very poor.[38] This calculation only includes the poorest children, and not those who live at or around the poverty level. The argument is that bringing the very poorest and most

[35] Orphans according to UNICEF are categorised as biological and social orphans. However for this case the vulnerability factor override the status

[36] Government of Tanzania, Ministry of Labour, Youth Development and Sport The Costed MVC Actions Plan: 2006 to 2010(2005) [subsequently revised for Ministry of Health and Social Welfare, May 2006]

[37] Lindeboom et al (2007)

[38] More specifically, this classification includes children living in child headed households; children living in elderly headed households with no adult of age 20 to 59 years present; children with both parents deceased; rural children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar poor conditions; and urban children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar poor con ditions.

vulnerable up to the poverty level will enable them to be better cared for and protected. Further, because such a large proportion of the population lives below the poverty line - 36% - a nationally funded programme is not likely to be funded for all those below the poverty level.

The authors also estimate[39] the annual cost in 2006 to provide direct support to 930,000 children considered to be the most vulnerable, and to bring them to the national poverty level, to be TShs 37.8 billion (US$ 31.5 million). Of this amount, TShs 30.7 billion (US$ 25,583 million) is needed annually (in 2006 prices) for food, and TShs 7.1 billion for non-food items. The national costs of establishing systems of identifying and providing support for most vulnerable children through local authorities and partner organisations are estimated to be TShs 50 million (US$ 42,000 per district), a total of TShs 6 billion (US$ 4.7 million). Administrative/overhead costs are estimated at an additional 15 per cent. Altogether, the total annual costs in 2006 – direct and indirect – of supporting the MVC is estimated to be TShs 43.5 billion (or USD 36.2 million) a year. Clearly this is not unaffordable – the financing data presented earlier on shows that funding through PEPFAR, the Global Fund, (and the World Bank Community Response Component – details in section 3.3), with some government and community support can easily meet this gap. There are also other potential sources of support. The World Bank supported National Village Fund Programme (TASAF) for example, a commitment of US$ 120 million for an unspecified period.[40] Each district is allocated a specific amount of money, based on a formula, from which village governments can apply to implement village development programmes, including projects to alleviate poverty and vulnerability. Obviously, with more funding available, a larger proportion of the poor and vulnerable could be included in a programme of support for them.

The real issues are of implementation – how to get support where it's most needed, taking into account all the constraints already discussed, including the very ethics of targeting the 'poorest of the poor' and what it

[39] The costing looked at the average expenditure of households with expenditures at 30% or below the poverty line on items for children in three age categories (0-6 years, 7-14 years, 15-17 years) and cal culate the gap between this and average expenditures on children of households at the poverty line. The gap was applied to the estimated numbers of the MVC

[40] Quoted in Lindeboom et al (2007)

does to the social fabric of a community, and the complexities at the local government level (sections 3.2 & 3.3). Further, the MVC identification process has not yet been carried out in almost two-thirds of the country. The numbers will change over time. How to sustain and support an identification system – a very expensive process, according to several implementing partners - poses a real challenge. For example, Pact supports the ID process in 20 wards, and this has cost US$ 39,000, and this does not even cover all allowances.[41] The MVC ID process has not yet having been carried out in almost two-thirds of the country.

2.2 Institutional framework

There are several Ministries that are charged with responsibilities and have an impact on children. Each ministry is supposed to have its own budget lines for the most vulnerable children's needs within their respective sectors, but the priority placed upon any particular issue (e.g., MVCs) is highly variable from one ministry to the next.

At the National level, the Ministry of Health and Social Welfare (MHSW) through its Department of Social Welfare (DSW) has the overall responsibility of coordinating the national response of stakeholders including government ministries, local government, to problems of the MVC. The DSW has the mandate to address issues related to the welfare of children and links directly with Development Partners that have a mandate to support MVCs. The DSW acts as an overall anchor of the MVC programme – it is expected to develop relevant policies, coordinate the efforts of all parties – national and external, set norms and standards, make follow ups on activities related to MVC support to ensure that minimum standards are met as per the guidelines, build capacity of service providers, and set standards for the MVC identification process. In addition, it is also responsible for developing systems of social services for the elderly and disabled, and for probation. Prior to January 2006, DSW was a department of the Ministry of Labour, Youth and Sports (MLYS). Now it is a Department of the MH&SW that is charged with the planning and implementation of health policies. Physically, DSW continues to be located in its earlier Ministry. The Department is badly understaffed at the national and district levels and under resourced. The Social Welfare Officer is supposed to advocate for child welfare budgets, needs and plans. Only a

[41] V/C Jane Caldwell, OVC Programme Manager, Pact Tanzania

third of the 126 districts are staffed and they are completely overwhelmed with the enormity of attempting to provide direct services to populations of 300,000 or more people in a district.

A paradigm shift worth noting here is the transfer of responsibilities and functions, and attendant resources, from the national government to the regional and local government levels in the spirit of taking forward the government's declared policy of Decentralisation by Devolution. Implementation of this policy, among other things, is expected to strengthen local government authorities and enable them to bring social services closer to the people, enhance transparency and entrench accountability in the use of both human and financial resources; and encourage participatory planning, thus fuelling the development process at the local level. The Government of Tanzania has been implementing the Local Government Reform Programme since 2000.[42] Most but not all of the Ministries have been devolved to the district level, and not all we be – LGAs have specific responsibilities for service delivery which affects only some of the central government ministries.

The DSW has been left behind in the decentralization process – it was one of the last and it is not clear if the Department has been devolved, although the rest of the MHSW has. This means that while the district level of government employs and directs Community Development Officers, Education Officers and Agricultural Officers, for example, the central government is the employer of the Social Welfare Officers, even those placed at the district level. As a result, while the rest of the central government program implementation is directed from the District Executive Officer's desk in each district, social welfare is administered by an already constrained Department in Dar es Salaam. This puts DSW at a severe disadvantage when it comes to converting national policy into local actions – unless it effectively coordinates and directs the implementation of the NPA through the Ministries and their community workers that are present at the District level.

The Department of Children Development in the Ministry of Community Development, Gender & Children (CDGC/MCDGC) is responsible for the

[42] Local Government Reform Programme 'Policy Paper On Local Government Reform' Dar Es Salaam, (October, 1998)

national child development policy. Each district is staffed with a Community Development Officer (CDO) and additional Community Development Workers (CDWs). The Ministry has over 1,700 CDWs in the field. In districts where there is no SWO available, the CDOs are to serve as focal persons for the District MVCC.

There continues to be confusion about the role of the MCDGC and DSW both at the district and the national levels. Each of the Ministries has been charged with responsibility for MVCs and each attempts to carry out what it sees as its responsibility.

The Ministry of Education and Vocational Training (MEVT) provides tuition assistance to around 12,000 secondary school children who have been identified by Village Education Committees and Village Councils to be the most vulnerable. The MEVT has its own criteria to identify MVCs, basically orphans only. As part of PEDP, around 14,000 school committees consisting of teachers and community members have been formed across Tanzania. These committees have been trained to manage school funds for operating, no-capital, non-salary costs of the local schools.

At the community level exist the Village MVC committees. This is where identification of the MVC begins and consequently service provision is also undertaken. These committees are supposed to monitor the status of the MVC, and coordinate the response at the village level. They also serve as the de facto system of last resort, taxing the community for the benefit of MVC and dedicating village plots to be cultivated by community members for the benefit of MVC. The ward level MVC committees - where they exist and are functional - play the role of coordinating activities of the various village MVC committees within the ward. The ward executive officer is supposed to chair this committee. Additionally, there are the District Council and Village Multi-Sectoral Aids Committees (CMACs and VMACs) established to facilitate the HIV/AIDS multi-sectoral response at the lower levels. Because of capacity and financial constraints, the CMACs and VMACs have been largely ineffective. The MVCCs, at both the ward and village levels, sometimes include members of the CMAC or VMAC, respectively, plus additional members with special interests in or relations to MVC - local and district level officials - who best know and understand who in their community is most vulnerable.

Then there are the service providers – the various CSOs that support the MVC agenda at all levels, from the village up to the national level.

Altogether, there is no significant evidence of systematic attempts to coordinate efforts between the districts and villages, the various committees, and between the staff of various ministries supporting children in one way or another - ME&VT, MCDGC and MH&SW, for example. This no doubt hampers effective support to MVC and their caretakers.

The National Steering Committee (NSC),[43] the high-level policy-making group described in the NPA Plan whose role is to "ensure transparency, efficiency and partnership in the efforts to respond to the needs of MVC"[44] has met once in three years. According to the National Plan, it is to be convened by DSW no less than twice a year. The National Technical Committee "is composed of relevant technical experts from sectoral and line ministries dealing directly or indirectly with MV children, including representatives from both local and international NGOs and FBOS, UN agencies and donor agencies. The committee is responsible for implementing instructions from the Steering Committee and is to be chaired by the Commissioner for Social Welfare Services." The NPA notes that the technical committee is meant to meet every three months. It has only met twice in two years. According to a number of stakeholders, the Department of Social Welfare has not been effective in seeking enough political support from the Government. Perhaps the DSW does not need to. External financial support, most of it off-budget, is largely supporting the roll out of the NPA. Apart from supporting the many policies and plans, commitment from the Government towards realising the rights of all children, in particular the most vulnerable, is not commensurate with the urgency of the problem. With the objective of achieving a more coordinated response at the district level, the current framework within the NPA envisages the MVC committees at the village and ward levels to be linked to the VMACs and CMACs at those levels. This is to ensure that the MVC become part of the CMAC agenda. The CMAC is a legal standing

[43] In principle it includes the Ministry of Community Development, Gender and Children (MCDGC), the Ministry of Education and Vocational Training (ME&VT), the Ministry of Justice and Constitutional Affairs (MJ&CA), the Ministry for Home Affairs (MHA), the Ministry of Labour, Employment and Youth Development (MLE&YD), Prime Ministers Office (PMO), the Ministry of Finance (MF), the Ministry of Health and Social Welfare (MH&SW), UNICEF and USAID.

[44] The Costed MV Children Action Plan p14.

committee within the Municipal Council's structure. And the District Social Welfare Office will facilitate linkages with other departments, CSOs and stakeholders. This of course also means that the training of VMACs and CMACs will need to incorporate a module on care and protection of MV children – existing training programme for CMACs consists of 10 modules, and not a single one covers children /OVC/MVC. There is a real concern amongst many stakeholders that linking the MVC committees to the HIV/AIDS multi-sectoral bodies may narrow the response to OVC, targeting only those orphaned or made vulnerable by HIV/AIDS, as opposed to the MV children.

The national Implementing Partners Group (IPG) is also a key player at the national level, though not a part of the official structure. This is a group of over 55 non-governmental organizations that implement MVC support programmes countrywide who come together periodically to share information, ideas and challenges they face as they implement their programmes. The IPG is chaired by the DSW. In the absence of state intervention, these organizations have stepped in to provide relevant technical support and move the agenda forwards – towards strengthening child welfare planning, budgeting, and programming processes and raising the profile of children's issues, including refining and promoting the National Costed Plan of Action. There are plans for a similar coordinating structure at district level - regular meetings of the Regional Implementing Partners Group organized initially with support from the PACT program but with the expectation that over time, the districts and/or the regional authorities will provide the necessary support to those district and regional IPG meetings. Several unresolved issues remain. The formation of the IPG is a USAID/PEPFAR initiative. The IPG is not a formally recognised body within the framework. The IPG reflects a willingness and intention to coordinate and cooperate among the international donors and NGOs. The extent to which the IPG network can facilitate a more coordinated response will depend on many things, most notably the degree to which external players and the IPG network can work together and support the strengthening of the existing fragile systems at national, district and village levels to develop and implement programmes - by interfacing their programs with it, rather than creating parallel systems and weakening the capacity of an already stretched district; and. by responding to community rather than donor-defined needs. It will also depend on its role and how the network links with other coordinating bodies at the national and LGA level.

2.3 Monitoring and evaluation environment

With support from FHI/PEPFAR, a national Data Management System has been set up by the Department of Social Welfare, under the Ministry of Health.[45] This database essentially attempts to map out the MVC programmes being implemented across the country by the big organizations. It captures information on the number of villages covered, the number of MVC identified and numbers served. It collects data from MVCCs. This can be useful for harmonising the work of different implementers, and of course for planning purposes. This database does not, however, give any indication if MVCs are receiving continued and adequate support. It is not clear how and if this system captures information from the smaller NGOs, CBOs, and FBOs, particularly those who are not registered in the districts where they work, and who are not supported by the major funders. Also, there are issues of how it links to other existing data systems - to Tanzania Output Monitoring System for HIV/AIDS (TOMSHA), for reporting on non-health and community level programme data; and to the quarterly performance reports that each LGA is now required to produce giving status of physical progress (for example, the number of MVC provided with uniforms) and financial progress. Overall, it is not clear what the data base aims to do and how it will work and be utilised – the extent to which this data can facilitate planning and coordination at the nation and local government level. Or does it simply serve the purposes of the funding body – how many MVCs have been supported to date? There are donor induced performance pressures on all stakeholders. Data entry for all the MVC is no doubt a massive and costly undertaking. Social welfare officers are involved in data entry – stretching an already understaffed DSW. At present FHI is supporting the system but it is not clear from where the resources for implementation of this system will come in the long run. There remain many unresolved issues.

Systems are only as good as the data that feeds into them. As noted earlier on, there was no evidence of systematic local monitoring and evaluation activity in any of the districts surveyed in the REPOA assessment of the pilot MVC programme - beyond the reporting which was required by UNICEF.

[45] URT, FHI & USAID (2007)

2.4 Targeting the most vulnerable children

Ideally, targeting MVCs allows for concentrating scarce resources on those most in need. However, targeting involves implementing mechanisms that discriminate between the MVCs and the non-MVCs, in identifying and reaching the neediest households, a procedure that involves high administrative and transaction costs and requires capacity. Poverty is rampant in Tanzania. Institutions are weak. The MVC programme employs community-based targeting mechanisms. Though this approach allows for better identification of the needy, it also has local political demands and prerequisites - what has to be allocated and to whom and for what reasons. Important administrative challenges remain.

For example, UNICEF provided funding for the initial establishment of protection and support systems, training facilitators and members of the MVC committees as well as matching funds for locally mobilised financing for the MVC fund. The UNICEF assessment indicated some problems with regard to the use of MVC funds, in particular in the districts where supervision was weak or non existent: information in records of districts did not match information from UNICEF; regular replenishment of village funds did not take place largely because of difficulties in the accounting system; village MVC funds had been used to pay "sitting allowances" for members of the committees; there were issues with the identification process which at times was said to be unethical and unduly intrusive. There was under coverage of the MVCs and leakage to the non-MVCs. Community reviews did not take place as planned. In the absence of grants from UNICEF for the village MVC funds, little local funding was provided after an initial contribution to establish the village fund. With many demands on communities for contributions for development programmes, especially those related to education and water, those programmes with the strongest political and governmental pressures take priority, and those with obvious external support may then be marginalised in local resourcing. In some instances it has exacerbated local differentiation. The poorest people, those most in need of support, are expected to contribute in ways that better-off do not have to. The whole concept is unsound.

The primary actors in the DSWs scheme for the MVC are the Most Vulnerable Children Committees that exist or are to be created at the district and village levels. The village MVCCs are entirely volunteers, which

seeks to assure community and cultural awareness and attempts to be demand driven. However, no matter how well it is conceptualized, the MVCC model can only work if the state steps up its responsibilities (duties) to its citizens, and especially to children, with adequate support –financial and human - from the districts and the NGOs, and with more 'caring' communities.

There are limits to what the MVC programme can achieve. The services provided from external sources seem to be overwhelmingly educational support, CHF cards for health care, and more recently some psychosocial support. All of these are essential but they are a small part of the services needed by vulnerable children and their caretakers. The push from external funders, and PEPFAR in particular, is on demonstrating that increasing numbers of MVCs are reached and supported, with little attention to what extent this addresses their immediate needs, and their long term vulnerability. This is a quality problem, a quantity problem and a delivery problem.

As the AIDS trajectory puts an increasing proportion of village children into the MVC category, the government needs to think and plan for the future. How many MVCs will there be in two, four or six years? What will be their demographic – under-fives, teenagers – and their needs? Community coping mechanisms and types of support structures that need to be in place to support households and communities to shoulder the growing burden also need to be though out. Can present and future needs be met through simply scaling up the current portfolio of responses?

2.5 Sustaining the most vulnerable children response – national commitment

International leverage in the form of the various policies, initiatives and financing appears to have played a significant role in the original creation of the MVC programme, and more recently in the drafting of the National Plan of Action and its formal adoption at the national level. In spite of efforts to have support for most vulnerable children community-based, the programme is largely seen as an external programme. Many stakeholders believe that the initial pilot was essentially a UNICEF idea but received support from Department of Social Welfare, was subsequently pushed by the Global Fund and now more so by US government/PEPFAR. International funding has played a critical role and will continue to do so. The three key financiers - PEPFAR, Global and UNICEF - have largely shaped the discourse and practice of support to MVCs. There is little direct support from national resources – financial or otherwise. Although global funding for HIV/AIDS may be anticipated for the immediate and near term, this funding is proxy funding for government services. Services provided by international NGOs will eventually need to be provided (or at least significantly supplemented) by the government budget. There is also some concern that the massive flow of external resources through international NGOs, most of which is off-budget, may undermine community responses and commitments in the long run.

Social protection is an important aspect of policy in Tanzania, as evidenced by its prioritisation in the MKUKUTA, which effectively "underscores the need to consider the inter-linkages between a range of quality social services in order to reduce poverty that is complex and multi-dimensional in nature."[46] Social protection stands at the intersection of many of these policies. It encompasses a wide range of interventions that address poverty through the lens of reducing risk and vulnerability. A Social Protection Task Team has been established and a social protection framework is currently being developed - to build coherence and coordination across the many different ministries, sectors and actors, and ensure that interventions are effective in tackling poverty experienced by the poorest and most vulnerable. Links between the emerging national plan of action, the suggested framework and the national social protection

[46] Wylde &Rutasitara (February 2008)

framework, which is in preparation, are unclear. According to several stakeholders, the very premise on which the NPA is based – targeting the most vulnerable from the generally poor and setting up a whole institutional infrastructure of committees around this concept – is flawed. This is an opportune time to foster greater understanding and building consensus around the emerging NPA and the suggested framework, the many different policies related to children, and the roles and responsibilities of all stakeholders in realising the rights of all children. As noted by Valerie Leach (2008) p20;

2.6 Policies and initiatives in support of the most vulnerable children

> "The poverty and generalised insecurity which is the condition of so many Tanzanians, especially rural Tanzanians, inevitably effects children….A national framework for social protection must address these overwhelming facets of life for large numbers of children. A framework which aims to reduce vulnerability, strengthen capabilities must therefore put priority on improving the rural economy and rural conditions of life, and on improving health care and other services in rural areas to reduce the toll of ill-health on children and their caregivers."

Thus at a national level, apart from signing the UN conventions targeting children (EWFCL, CRC, ACRWC) the recently launched National Plan of Action (NPA) by Mrs Bush and Mrs Kikwete, the development of a costed National Plan of Action,[47] and a national MVC database all form part of a major attempt to fulfil the UNGASS obligations for an effective scaled up national response to vulnerable children. The NPA "represents the commitment, the goals and intention of the Government of Tanzania and all its partners, to respect the rights of all children in Tanzania, and to address the problems they face." The NPA is fully consistent with and linked to broader development policies including Tanzania's Vision 2025, MKUKUTA (the Swahili acronym for the National Strategy for Growth and Reduction of Poverty), the National Policy on HIV/AIDS and other relevant policies and strategies that have a bearing on children.

[47] Government of Tanzania, Ministry of Labour, Youth Development and Sport The Costed MVC Actions Plan: 2006 to 2010 (2005) [subsequently revised for Ministry of Health and Social Welfare, May 2006]

III. What are the opportunities for action?

We return to the central concern: what is the best way to enable support for children, and especially the most vulnerable children, given limited resources and often weak administrative structures, within a keen appreciation of the policy/politics dynamic?

"Designing effective forms of support for children affected by HIV/AIDS is not simply a matter of choice of instruments. It depends on establishing effective institutions, making tough choices between long term sustainability and short term delivery options and depends on government commitment as well as long term support from donors. Years of underinvestment in state systems means that any kind of scale up of social welfare services is challenging. Unless this is addressed there is a risk that scale up will be compromised by overburdening existing systems and continued institutional failure to deliver." Maia Green (2008) p2[48]

Governments face tough choices between short term programmatic responses versus long term institutional investment in effective national systems. Is the MVC model a viable alternative in the long run? Should the focus not be on increasing support to all children, including the MVC to access essential services through budget allocation[49]- ensuring the MVC receive social welfare support and for secondary schools, and that all children have access to primary schools and basic health care, for example, as presently is the case with Universal Primary Education programme? This might increase prospects of sustainability and institutionalisation and a sense of ownership. Ensuring appropriate accountability structures are in place and promoting citizens' participation in the decisions that determine their rights and entitlements to services is essential. Rajani notes: "The key question is not how can we get more attention and funding for children and AIDS or primary education in Tanzania, but what specific policies, mechanisms and accountabilities can be put in place to promote the wellbeing of children, in a manner that can go to scale and is lasting."[50] There is increasing recognition of national ownership and of state

[48] Green, Maia 'Social Cash Transfers and Children affected by HIV/AIDS' Background Paper for DFID (December 2007)

[49] The World Bank for example, has committed TShs 6,489,000,000 for every financial year from 2004/05 to 2009/10 to provide support to the most vulnerable children for secondary education. The MVC are identified by Local Government Authorities and the names of the identified MVC are sent to the Ministry of Education, quoted in Lindeboom et al (2007)

[50] See Rajani, Rakesh 'Primary Education Policy case study' p16.

responsibilities (duties) to its citizens, and especially to children. The state has the reach, can provide the required continuity, and the authority – the ability to implement legislation, enforce compliance and create policy environments. There is a strong case to be made for universalism on grounds of human rights.[51]

There is an emerging consensus that a programme of social assistance to protect the most vulnerable children is not only necessary but that this should be publicly provided. The process has to be twofold: one is to strengthen existing systems of support and ensure universal access of all children to quality social services and child protection. Secondly, implementing existing policies in support of MVCs and directing 'extra' benefits to the MVCs through budget allocation, to ensure that they enjoy the same benefits as the rest of the children. Possibly by mainstreaming the MVC identification process in local government and respective sectors, with a view that issues of the MVC are multi-sectoral and cross-cutting. This requires not only policy commitments and availability of funds, but also integration of planned strategies and actions in the Medium Term Expenditure Frameworks (MTEFs) of Government Ministries and into the budgets of the Local Government Authorities in the longer term, appropriate institutional arrangements for implementation, and the required capacity. It requires the support and commitment of the government at the highest level. In the context where community groups, several committees, local and international CSOs, local governments and national governments have been involved, it is important to coordinate and streamline responses and ensure their complementarities as they are scaled up. CSOs, international and national, can continue to provide a useful contribution - in monitoring the implementation of existing programmes, providing evidence about impact and in advocating what works for whom and where, and help ensure that the best interests of MVC are met. Strong institutional arrangements are vital to effective national-scale social protection. A systemic government-led response is essential to address the complexity, scale and duration of impacts of the epidemic on children.

[51] Thandika (December 2005)

P.O. Box 1179, Addis Ababa, Ethiopia
Telephone: +251 116 62 81 92/96
Fax: +251 116 62 82 00
E-mail: info@africanchildforum.org
www.africanchild.info
www.africanchildforum.org

© 2009 African Child Policy Forum