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Tanzania

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2012

Policy Goals	Status
1. Establishing an Enabling Environment Laws to promote the health and nutrition of women and young children in Tanzania are strong but current policies do not promote preschool enrollment strongly. Once approved, the draft Early Childhood Development (ECD) policy will need to be costed and increase access to scale, particularly for preprimary school.	Emerging
2. Implementing Widely The scope of programs in Tanzania is adequate to provide all stakeholders with the services they need, but some interventions are not at scale. Interventions to reach children age 0-3 could be improved and expanded. Coverage of essential ECD services has increased in Tanzania in recent years but significant gaps in access remain between regions, urban and rural areas and socioeconomic groups.	Emerging
3. Monitoring and Assuring Quality Data are available in Tanzania for some important indicators, but not all. There is not a comprehensive system to monitor children's development across sectors and financial information is particularly scarce. Standards for early learning have been recently established but compliance is not adequately enforced.	Emerging

This report presents an analysis of the Early Childhood Development (ECD) programs and policies that affect young children in Tanzania.[1] This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework[2] and includes analysis of early learning, health, nutrition and social and child protection policies and interventions in Tanzania, along with regional and international comparisons.

Tanzania is home to 7.6 million children age 0-6. Child and infant mortality have declined significantly in the last decade. Access to necessary health interventions is improving, but malaria continues to be the leading killer of children and the HIV/AIDS epidemic has orphaned nearly one million children. Currently, 34percent of all children age 5-6 attend preprimary school. Though primary school enrollment is nearly universal, late entry to primary school (typically at age 8) and the quality of available education remain serious challenges. The significant resource constraints and quality control issues which affect the delivery of health and education services across the entire population impact efforts to promote ECD. Efforts to increase access to ECD services and improve coordination amongst Government agencies are ongoing. The Inaugural Tanzania Biennial National ECD Forum, held in February 2012, demonstrated Government commitment to the ECD agenda in Tanzania, with high-level Government officials joining civil society, practitioners and development partners. Despite this commitment, the drafted Integrated Early Childhood Development Policy (IECDP) is awaiting approval by Parliament.

SABER – Early Childhood Development

SABER – ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, multi-sectoral information is collected on ECD policies and programs through a desk review of available government documents, data and literature, and extensive interviews with a range of ECD stakeholders, including government officials, service providers, civil society, development partners and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies to support young children and their families.

Snapshot of ECD Indicators in Tanzania with Regional Comparison				
	Tanzania	**Ethiopia**	**Kenya**	**Uganda**
Infant Mortality (deaths per 1,000 live births)	**50**	**68**	**55**	**63**
Under-5 Mortality (deaths per 1,000 live births)	**76**	**106**	**85**	**99**
Moderate and Severe Stunting (under-5)	**42%**	**51%**	**35%**	**38%**
Net Preprimary Enrollment Rate (36 to 59 months, 2009/2010)	**33%**	**4%**	**29%**	**14%**
Birth registration 2000-2010	**16%**	**7%**	**60%**	**21%**

[1]This report analyzes ECD policy in Tanzania mainland and does not include analysis of policies in Zanzibar.

[2]SABER-ECD is one domain within the World Bank initiative, Systems Approach to Better Education Results (SABER), which is designed to provide comparable and comprehensive assessments of country policies.

Box 1: A checklist to consider how well ECD is promoted at the country level

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families? (**This requires coordination and planning across sectors**)
Healthcare
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early Learning
• Parenting programs (during pregnancy, after delivery and throughout early childhood) • High-quality childcare, especially for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social Protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation and access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc)
Child Protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially for young children) • Training for law enforcement officers in regards to the particular needs of young children

Box 1 presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive, but is meant to provide an initial checklist for countries to consider the key policies and interventions needed in key sectors.

Three Key Policy Goals to Promote Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: *Establishing an Enabling Environment, Implementing Widely and Monitoring and Assuring Quality.* Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of *policy levers* are identified, through which decision-makers can strengthen ECD.[3] Strengthening ECD policies can be viewed as a continuum; as described in Table 1, countries can range from a latent to advanced level of development within the different policy levers and goals.

[3]These policy goals were identified based on evidence from impact evaluations, institutional analyses and a benchmarking exercise of top-performing systems. For further information see "Investing Early: What Policies Matter" (World Bank, forthcoming).

Figure 1: Three Core ECD Policy Goals

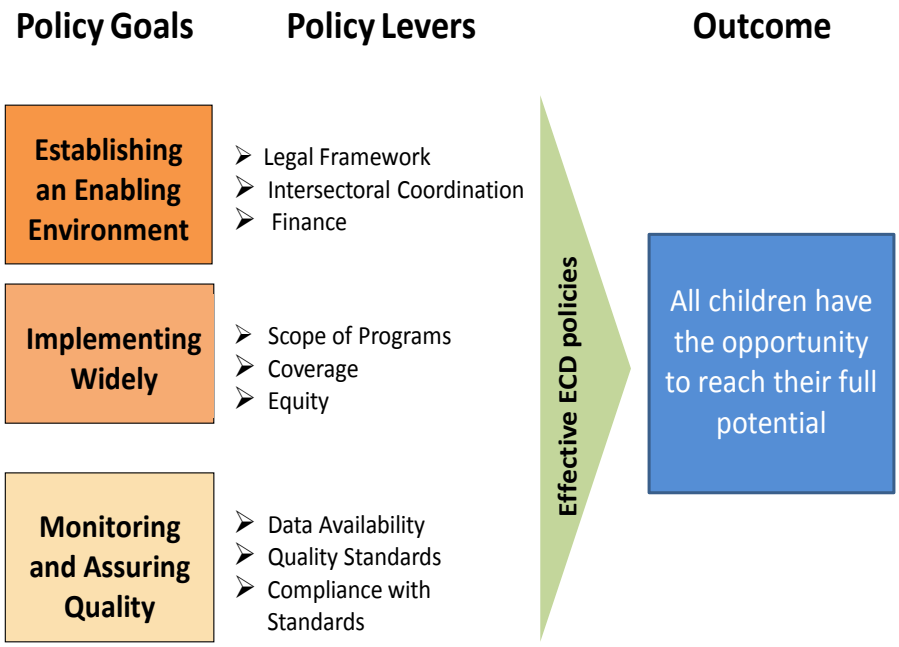


Table 1: ECD Policy Goals and Levels of Development

ECD Policy Goal	Level of Development →			
	Latent ●ooo	Emerging ●●oo	Established ●●●o	Advance ●●●●
Establishing an Enabling Environment	Non-existent legal framework; ad-hoc financing; low inter-sectoral coordination.	Minimal legal framework; some programs with sustained financing; some inter-sectoral coordination.	Regulations in some sectors; functioning inter-sectoral coordination; sustained financing.	Developed legal framework; robust inter-institutional coordination; sustained financing.
Implementing Widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes.	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes.	Near-universal coverage in some sectors; established programs in most sectors; low inequality in access.	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted.
Monitoring and Assuring Quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement.	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance.	Information on outcomes at national, regional and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance.	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance.

Policy Goal 1: Establishing an Enabling Environment

➢ Policy Levers: Legal Framework • Intersectoral Coordination • Finance

An *Enabling Environment* is the foundation for the design and implementation of effective ECD policies.[4] An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD; coordination within sectors and across institutions to deliver services effectively; and, sufficient fiscal resources with transparent and efficient allocation mechanisms.

Policy Lever 1.1: Legal Framework

The legal framework comprises all of the laws and regulations which can affect the development of young children in a country. The laws and regulations which impact ECD are diverse due to the array of sectors which influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young children and parents and caregivers.

National laws and regulations promote appropriate dietary consumption for pregnant women and young children. The iodization of salt is mandatory in Tanzania. The fortification of staples with iron is also mandatory and is managed and monitored by the Iron Deficiency Control Program and the Food Fortification Program. *The Food (Control of Quality) Marketing of Breast Milk Substitutes and Designated Products Regulations (1994)* regulates the marketing of all breast milk substitutes and feeding supplies and promotes the dissemination of evidence-based information to parents. These regulations are in accordance with *The International Code of Marketing of Breast Milk Substitutes,* an international resolution intended to serve as a minimum requirement for all countries to protect infants and young children.

National laws and regulations do not adequately promote early learning. According to law, all children are guaranteed access to two free years of preprimary school in Tanzania, but attendance is not compulsory. By law, all public primary schools must have at least one preprimary classroom which children may attend free of charge; severe shortages of preprimary classrooms at the school level and fees levied, however, are a constraint to universal preprimary enrollment. This issue is further exacerbated by increased demand, which has lead to further overcrowding of classrooms. There are no compulsory parenting education or support programs for parents, though elements of parenting education are incorporated into some health, nutrition and community-based programs.

Though national laws and regulations mandate the provision of free healthcare for pregnant women and young children, shortages and user fees at the service delivery level limit access. Young children in Tanzania are required to receive a complete course of immunizations. Young children are also required to attend periodic well-child visits and a referral system is in place to ensure that children and their families can be directed to additional services, as needed. Pregnant women are required to have health screenings for sexually-transmitted diseases and to be tested for HIV/AIDS. Officially, healthcare for pregnant women and young children is provided free of charge; at the service delivery level, however, patients are often charged for treatment.

[4] Enabling Environment references: Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005.

Table 2: Comparison of parental leave policies in East Africa

Tanzania	Kenya	Ethiopia	Uganda
84 days of paid maternity leave at 100% of salary for women; three days of paternity leave for fathers.	90 days paid maternity leave at 100% salary for women; two weeks of paternity leave for fathers.	A minimum of 90 days paid maternity leave at 100% salary for women; no paternity leave for fathers.	60 days of maternity leave at 100% of salary; 4 days of paternity leave at 100% of salary

National laws and regulations could be strengthened to better promote opportunities for parents and caregivers to provide care to newborns and infants during their first year of life. Women are entitled to 84 days of maternity leave according to the *Employment and Labor Relations Act* (Article 33). This applies to women employed in both the public and private sector. Men are entitled to three days of paternity leave (Article 34). Given the high levels of employment within the informal sector in Tanzania, the vast majority of women do not, in reality, benefit from paid maternity leave. The Employment and Labor Relations Act also provides pregnant women and new mothers with protection, mandating breaks for nursing mothers and preventing the dismissal of pregnant women. Table 2 presents information on parental leave policies in neighboring East African countries.

National laws and regulations promote child protection and care for disadvantaged children. The registration of children at birth is mandatory in Tanzania and is overseen by the Registration Insolvency Trusteeship Agency (RITA) in the Ministry of Justice and Constitutional Affairs. The *National Policy for Disability* (2004) and *The Education and Training Policy* (2011) guarantee children with special needs access to inclusive education. The draft IECDP recognizes the particular needs of children with special needs (Chapter 2) and recognizes that the needs are multi-sectoral (Chapter 8).

The child welfare system in Tanzania covers children aged 0-18. In 2010, 779,250 children were enrolled in the system, with 69,801 new cases entering in 2011. The number of children exiting the system is not currently tracked. The *Child Development Policy* (2008) outlines provisions to provide the most vulnerable children (MVC) with ECD services; it is a national policy, implemented at both the national and local level. At the national level, Remand and Children's Homes are managed through the Ministry of Health and Social Welfare (MoHSW). At the local level, Social Welfare Officers (through District Councils) make up Early Protection Teams that are tasked with ensuring the welfare of children.

Box 2: Key Laws and Regulations Governing ECD in Tanzania

- Tanzania ratified the UN Convention on the Rights of Children in June 1992.
- The Law of the Child Act, No. 21 (2009) guarantees children age 0-18 access to a minimum of services in health, education, nutrition and social protection.
- The Child Development Policy (2008)
- The Education and Training Policy
- The Integrated Early Childhood Development Policy (drafted 2010, awaiting approval)

Free temporary and long-term housing are provided for abandoned children through Community-Based Care Support and Protection. This is included in the *National Costed Plan of Action for MVC*, The *National Guidelines for the Establishment and Management of Children's Homes* and *National Guidelines for the Provision and Management of Foster Parent and Adoption Services*. Specialized child advocates have been created as part of the *National Costed Plan of Action for MVCs*.

In 2009, the Government of Tanzania (GoT) launched the first national survey of violence against children in the United Republic of Tanzania. It is a nationally

representative study of 3,739 young people aged 13 to 24. The study was designed to yield separate estimates of experiences of sexual, physical and emotional violence experienced prior to turning 18. The study revealed that violence against children is a serious problem in Tanzania: almost three-quarters of all children experienced physical violence and one-quarter experienced emotional violence. Nearly three out of ten girls and one out of seven boys experienced sexual violence. While the study did not include specific details for levels of violence occurring during a child's earliest years, international research indicates that young children are particularly at risk for abuse. The detailed results of the survey have implications for policy planning in regards to social and child protection and are currently being considered by relevant GoT agencies and stakeholders.

Policy Lever 1.2: Intersectoral Coordination

Development in early childhood is a multi-dimensional process.[5] In order to meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries non-state actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with non-state actors are also essential.

Tanzania has a multisectoral ECD strategy that is still in draft form and has yet to be approved by Parliament. Tanzania's ECD policy, the IECDP, was drafted in 2010 after a multi-year consultative process. It is a holistic policy which includes the sectors of education, health, nutrition and social and child protection. The IECDP is awaiting approval from Parliament and, unfortunately, a costed implementation plan cannot be developed until the IECDP is approved.

With all social sector service provision, the central Government is responsible for the design of policy in Tanzania. The responsibility for implementation and provision of ECD services is decentralized to the local level to District Councils under the supervision of the Prime Minister's Office – Regional and Local Government (PMO-RALG).

Box 3: Key Sectoral Policies with ECD Components in Tanzania

- The Primary Education Development Programme II (2007-2011)
- The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008-2015)
- The Tanzania Food and Nutrition Strategic Plan (2005/06-2009/10)
- The National Costed Plan of Action for Most Vulnerable Children (2007-2010).

There are national, costed plans within key social sectors which include components of ECD service provision, including established coverage goals. Progress against established goals is monitored by the three relevant ministries: Ministry of Education and Vocational Training (MoEVT), the MoHSW and PMO-RALG. Results are reported in two key publications: The Basic Education Statistics Report (BEST) and The Health Sector Performance Profile Report (HSPPR). These publications are available to the general public and online.

Tanzania has established an institutional anchor to lead ECD policy and coordinate across sectors but the anchor does not seem to have the necessary resources to fulfill its mandate. The Ministry of Community Development, Gender and Children (MCDGC) is the coordinating ministry for ECD in Tanzania. Focal points have been established in other key ministries, including in: MoEVT, MoHSW, Ministry of Finance (MoF) and PMO-RALG. There is no ECD-specific budget allocation or dedicated ECD staff within the MCDGC. The infrequency of meetings and lack of progress to pass the IECDP and develop an implementation plan suggest that the MCDGC may

[5] Multi-dimensional process of ECD references: Naudeau et al., 2011; UNESCO-OREALC, 2004; Neuman, 2007.

not have the resources necessary to fulfill its mandate and serve as a strong institutional anchor.

In 2006, three national committees on ECD were established: The National Steering Committee, The National Technical Committee and The National ECD Secretariat. As described in
, these committees are tasked with: setting policies for ECD, establishing standards for service delivery, monitoring access to ECD services and quality of ECD services and playing a coordination role across different entities and agencies. The Steering Committee meets semi-annually to conduct business and the Technical Committee and ECD Secretariat meeting quarterly. When the Steering Committee approves a policy and/ or strategy, it is sent to the Cabinet Secretariat for approval. None of the committees produce periodic progress reports. In addition to the formal mechanisms for coordination, the ECD focal points within each ministry regularly communicate and this positive working relationship is noted by development partners as a key factor in the successful inter-sectoral coordination in Tanzania, relative to neighboring countries.

Mechanisms for collaboration between state and non-state stakeholders exist. The Tanzania Early Childhood Development Network (TECDEN) is a national umbrella organization for ECD in Tanzania, serving as the official civil society representation for ECD service providers. TECDEN has network members in 14 out of 30 regions in Tanzania mainland and Zanzibar. As described in Figure 2, TECDEN serves on the National ECD Secretariat as the civil society representative.

A group of development partners in Tanzania has formed an ECD Working Group (as described in Figure 2) and actively coordinates with the GoT on ECD matters. This group originally came together to support the development of the IECDP and worked closely with the GoT to finance and organize the Inaugural Biennial Tanzania ECD Forum, held in February 2012 in Arusha. Key members of this group include: TECDEN, UNICEF, Children in Crossfire (CiC), Aga Khan Development Network (AKDN), the Bernard Van Leer Foundation (BVLF), Save the Children, Elma Philanthropies and the World Bank.

The delivery of ECD services is somewhat integrated at the sub-national level and at service delivery. Figure 3 depicts the range of stakeholders involved in funding, managing, and monitoring ECD services in Tanzania. There are 113 districts in mainland Tanzania. In each district, district- and ward-level officials from MoEVT are responsible for management and oversight of primary schools and associated preprimary schools. District representation for MoHSW is split between a Health Officer and a Social Welfare Officer. The Health Officer oversees health services provided in district hospitals, ward health clinics, and village health posts, as well as services provided by volunteer health workers at the community level. The Social Welfare Officer is responsible for management and oversight of daycare centers (ECCE facilities for children prior to preprimary school). A District Social Welfare Co(composed of officers from the district departments of MoEVT and MoHSW) oversees implementation of health and social welfare services in the district. At the ward level, the management structure includes the Ward Executive Officer (WEO), the Ward Education Coordinator (WEC), the Ward Health Coordinator (WHC) and the Ward Community Development Officer (WCDO).

All social sector service delivery in Tanzania is coordinated by PMO-RALG at the local level – this institutional arrangement does ensure a degree of intersectoral coordination at the level of ECD service delivery. PMO-RALG is, however, a relatively young Ministry, with some limitations in capacity. Efforts to design integrated interventions at the national level could be improved. For example health workers currently deliver 17 core messages to new mothers focused on key nutrition and health issues, such as exclusive breastfeeding for the first six months and proper hygiene and care; messages on early stimulation for young children could be more directly incorporated into the core messaging.

Figure 2: ECD Coordination at the national level in Tanzania

LEAD MINISTRY
Ministry of Community Development, Gender and Children (MCDGC)

Ministry of Education and Vocational Training (MoEVT)

Ministry of Health and Social Welfare (MoHSW)

Prime Minister's Office – Regional and Local Government (PMO-RALG)

Ministry of Social Protection (MoSP)

Ministry of Finance (MoF)

National ECD Steering Committee

- MCDGC chair
- Permanent Secretaries of Key Ministries (MCDGC, MoHSW, MoEVT)
- Tasked with promoting intersectoal linkages

National ECD Technical Committee

- Directors of key ministries
- Tasked with setting strategic direction of ECD initiatives

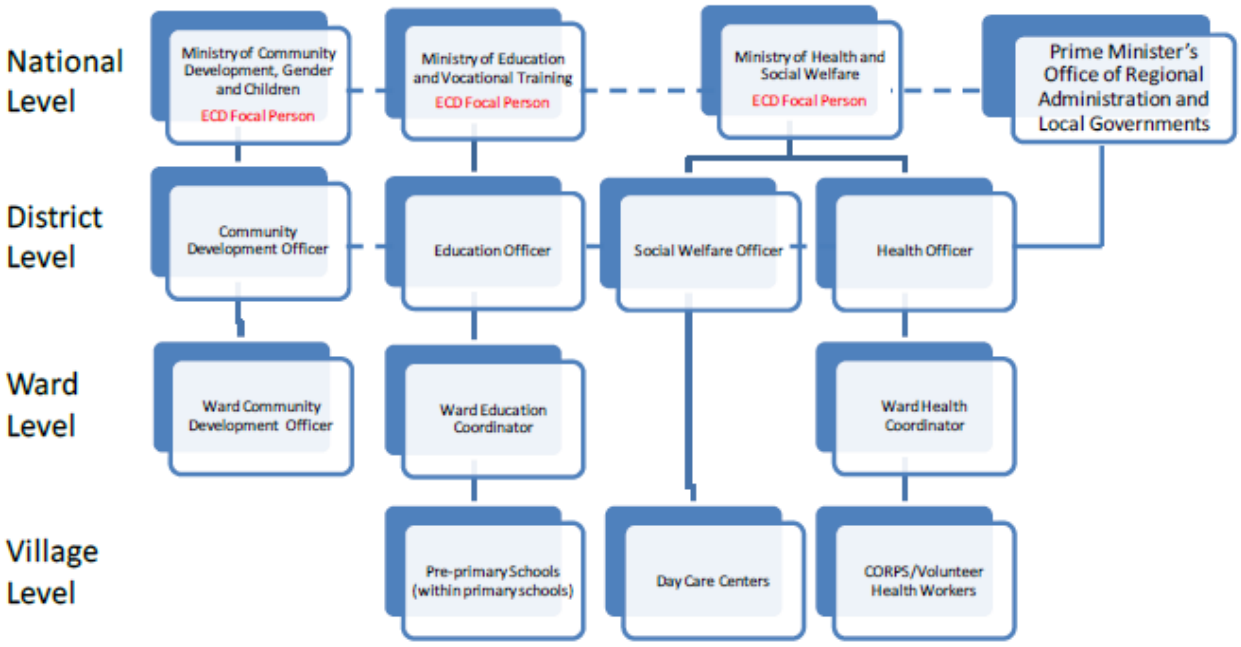
National ECD Secretariat

- Focal points from MCDGC, MoHSW, MoEVT, and TECDEN

ECD Working Group

- Government representatives from National ECD Secretariat plus TECDEN, AKDN, BVLF, WB, UNICEF, ELMA, CiC and UNESCO.

Figure 3: Institutional arrangements across ministries from the national to local level



Source: UNICEF: Evaluation of the UNICEF Early Childhood Development Programme with Focus on the Government of Netherlands Funding (2008-2010): United Republic of Tanzania Country Case Study Report (2011

Policy Lever 1.3: Finance

While legal frameworks and inter-sectoral coordination are crucial to establishing an Enabling Environment for ECD, adequate financial investment is key to ensure that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns, but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits.[6] Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.

The budget process for ECD allocations in Tanzania is relatively transparent but information on specific spending levels for ECD is not available consistently. There is no national law or policy establishing a minimum level of funding for ECD and there are no mechanisms to coordinate budgeting across ministries. Budgeting and information systems do not allow for an identification of ECD-specific spending and it is not possible to disaggregate spending for young children within sectors in a comprehensive manner.

Explicit criteria are used to determine sub-national funding allocations within some sectors of ECD service provision. For example, funding for health worker salaries is determined by the size of the workforce at the sub-national level; the formula for determining allocations for recurrent finance items is: under-5 mortality (10 percent); total population (70 percent); number of poor residents (10 percent); and, district medical vehicle route (10 percent). In the education sector, primary schools receive capitation grants (based on number of pupils served) and are expected to finance preprimary school out of these grants. There is not an explicit process for determining funding allocations for nutrition at the sub-national level.

[6]Finance references: Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek % Luque, 2003.

The burden of finance for ECD services is not distributed evenly across various segments of society and the cost of services remains a barrier to access. While preprimary school has officially been declared free, the government has made no resources available to schools to expand coverage. Accordingly, even at many State schools, families are asked to pay fees and the number of children who can attend is severely constrained by the number of places within existing classrooms. In some schools, preprimary students are charged fees for the following: personal school supplies, uniform, meals, transport, and medical services. Official data on the cost of these fees or variations between schools are not available. Enrollment in non-State preschools is increasing, indicating a willingness by parents to pay for preprimary education.

According to policy, pregnant women and young children should receive comprehensive free medical treatment, including for labor and delivery, immunizations, well-child visits, treatment for malaria, diarrhea or pneumonia and HIV/AIDS related treatment. Due to funding constraints, at the service delivery level, many pregnant women and young children pay fees for consultations and for the cost of treatment.

The level of ECD finance is not adequate to meet the needs of the population It is difficult to quantify GoT expenditures for ECD within sectors or in the aggregate, due to the way in which budgets are allocated and tracked. For example, the percentage of the education sector budget allocated to preprimary cannot be tracked. This funding is distributed through capitation grants to primary schools, with no mechanism to monitor the portion of each grant channeled towards preprimary (anecdotal evidence suggests a nearly negligible amount of each capitation grant is allocated to preprimary at the school level).

A large portion of the financing for social and child protection in Tanzania is provided by international development partners. The Government finances trained caregivers at the national level. Service providers at the district level are volunteers. In 2005, the Government allocated a one-time budget of TSH 200 million for the construction of housing for MVC.

Table 3: Regional comparison of health expenditures

	Tanzania	Ethiopia	Kenya	Uganda
Out-of-pocket expenditure as a percentage of all private health expenditure	42%	80%	77%	64%
Out-of-pocket expenditure as percentage of total health expenditures	14%	37%	43%	50%
General government expenditure on health as a percentage of GDP	6%	5%	5%	9%
Total expenditure on health per capita (2009, adjusted for purchasing power parity)	USD 48	USD 23	USD 33	USD 26
Percentage of routine EPI vaccines financed by government	18%	5%	48%	36%

Source: WHO Global Health Expenditure Database, 2010; UNICEF Country Statistics, 2010.

In 2010, the GoT financed 18 percent of the cost of providing routine EPI vaccines to all young children. In this same year, approximately 49 percent of total expenditures on health were financed from external sources. In 2009, 31 percent of all private health expenditures went to the purchase of pharmaceuticals.

Table 3 presents regional comparisons of key health expenditure statistics in East Africa. Out-of-pocket expenditures account for a smaller proportion of total health expenditures in Tanzania (14 percent) than in neighboring countries. Total expenditure on health per capita is significantly higher in Tanzania than in any other country in the region. The GoT finances a smaller proportion of routine vaccines than the Governments of Kenya and Uganda but more than the Government of Ethiopia.

The level of remuneration for ECD service providers is difficult to assess in Tanzania, though official wages for preprimary teachers in State schools are reasonable. The pay scale for preprimary teachers (in State schools) ranges from TSH220,200 (USD 139) to TSH649,440 (USD 413) per month. Gross National Income (GNI) per capita is 1,420 adjusted for purchasing power parity (non-adjusted USD 530) in Tanzania. Though an annual starting salary of USD 1,668 for a preprimary teacher is above GNI per capita, in reality many preprimary teachers are paid by the community and are paid significantly lower levels.

Policy Options to Strengthen Tanzania's Enabling Environment for ECD

- **Legal Framework –** A significant amount of work has been expended by various Government entities and non-state stakeholder to develop the draft IECDP; this policy should be approved as a matter of urgency. Once approved, the critical next step will be the creation of a costed implementation plan.
- **Intersectoral Coordination –** Although the MCDGC has been identified to serve as the institutional anchor for ECD in Tanzania, it is unclear if it has the mandate and resources to fill this role. Similarly, the infrequent meetings of the three National ECD Committees and the limbo status of the IECDP suggest that intersectoral coordination could be improved in Tanzania.
- **Finance –** The current policy which compels primary schools to finance preprimary education without providing any additional funding for preprimary education limits children's access to preprimary school and compromises the quality of preprimary school available. Schools already facing resource constraints divert minimal amounts of funding to set up preprimary classrooms; as a result, often preprimary classrooms have the least qualified teachers and inadequate materials and are severely over-crowded. To remedy this, the Government could consider a range of policies to improve finance for

Box 4: Relevant Lessons from International Experience Financing ECD

Example from Mauritius: Conditional Cash Transfers (CCTs) to Promote ECCE Enrollment

Summary: The Government of Mauritius has focused policy efforts on increasing preprimary school enrollment in the last decade. In order to encourage parents to enroll their children, the Government provides all families with financial support contingent upon the child attending the final year of preprimary school (age 4 in Mauritius). The transfer amounts to USD 6 per month and has helped achieve an 85 percent enrollment rate in preprimary school for children age 3-5 in Mauritius. Provision is largely through non-State centers (17 percent of all preschools are State-managed), but the design and enforcement of quality control mechanisms has remained central to Government policy efforts.

Key considerations for Tanzania:

- ✓ Incentivizing on-time enrollment in the last year of preprimary school (i.e. at age 6 in Tanzania) could also help address the significant problem of late enrollment in primary school.
- ✓ It will be important to determine the appropriate funding level to maximize effectiveness of policy.

preprimary education addressing both supply and demand constraints. These options include, for example: capitation grants to schools specifically for preprimary expenditures or cash transfers or vouchers for families contingent upon enrolling a child in preprimary school or accessing other ECD services. Differentiating spending for ECD is also an important tool to promote increased and more efficient finance for ECD. The key Ministries of MoEVT, MoH, MoSP, PMO-RALG and MCDGW cannot currently distinguish ECD spending within budgets; these Ministries could consider inserting line items for ECD into their budgets or improving finance and information systems to be able to better track and monitor ECD spending.

Policy Goal 2: Implementing Widely

➢ Policy Levers: Scope of Programs • Coverage • Equity

Implementing Widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population) and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, and social and child protection, and should target pregnant women, young children and their parents and caregivers. A robust ECD policy should include programs in all essential sectors; provide comparable coverage and equitable access across regions and socioeconomic status – especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 4 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

ECD programs are established to target relevant groups of beneficiaries in Tanzania but interventions to reach parents could be improved and expanded. Tanzania has a range of ECD programs established in each of the essential ECD sectors: education, health, nutrition, and social and child protection. Interventions are established that serve pregnant women, young children and parents and caregivers. As presented in Figure 5, interventions targeting parents and caregivers are limited. Some care messaging is incorporated into health and education programs, but there are no direct interventions targeting parents and caregivers.

ECD programs are established in all essential areas of focus. A variety of interventions are established in all essential areas of ECD service provision, including in health, nutrition, education, and social and child protection. Key programs are summarized in Table 4, which shows that, while a range of ECD interventions exist, coverage is not universal.

Figure 4: Essential interventions during different periods of young children's development

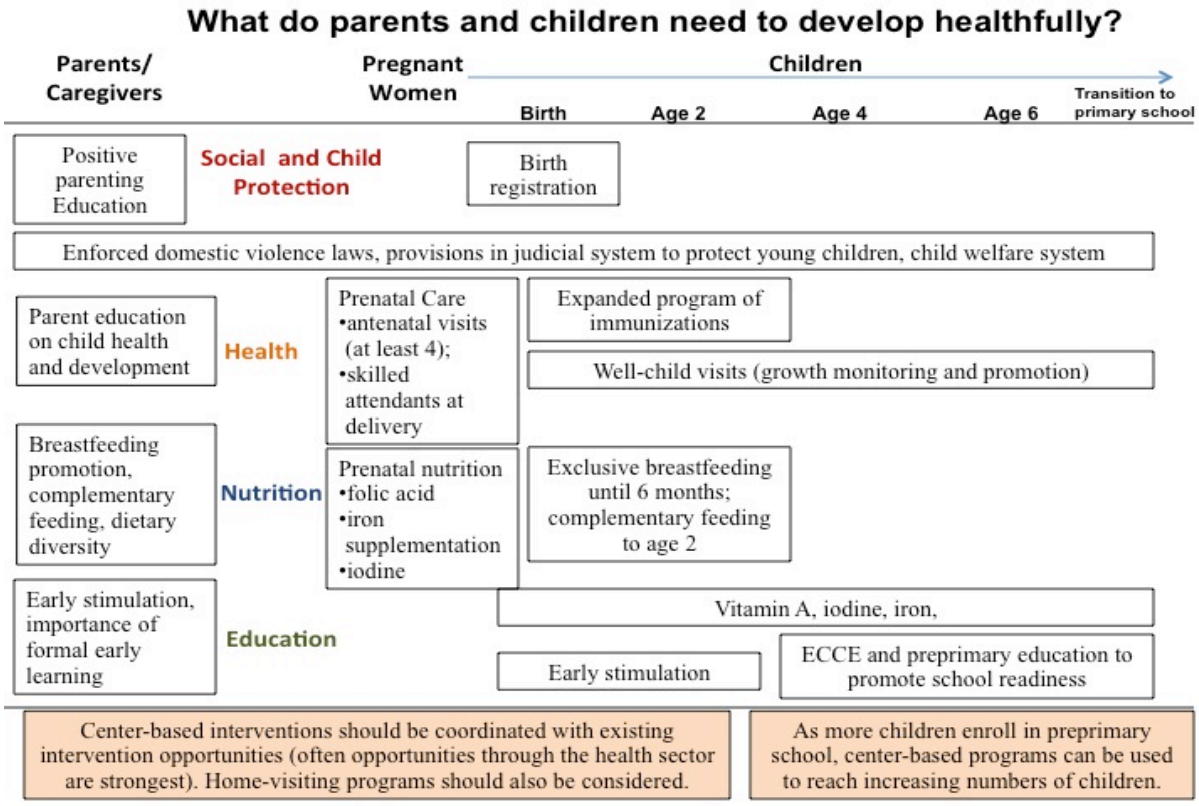


Figure 5: Scope of ECD interventions across sectors and beneficiaries

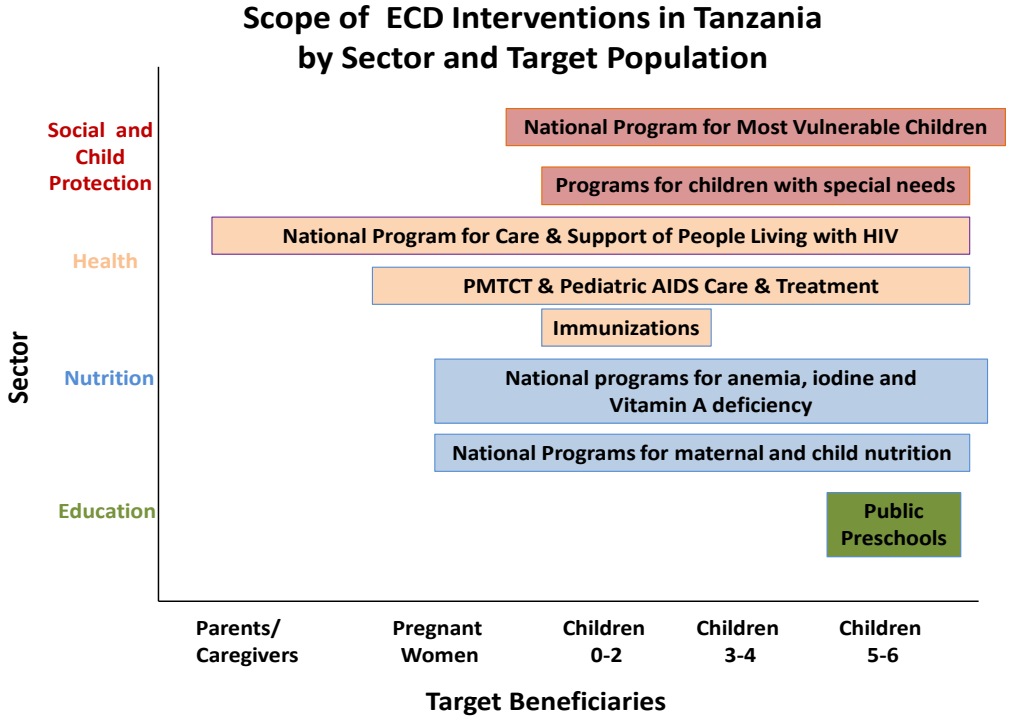


Table 4: Coverage of ECD interventions in Tanzania

ECD Programs and Coverage in Tanzania			
ECD Intervention	Scale		
	Pilot programs	Number of Regions Covered (out of 21)	Universal coverage
EDUCATION (STIMULATION AND EARLY LEARNING)			
State-sponsored preprimary education (Primary Education Development Programme II- preprimary classrooms attached to primary schools) (GoT)		All	No
Community-based ECCE (Aga Khan Foundation is a key funder in some communities)		All	No
HEALTH			
Newborn Care Program (GoT)		All	
Integrated Management of Childhood Illnesses (GoT)		All	
Growth Monitoring Program (GoT)		All	
Immunizations		All	Yes
NUTRITION			
National Program for Improving Maternal Nutrition (GoT)		All	
Program for the Management of Acute Malnutrition (GoT)			
National Program for Control of Anemia (GoT)		All	
National Program for Control of Iodine Deficiency (GoT)		All	
National Program for Control of Vitamin A (GoT)		All	
**Anti-obesity programs encouraging healthy eating/exercise		None	No
PARENTING			
**Parenting integrated into health/community programs		None	No
**Home visiting programs to provide parenting messages		None	No
ANTI-POVERTY			
**Cash transfers conditional on ECD services or enrollment		None	No
SOCIAL AND CHILD PROTECTION			
Programs for OVCs		All	No
Interventions for children with special needs		All	No
Interventions for children with special needs		All	No
MULTI-SECTORAL OR COMPREHENSIVE			
Feeding programs in preprimary schools (World Food Program, operating in some districts)		7	No
**A comprehensive system that tracks individual children's needs and intervenes, as necessary		None	No

Policy Lever 2.2: Coverage

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage and reach the entire population equitably–especially the most disadvantaged young children–so that every child and expecting mother have guaranteed access to essential ECD services.

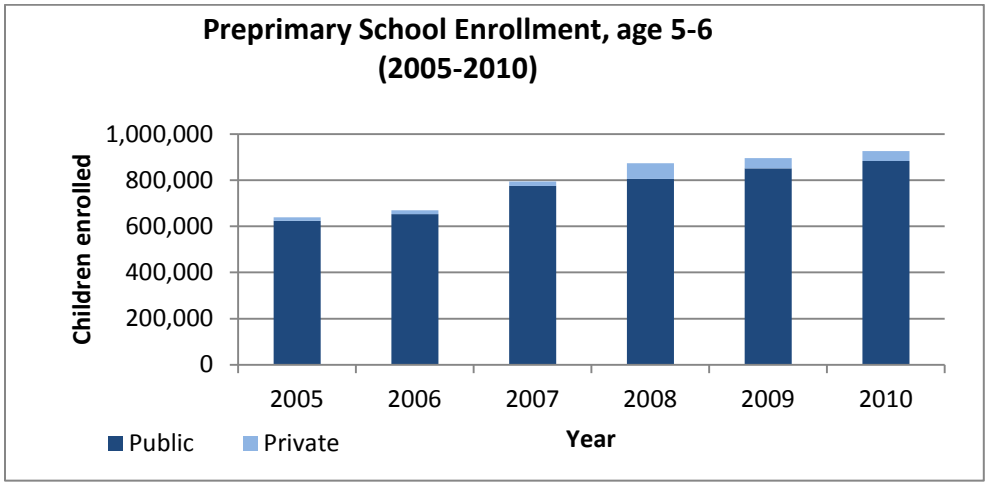
Access to Early Childhood Care and Education (ECCE) in Tanzania is limited. The GoT expansion strategy for preprimary schools has consisted of attaching preprimary classrooms to existing primary schools. By law, each primary school must have at least one preprimary

classroom. As already discussed, this expansion has been financed out of the capitation grants provided to primary schools, with no separate funding provided for preprimary schools. As a result of this limited funding, most preprimary classrooms are overcrowded and under-resourced- the average student-to-teacher ratio in preprimary schools is 100:1. Efforts to expand access to preprimary school in Tanzania should be considered in light of recent trends in primary school enrollment. Tanzania is one of a number of Sub-Saharan countries which has achieved dramatic success increasing primary school enrollment rates in the last decade from 59 percent in 2000 to 96 percent in 2009. Unfortunately, this increase in enrollment was not met with a commensurate increase in resources, resulting in overcrowded classrooms and a significant decline in quality and outcomes. Currently, 50 percent of all children in the 7th and 8th grade in Tanzania read at a 2nd grade level and 90 percent of all children who complete secondary school fail their exit exams. A recent survey of secondary schools found that just 4 percent of all secondary schools in the country are equipped with the bare minimum of facilities (defined as potable water, electricity, classrooms, a science laboratory and toilets). The significant resource constraints and quality control issues that affect the larger education sector affect early learning opportunities and efforts to promote ECD. Another problem impacting education outcomes is the proportion of children starting primary school at a late age. The age of primary school entry is 7 in Tanzania (already fairly late by international standards); on average, however, most children enter primary school at the age of 8.5 years.

MoEVT tracks enrollment trends in preprimary school for children age 5 and 6 only. Enrollment in preprimary school for this age group is currently 33 percent and increased 45 percent between 2005 and 2010.

As Figure 6 and Table 5 show, enrollment increased 42 percent in State preprimary schools over this period and by 191 percent in non-State preprimary schools. Despite the substantial increase in non-State enrollment, as of 2010, non-State enrollment accounted for less than 5 percent of all enrollment for children age 5-6. If data were available to track enrollment for children below the age of 5, the relative proportion of enrollment in non-State ECCE would climb as all provision for children below the age of 5 is provided by non-State sources.

Figure 6: Preprimary school enrollment trends 2005-2010



In comparison to other countries in East Africa, preprimary school starts at a later age in Tanzania and lasts just three two years, as compared to three years in neighboring countries. As Table 6 shows, gross and net enrollment rates are low across the region. The portion of preprimary school provided via the private sector is significantly lower than in all neighboring countries.

Access to essential ECD health interventions in Tanzania is better than in neighboring countries but could still be improved. Table 7 shows the level of access to a selection of essential ECD health interventions for young children and pregnant women in Tanzania with regional comparisons. As illustrated in Table 7, the level of access to essential health interventions is higher (or comparable) in Tanzania in comparison with neighboring countries. In particular, Tanzania has had more success scaling up coverage of ITNs for children below the age of 5 – given that malaria is the leading killer of young children in Tanzania, this is a critical policy intervention. While Tanzania leads the region is access to skilled attendants at birth, the data indicate that less than half of all women have access to a skilled attendant, which is critical to ensuring safe deliveries.

Access to essential ECD nutrition interventions could be improved. Under-nutrition is the underlying cause for an estimated one-third of all deaths of young children worldwide. The period between conception and the age of two is a window of opportunity to address and prevent the damage that can be caused by under-nutrition. Nutrition interventions that begin in the prenatal period are essential. In Tanzania, 58 percent of all pregnant women are anemic, signifying a need to increase outreach efforts to promote healthy nutrition for pregnant women. Tanzania has achieved near universal coverage of Vitamin A supplementation for young children – the lessons learned from this success could potentially be applied to other nutrition interventions and should be considered. While the 50 percent rate of exclusive breastfeeding for children until 6 months of age is high by international standards, there is still scope to improve – given the high returns to breastfeeding and low cost, improved public information campaigns and interventions for new mothers should be considered. Table 8 summarizes access to nutrition interventions and outcomes for pregnant women and young children in Tanzania, along with regional comparisons.

Policy Lever 2.3: Equity

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every Government should pay special attention to equitable provision of ECD services.[7] One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

Access to preprimary school is uneven in Tanzania. Enrollment rates for girls and boys in preprimary school are nearly equivalent in Tanzania. Overall preprimary school enrollment levels vary considerably between different regions, however, with some regions significantly higher than the national average of 44 percent and others well below. As Figure 7 shows, Mwanza province has the highest preprimary enrollment rate, at 90 percent, and Dar es Salaam has the lowest rate, at 19 percent.

Access to essential ECD services in the sectors of health, nutrition and social protection is highly uneven by location and socioeconomic status. Using data from the Multiple Indicator Cluster Survey (MICS) in Tanzania, access to ECD services can be compared based on wealth and by urban-rural location.

[7] Equity references: Engle et al, 2011; Naudeau et al., 2011.

Table 5: Increasing enrollment in State and non-State preprimary schools 2005-2010

Number of Children in Enrolled in Preprimary schools (age 5-6)			
Year	**State**	**Non-State**	**Total**
2005	624,204	14,387	638,591
2006	653,485	15,652	669,137
2007	775,313	19,698	795,011
2008	805,407	68,574	873,981
2009	851,084	45,062	896,146
2010	883,667	41,798	925,465
Increase 2005-2010	**42%**	**191%**	**45%**

Table 6: Comparison of preprimary school provision in East Africa

	Tanzania (2010)	Ethiopia (2010)	Kenya (2009)	Uganda (2010)
Age of preprimary entry	5 years old	4 years old	3 years old	3 years old
Duration of preprimary	2 years	3 years	3 years	3 years
Gross enrollment rate	33%	5%	52%	14%
Net enrollment rate	33%	4%	29%	14%
Percentage of private enrollment	5%	95%	38%	100%

Source: World Bank EdStats, UNESCO Institute of Statistics

Table 7: Access to essential ECD health interventions in East Africa

	Tanzania	**Ethiopia**	**Kenya**	**Uganda**
Children below 5 with diarrhea receive oral rehydration/ continued feeding (2006-10)	50%	15%	43%	39%
1 year olds immunized against DPT	91%	90%	93%	60%
Children below 5 with suspected pneumonia receive antibiotics (2006-10)	No data	5%	50%	47%
Children below 5 sleeping under insecticide-treated bed net (2006-10)	64%	33%	47%	33%
Children below 5 with fever, receive anti-malarial drugs (2006-10)	59%	10%	23%	60%
Births attended by skilled attendants (2006-10)	49%	6%	44%	42%
HIV+ pregnant women/exposed infants receive ARVs for PMTCT	59%	No data	43%	No data

Source: World Bank and UNICEF country statistics

Table 8: Access to nutrition interventions for pregnant women and young children in East Africa

	Tanzania	**Ethiopia**	**Kenya**	**Uganda**
Children below 5 with moderate/severe stunting (2006-10)	42%	51%	35%	38%
Vitamin A supplementation coverage (6-59 months) (2010)	99%	84%	62%	No data
Infants with low birth weight (2006-10)	10%	20%	8%	14%
Infants exclusively breastfed until 6 months of age (2006-10)	50%	49%	32%	60%
Population that consumes iodized salt (2006-10)	59%	20%	98%	96%
Prevalence of anemia in pregnant women (2010)	58%	62.7%	55.1%	41.2%

Source: UNICEF MICS Country Statistics; WHO Global Database on Anemia

As Figures 8 and 9 show, there are significant disparities in access to essential ECD services by both wealth and by urban-rural location. Children from wealthy families are more than 13 times as likely to be registered as those from the poorest families, and pregnant women from wealthy families are three times as likely to deliver a baby with a skilled attendant present as pregnant women. More than one-fifth of children from the poorest families are underweight, compared to less than one-tenth of children from the wealthiest families. The urban-rural disparities are not as stark as those between families with different levels of wealth, but are still apparent.

Figure 7: Regional variation in preprimary school enrollment

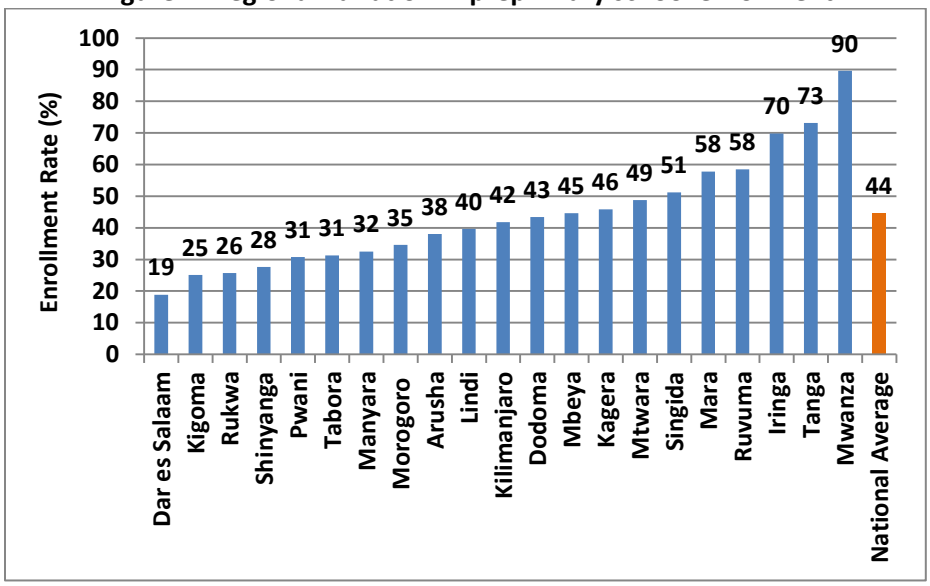


Figure 8: Disparities in ECD by wealth

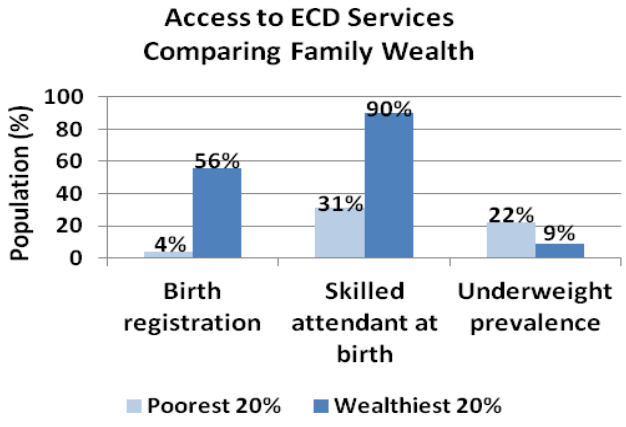
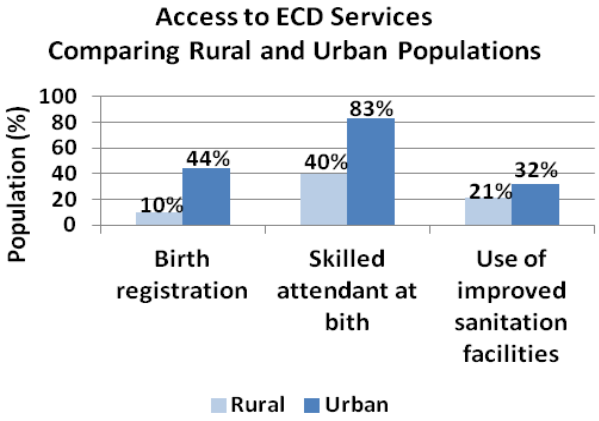


Figure 9: Disparities in ECD comparing urban and rural populations



Children in urban areas are four times more likely to be registered than their rural counterparts and pregnant women in urban areas are twice as likely to give birth with a skilled attendant as women in rural areas. The use of improved sanitation facilities is low across the country: just one-third of the urban population and one-fifth of the rural population have access to improved sanitation.

Though Tanzania is considered one of the most stable and peaceful countries in the region, it is home to a large refugee population due to conflicts in neighboring countries such as Rwanda and Burundi. Refugee populations often require specialized interventions and targeting mechanisms. Investments in ECD can be highly effective ways to reach marginalized populations and ensure integration into society from an early age.

Given the potential benefits, the needs of young refugees in Tanzania should be taken into account in policy planning.

Policy Options to Implement ECD Widely in Tanzania

- **Scope of Programs –** Parent and caregiver education is an area that is currently underdeveloped within the scope of ECD interventions in Tanzania. Given the critical role that parents and caregivers play in promoting the healthy development of children, the GoT should consider purposeful incorporation of parenting and caregiver education into existing outreach mechanisms to promote early stimulation and holistic care for young children. A public information campaign could also be considered.
- **Coverage –** The current informal status of community health workers limits the level of coverage which can be achieved; the GoT could consider formalizing the role of community health workers (this would, of course, have financial implications). Though basic healthcare for pregnant women and young children is officially free in Tanzania, shortages at the service delivery level often result in fees being levied – consideration should be given to the impact of these additional costs on families.
- **Equity –** Given the significant disparities which exist in access to ECD services based on family income level, the GoT should consider targeting mechanisms to reach the poorest families with young children. One option to consider is a Conditional Cash Transfer (CCT) to promote access to ECD services (either enrollment in preprimary school or health services).

Policy Goal 3: Monitoring and Assuring Quality

Policy Levers: Data Availability • Quality Standards • Compliance with Standards

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children, standards for ECD services and systems to monitor and enforce compliance with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible, or even detrimental.

Policy Lever 3.1: Data Availability

Accurate, comprehensive and timely data collection can promote more effective policy-making. Well-developed information systems can improve decision-making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards and efforts to target children most in need.

Both administrative and survey data are collected in Tanzania, though the collection of administrative data, particularly in regards to finance levels, could be improved. Tanzania participated in UNICEF's Multiple Indicator Cluster Survey (MICS) in YEAR and YEAR. The MICS data provide a rich source of information on a number of indicators related to young children's healthy development. Table 9 presents a series of key indicators that a country can collect to track the provision of services to promote young

Table 9: Availability of data to monitor ECD in Tanzania

Administrative Data	
Indicator	**Tracked**
Special needs children enrolled in ECCE (number of)	✓
Children attending well-child visits (number of)	X
Children benefitting from public nutrition interventions (number of)	✓
Women receiving prenatal nutrition interventions (number of)	✓
Children enrolled in ECCE by sub-national region (number of)	✓
Average per student-to-teacher ratio in public ECCE	✓
Is ECCE spending in education sector differentiated within education budget?	X
Is ECD spending in health sector differentiated within health budget?	X
Survey Data	
Indicator	**Tracked**
Population consuming iodized salt (%)	✓
Vitamin A Supplementation rate for children 6 -59 months (%)	✓
Anemia prevalence amongst pregnant women (%)	✓
Children below the age of 5 registered at birth (%)	✓
Children immunized against DPT3 at age 12 months (%)	✓
Pregnant women who attend four antenatal visits (%)	✓
Children enrolled in ECCE by socioeconomic status (%)	X

children's development. These indicators are divided into both administrative data (census data, reflecting total uptake) and survey data (based on sampling of a specific population). Both administrative and survey data are useful and necessary to track access to services and outcomes.

Tanzania's Education Monitoring and Information System (EMIS) tracks access to ECCE for specific sub-groups of young children. Tanzania's EMIS differentiates ECCE enrollment by urban-rural location, sub-national division, gender and for students with special needs. This information is publicly available annually in the BEST publication. The EMIS system does not currently track enrollment by mother-tongue or by socio-economic status. The EMIS system currently tracks enrollment in preprimary school and early learning for children age 5 and 6. This system limitation neglects the need to monitor enrollment trends and levels of service quality for younger children and an expansion in the range of ages tracked should be considered.

Child development outcomes are not adequately tracked in Tanzania and there is no system in place to comprehensively monitor the development of individual children. Through the health information monitoring systems, some data on children's physical outcomes are collected and monitored. Children's cognitive, linguistic and socio-emotional development are not tracked. Without some monitoring of children's outcomes in these interrelated domains, it is difficult to holistically assess children's development and the degree to which existing interventions are successful.

There is no system to comprehensively track children's development across the four interrelated domains of child development and mechanisms to intervene when necessary are not well developed.

Policy Lever 3.2: Quality Standards

Ensuring quality ECD service provision is essential. A focus on access – without a commensurate focus on ensuring quality – jeopardizes the very benefits that policymakers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children.[8]

Standards for ECCE have recently been drafted in Tanzania. Standards for ECCE were established in 2011 by

[8] Quality references: Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et al, 2011V; Victoria et al, 2003.

the Inter-Ministerial ECD Steering Committee, with support from UNICEF. These include operational guidelines, minimum standards for ECD service providers and draft curricula. Because the standards are recent, no information is available on adherence to standards, but anecdotal evidence suggests adherence is minimal.

There are clearly established requirements for ECCE professionals teaching in public preschools; the requirements may, however, be overly rigid and limit opportunities to scale access to ECCE more broadly. Preprimary teachers serving in State preprimary classes are required to have completed secondary school and two years of full-time pre-service training – this tertiary education conveys upon them a certificate for participation in a specialized course of studies (corresponding to the international standards of ISCED 4A, 5B and 5A). ECCE teachers are not required to have completed a supervised internship or teaching practicum prior to certification or employment. For teachers in non-State ECCE facilities, the standards are less stringent. In practice, most teachers have completed secondary school and "certificate" courses which vary in length from several weeks to several months and are offered by private teacher training centers (through the Aga Khan University, for example).

ECCE teachers serving children below the age of 5 are required to have completed lower-secondary school. There is no mandatory in-service training for ECCE caregivers for children below the age of 24 months. For caregivers and teachers of children above the age of 24 months, an annual training of 40 hours is required, which covers the topics of health, cognitive development, social development and emotional development. The training is provided by the Government and takes place at Teacher Resource Centres.

There are established service delivery standards for ECCE in Tanzania; specific infrastructure standards for ECCE are not developed, but State preprimary schools must comply with established infrastructure standards for primary schools. There are no detailed infrastructure standards for preprimary schools in Tanzania, apart from minimum standards related to floors, roofing and windows. For State preschools, in practice, standards exist because the policy introducing preprimary schooling requires that they be located in existing primary schools; hence public preprimary schools are required to adhere to the detailed primary school construction standards, which include requirements for structural soundness and connection to electricity. According to policy, primary schools in Tanzania (and accordingly, preprimary schools) are not required to have access to a potable water source, but they are required to have functional hygienic facilities.

There are established registration and accreditation procedures for both state and non-state ECCE facilities. All ECCE facilities are required by law to be registered and undergo standard inspections as part of the registration process. In practice, some non-State ECCE facilities – particularly those serving children below the age of 5 – are not registered and do not undergo any inspection.

Policy Lever 3.3: Compliance with Standards

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

Preprimary teachers meet established pre-service training requirements in most preprimary schools. There are a total of 10,830 teachers, working in State and non-State preprimary schools in Tanzania. The official requirement for teachers to work in a primary school is a Grade A Teaching Certificate (which signifies the completion of a two-year pre-service teaching course); this same requirement is applied to preprimary teachers in State schools. While 85 percent of all teachers do meet this requirement, just 28 percent have a specialized pre-service ECD certificate. Anecdotal feedback from primary and preprimary teachers, as well as school and EMIS records, indicate that the training institutions currently approved to provide pre-service ECD certificates now have adequate capacity to meet demand.

Preprimary schools do not comply with established service delivery and infrastructure standards. Average child-to-teacher ratios in preprimary schools have increased dramatically in recent years. As Figure 9 shows, this trend has been consistent in both State and non-State schools. For State schools, the average student to teacher ratio has increased from 45:1 in 2007, to 100:1 in 2011. For non-State schools, the

Figure 10: Student to teacher ratios in preprimary classrooms

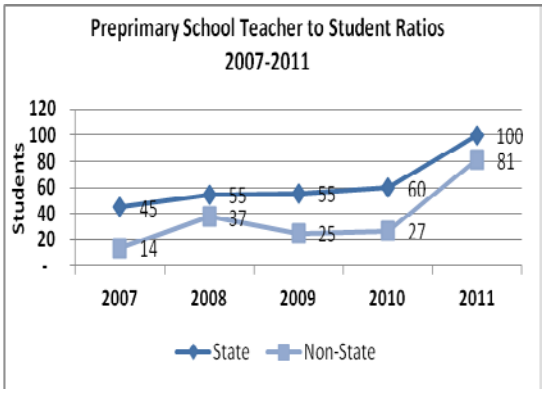
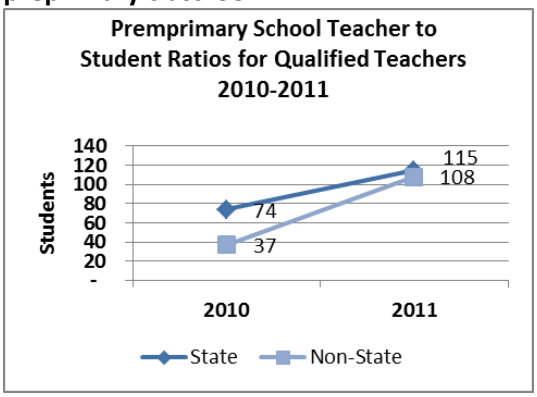


Figure 11: Student to qualified teacher ratios in preprimary classroom



average has increased from 14:1 in 2007 to 81:1 in 2011. Since 2010, the number of students per qualified teacher has been tracked (as opposed to all teachers, regardless of qualifications, as shown in Figure 9).

As Figure 10 shows, in just one year, the number of students per qualified teacher increased from 74 to 115 and 37 to 108 in State and non-State schools, respectively. These data are for preprimary schools serving children age 5 and 6; data for ECCE centers serving children below the age of 5 are not available.

Both State and non-State preprimary schools are required to comply with established service delivery and infrastructure standards; in practice, however, compliance is not well-monitored or enforced. Compliance with infrastructure standards is enforced during the school registration process. According to policy, preprimary schools should be inspected quarterly. The recent policy guidelines for construction standards that apply to preprimary schools were established in 2011; as such, no data monitoring compliance are available yet. Non-State schools are inspected during the registration process, at which time the qualifications of teachers are verified, but teachers are not required to have completed a two-year full-time teaching course (as is the case for teachers in State preprimary schools). State schools are required to adhere to established personnel recruitment standards. Schools that fail compliance tests are not granted annual operating licenses.

Policy Options to Monitor and Assure ECD Quality in Tanzania

- **Data Availability –** Relatively reliable administrative and survey data are available in Tanzania to monitor children's access to essential ECD services. The age range of available early learning and preprimary school data (covering children age 5 and 6) is, however, a serious limitation. The monitoring of children's development and outcomes across the interrelated domains of ECD is not well-developed. The GoT could consider conducting a survey to collect information on children's development to get a baseline from which to consider a scalable approach to tracking child development outcomes, including the development of individual children. Improved tracking of ECD expenditures within and across sectors – at the local, sub-national and national level should be considered to allow for the assessment of the cost-effectiveness of interventions and improved policy planning and allocation of resources.
- **Standards –** The current policy requiring two years of full-time pre-service training for preprimary teachers may not be the most effective approach as the GoT works to scale access to preprimary school. The institutions currently preparing preprimary teachers do not have the capacity to train enough teachers to meet the growing demand and the two-year full-time requirement is expensive and time-intensive. The GoT may want to consider a more

flexible approach to training, with a focus on high-quality but shorter duration training programs and those programs that allow teachers to work towards certification while teaching (which has the added advantage of giving teacher practical experience to apply in their studies).

- **Compliance with Standards –** Now that new standards have been developed, it will be important to monitor and enforce compliance. Currently, child to teacher ratios are extremely high in preprimary classrooms in Tanzania - new classrooms and new teachers are urgently needed to meet demand without sacrificing quality. The GoT could also consider policy options to encourage non-State providers to increase service provision or formally register existing facilities.

Comparing Official Policies with Outcomes

The existence of laws and policies alone do not always guarantee a correlation with desired outcomes. In many countries, a disconnect exists between policy intent and the reality of implementation and service delivery on the ground. In Tanzania, for example, despite a policy mandating the registration of children at birth, just 22% of all children are registered. Similarly, despite a policy mandating the iodization of salt, just 59% of households are consuming iodized salt. These discrepancies between policy intent and outcome indicate a need to examine the policies and their implementation. Conversely, the policy and implementation of vaccines has yielded a successful 91% coverage rate.

Table 11 summarizes key policy provisions in East Africa, along with related outcomes. Despite mandatory salt iodization policies in all four countries, household consumption of iodized salt varies from a low of 20% in Ethiopia to a high of 96% in Uganda. Birth registration seems to be a challenge throughout the region; all four countries have mandatory registration policies – these policies, however are currently yielding registration rates of less than a quarter of the population in each country. The approaches to breastfeeding promotion and preprimary school vary from country to country, yielding mixed outcomes.

Table 10: Comparing policy intent with ECD outcomes in Tanzania

Policy	Outcomes
Tanzanian policy complies with the International Code of Marketing of Breastmilk Substitutes →	Rate of exclusive breastfeeding until six months: **50%**
Tanzania has a national policy to mandate the iodization of salt →	Household consumption of iodized salt: **59%**
Preprimary school is officially free in Tanzania, but it is not compulsory →	Preprimary school enrollment (age 5-6): **33%**
Young children are required to receive a complete course of childhood immunizations →	Children with DPT (12-23 months): **91%**
Registration of children at birth is mandatory through the Registration Insolvency Trusteeship Agency →	Completeness of birth registration: **22%**

Table 11: Comparing policy intent with ECD outcomes in East Africa

Comparing Policies with Outcomes in East Africa				
	Tanzania	**Ethiopia**	**Kenya**	**Uganda**
Salt Iodization				
Salt Iodization Policy	Mandatory since 2006	Mandatory since 2011	Mandatory	Mandatory
Population Consuming Iodized Salt	59%	20%	90+%	96%
Appropriate Infant Feeding and Breastfeeding Promotion				
Compliance, Code of Marketing of Breast Milk Substitutes	Law		Some provisions law	Law
Exclusive Breastfeeding until 6 Months	50%	49%	32%	60%
Preprimary Education				
Preprimary School Policy	Not compulsory; State-provided free for two years officially but user fees are common	Not Compulsory; Government does not finance recurrent costs and user fees are common	Not compulsory; Government does finance some recurrent costs but user fees are common	Not compulsory; all provision is non-State
Preprimary School Enrollment Rate	33%	5%	42%	6.6%
Birth Registration				
Birth Registration Policy	Mandatory		Mandatory	Mandatory within 3 months of birth
Birth Registration Rate	22%	7%		21%

Preliminary Benchmarking of ECD in Tanzania with International Comparisons

Table 12 presents the classification of ECD policy in Tanzania within each of the nine policy levers and three policy goals. For each of the three policy goals, Tanzania's level of development is classified as "Emerging." While recent efforts to develop the IECDP, improve coordination and develop minimum standards for ECCE are all notable steps, significant areas for improvement remain.

Table 13 presents the status of ECD policy development in Tanzania alongside a selection of neighboring and OECD countries. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers.

Table 12: Classifying the level of ECD policy development in Tanzania

ECD Policy Goal	Level of Development	Policy Lever	Level of Development
Establishing an Enabling Environment	●●○○	Legal Framework	●●○○
		Coordination	●●●○
		Financing	●○○○
Implementing Widely	●●○○	Coverage	●●○○
		Equity	●○○○
		Area of Focus	●●●○
Monitoring and Assuring Quality	●●○○	Data Availability	●●○○
		Quality Standards	●●●○
		Compliance with Standards	●●○○

Table 13: Comparing ECD policy in Tanzania internationally

ECD Policy Goal	Policy Lever	Level of Development					
		Tanzania	Kenya	Chile	Ethiopia	Sweden	Turkey
Establishing an Enabling Environment	Legal Framework	●●○○	●●○○	●●●○	●●●○	●●●●	●●●○
	Coordination	●●●○	●●●●	●●●○	●●○○	●●●●	●●○○
	Financing	●○○○	N/A	●●●○	●○○○	●●●●	●●○○
Implementing Widely	Coverage	●●○○	●●○○	●●●○	●○○○	●●●●	●●○○
	Equity	●○○○	N/A	●●○○	N/A	●●●●	●●○○
	Area of Focus	●●●○	●●●○	●●●●	●●○○	●●●●	●●●○
Monitoring and Assuring Quality	Data Availability	●●○○	●●○○	●●●○	●○○○	●●●●	●●○○
	Quality Standards	●●●○	●●●○	●●○○	●●○○	●●●●	●●●○
	Compliance with Standards	●●○○	●●○○	●●○○	●○○○	●●●●	●●○○

Table 14: Summary of policy options to improve ECD in Tanzania

Policy Dimension	Policy Options and Recommendations
Establishing an Enabling Environment	• Approve the draft IECDP as a matter of priority • Develop and approve a costed implementation plan for the IECDP once approved • Insert line items for ECD into the budgets of the five key ministries: MoEVT, MoH, MoSP, PMO-RALG, MCDGW and/or improve mechanisms to track ECD expenditures • Consider capitation grants to schools for preprimary expenditures • Consider impact of additional costs for services on families and potential solutions (such as conditional cash transfers)
Implementing Widely	• Target programs to reach the poorest, most marginalized young children • Formalize community health workers and ensure that messages around early stimulation are incorporated to reach children age 0 to 3 • Increase access to skilled attendants at birth • Reach parents more education and messages on ECD and early care and stimulation
Monitoring and Assuring Quality	• Ensure that compliance with standards is enforced according to new quality standards • Increase availability of training opportunities for ECD service providers to address skills shortages • Consider reforms to preprimary teachers preparation policy to scale up training of preprimary teachers in a cost-effective and high-quality manner so that high child-to-teacher ratios can be addressed • Consider mechanisms to support for private providers to enter the market to provide affordable and high-quality ECCE

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities to develop effective ECD systems. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges. This Country Report presents a framework to compare Tanzania's ECD system with other countries in the region and internationally.

The approval of the draft IECDP is a critical step to build upon recent momentum for ECD following the Inaugural Biennial National Forum on ECD (held in Arusha in February 2012). Once approved, the challenge will be to develop a costed implementation plan to scale coverage and ensure quality. The scale-up of access to preprimary school presents the GoT with a particular challenge given that the national average child-to-teacher ratio is already 100:1, with just 33 percent of children age 5 and 6 enrolled. Adequate finance and quality assurance frameworks will be necessary to ensure that quality does not decrease as access increases - if not, the very benefits that children and families seek from early learning opportunities will be jeopardized. The recent development of standards for preschool service delivery is a positive step towards monitoring and ensuring quality, but current enforcement mechanisms are not sufficient to ensure compliance.

Within each Policy Goal, opportunities exist to strengthen ECD policy and service delivery to ensure that all young children have a strong start in life and are afforded the opportunity to reach their full potential. Table 14 summarizes these policy options and recommendations.

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The **Systems Approach for Better Education Results (SABER)** initiative produces comparative data and knowledge on education policies and institutions, with the aim of helping countries systematically strengthen their education systems. SABER evaluates the quality of education policies against evidence-based global standards, using new diagnostic tools and detailed policy data. The SABER country reports give all parties with a stake in educational results—from administrators, teachers, and parents to policymakers and business people—an accessible, objective snapshot showing how well the policies of their country's education system are oriented toward ensuring that all children and youth learn.

This report focuses specifically on policies in the area of Early Childhood Development.

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