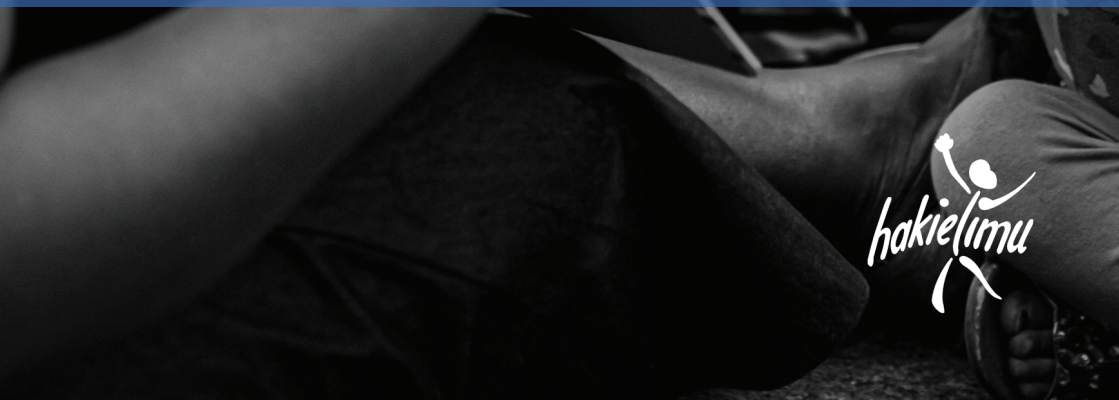
BRIEF REPORT

The Political Economy of Early Childhood Development in Mainland Tanzania

Issues, Practices, Challenges and Opportunities



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Introduction

The international law recognise children as holders of basic universal human rights and child-specific rights (**Gal & Davidson-Arad, 2014**). Therefore, certain unique needs and interests of children are legally enforceable rights. Early childhood development (ECD) is one of the basic principles of the UN Convention on the Rights of the Child and among the most promoted child specific rights (**Woodhead, 2005**). Early childhood is the first phase of human life and refers to a time that "spans the prenatal period to eight years of age and it is the most intensive period of brain development throughout the lifespan" (**Manas, 2020:13933**). Relatedly, it is has been unequivocally established that early childhood, particularly the first 8 years of life, impacts an individuals long-term social, cognitive, emotional, and physical development. Furthermore, ECD is strongly related to flourishing societies (**Kouamé, 2019**). A positive start in life gives each child an equal chance to flourish and become an adult who contributes positively to the community, both economically and socially (**Irwin et al., 2007**). Accordingly, early childhood inputs strongly affect the productivity of later inputs, particularly in the economy and in society at large (**Heckman, 2006**).

Consistent with the global inclination, in 1992 Tanzania adopted a national 'Child Development Policy' (CDP), and for the first time in the country catapulted 'child development' in the national policy agenda. In Tanzania, early childhood development refers to the optimal development of a child from conception to eight (8) years (**MoHCDGEC, 2020**). Overall, Tanzania Mainland has 16,204,920 children, (i.e., 27.07% of its total population) in the early childhood phase **MoFP, et al. (2022)**. Majority of them 11,376,763 (70.20%) i.e., 5,681,430 male and 5,695,333 female, reside in rural settings and 4,828,157 (29.80%), i.e., 2,403,254 male and 2,424,903 female reside in urban settings (ibid.). Tanzania, demonstrate strong policy and political commitment towards ECD. Therefore towards attaining universal ECD services in Tanzania, this report explores the political economy of early childhood development in the country.

The Political Economy of Early Childhood Development

The crucial thesis of a political economy analysis is to relate political and policy domains to conditions on the ground (**Sharma, 2021**). The political economy approach to ECD look at societal structures and processes that distribute or obstruct material and social resources to families and children to support child development (**Bryant & Raphael, 2015**). It examines the interaction between the state and the market through political, economic, and societal institutions and actors and how that interplay frame deliverable outcomes as public goods (**Reis, 2012**). In this context, public goods are understood to be ECD goods and services readily provided to all children and their families, either by the state, or by private individuals or organisations without a commercial profit motive.

Elements of political economy analysis therefore include, international law. This is because universal rights are viewed as common concerns of states and therefore codified in international law through the process of rendering them in binding written agreements **(Charney, 1993)**. Other elements are international organisations (IOs), i.e., multilateral organizations. In the same breadth as IOs, are bilateral funds, agencies, philanthropic organisations and International Non Governmental Organisations (INGOs). Other elements are national policies and legislations which itemise the rights, and delineates obligations to specific actors responsible for delivering those rights.. Other key elements in the political economy analysis are administrative systems which constitute the actors, processes, procedures and resources in place (i.e, developed, established and/or mandated) to actualise legislative and/or policy provisions.

Objectives of the Study

The study aim to contribute in the understanding of the state of Early Childhood Development (ECD) services in mainland Tanzania. The specific objectives are:

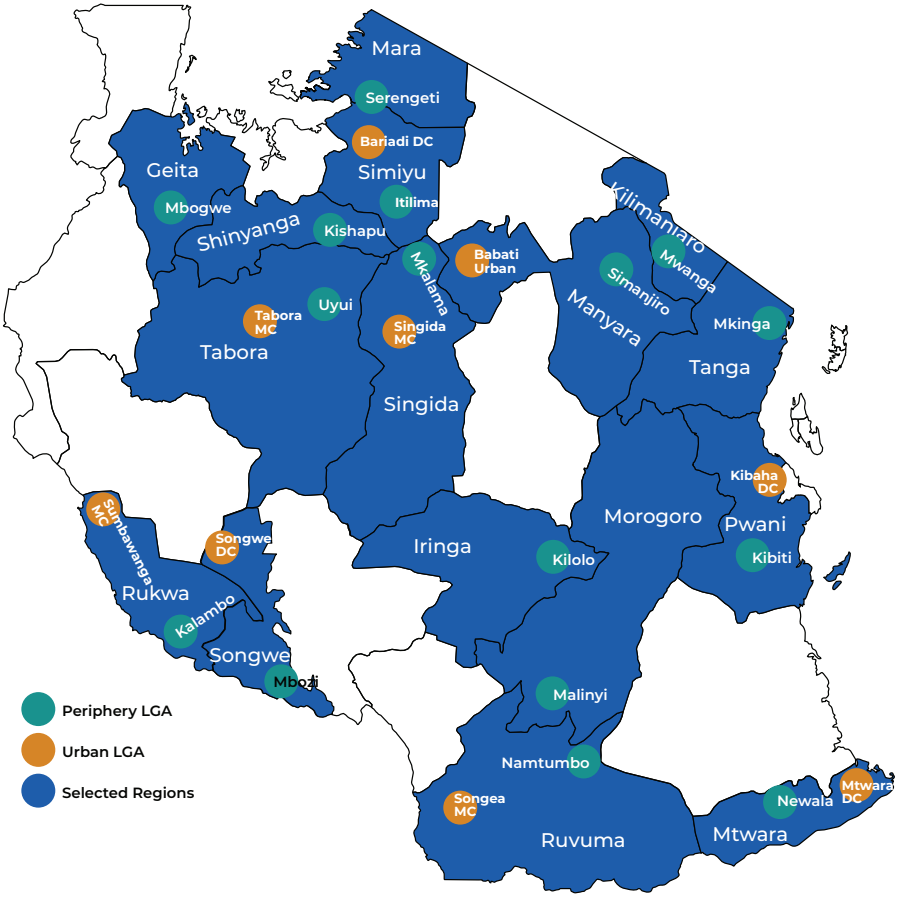
i	To examine the Tanzanian early childhood development policy environment;
ii	To explore the integration of 'inclusion 'in Early Childhood Education
iii	To explore the financing of ECD programs and services.
iv	To scan the level of public awareness and participation towards attaining universal access to quality ECD services.
v	To appraise ECD Coordination and Accountability Mechanisms

Location of the Study

Across the seven geographical zones of the country, i.e., Southern, Southern Highlands, Central, Westlake, Lake, Coastal, and Northern, out of a total of 26 regions, the study covered 16 regions. In each of the geographical zone 50% of the regions were deemed as an appropriate sample size and the regions were selected through simple random sampling. Within the 16 regions, 32 local government authorities (LGAs) were involved in the study. Of these LGAs, 16 were purposively selected to represent urban

settings. The LGAs that hosted the regional headquarters was considerer an ideal representative of the urban setting. The other 16 LGAs were selected through simple random sampling to represent periphery settings. In each of the urban and periphery LGAs, one ward and within the selected wards, one Mtaa (for urban), and one village (for periphery), were selected through simple random sampling. Respectively, a total of 32 wards, 16 mitaa and 16 villages were covered.

Map 1: Location of the Study: Regions and LGAs

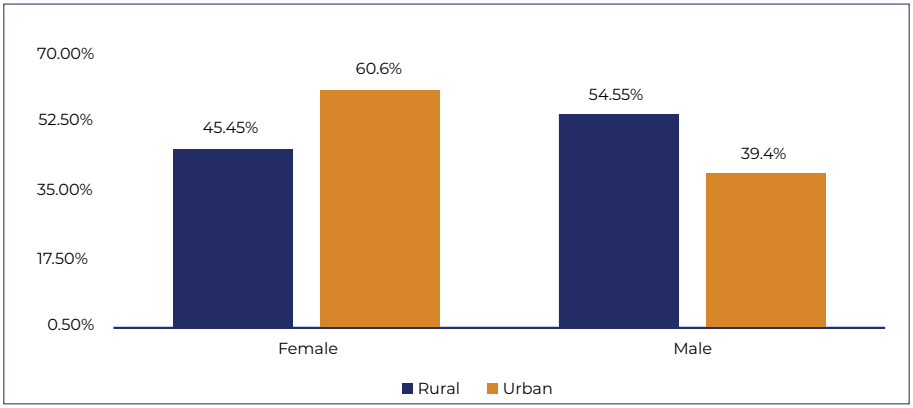


Methodology

The study was guided by the "Child Protection Systems: Actors, Context, and Components" conceptual framework developed by **Wulczyn et al. (2010)**. The study is underpinned by practice orientation and is primarily exploratory, therefore designed to be undertaken through an interpretive-descriptive (ID) methodology. The ID methodology seek to generate general knowledge that can then be applied in particular situations that arise in practice context to help orient practice reasoning (**Hunt, 2009**). The study used five data collection techniques:

i) **Survey**: A sampling frame was prepared entailing all eligible HoHs in each 16 mitaa and 16 villages. Eligible households were those with children that are in the early childhood phase, i.e., 0-8 years old. A total of 4,205 eligible respondents (1,990 male and 2,215 female) were identified across the localities of the study. The sample size per locality was 20% of the total population of study. Systematic sampling procedures was used to identify respondents from the sampling frame. Respectively, the study involved a total of 841 Head of Households (HoH), among them 398 were male and 443 were female. The analysis however will based on the rural-urban desegregation than male-female.

Figure 1: Heads of Households (HoH) Sex by Residency Category



ii) **Focus Group Discussions (FGDs)**: These were conducted at the community level and each involved a combination ward and mtaa/village leadership as well as key ECD institutional actors. Respondents were Ward Executive Officers, Ward Education Officers, Ward Community Development Officers, Ward Health Officers, Ward Social Welfare Officers, Village/Mtaa Executive Officer, Medical Officer in-Charge at the ward/village level, Police Officer in-Charge at the ward/village level, Community Health Worker, Chairperson of village/mtaa vulnerable children committee, two mtaa/village council members. An average of 8 respondents participated in 31 FGDs, hence an average of 248 respondents.

iii) Semi-structured self-administered questionnaires were used to collect data from purposefully identified key

iv) institutional actors across ECD sectors at the LGA level. Respectively, data was collected from DMOs (19),

v) DEOs (31), DSWOs (31), DNuOs (29), District Police Officer Gender Desk in-Charge (25), and District Courts

vi) A checklist administered to village/mtaa executive officers was developed to determine the availability of basic ECDs facilities at the community level. A total of 29 checklists were filled.

vii) **Secondary Data**: Various sources of secondary data were used as respectively acknowledged throughout the report.

Ethical considerations

Some measures to ensure the study upheld expected ethical standards, include:

i) The study sought and attained an ethical clearance from the National Institute for Medical Research (NIMR)

ii) The study sought and attained research permit and clearance from the University of Dar es Salaam

iii) The study sought and attained research permit and clearance from the Commission for Science and Technology (COSTECH).

iv) HakiElimu constituted a Technical Review Team (TRT), involving Public Sector ECD Actors, ECD experts including academicians/Researchers/consultants, and Non State Actors, who acted as an oversight body of the study. The TRT is responsible for reviewing the proposal, tools and validation of the report.

Findings

1. The Tanzania Early Childhood Policy Environment

The study learnt that Tanzania has ratified key international instruments on child's rights, including the United Nations Convention on the Rights of the Child (UNCRC), in 1991. Subsequently, the country localised core provision of UNCRC in the Child Development Policy (CDP), 1996 and the Law of the Child Act [Cap. 13 R.E. 2019]. The two constitute the cardinal child's rights instruments in the country. In both instruments, child development is embedded with the broad definition of a child, i..e., a person below 18 years of age. However, in these key instruments, early childhood development is not specifically identified, defined or provided for. The blanket definition potentially leave crucial details relevant to the development of 0-8 years olds. The blanket coverage potentially obscure crucial details, protections and provisions relevant to the early childhood phase.

Early Childhood Nutrition (ECN)

The child's right to food is provided for but not the right to nutrition. Considering the significance of nutrition during the early childhood phase, it is crucial that food security and nutrition security be unequally provided for in key national child's rights instruments.

There are also several instruments which are particularly relevant for ECN. These include Food, Drugs and Cosmetics (Marketing of Foods and Designated Products for Infants and Young Children) Regulations, 2013; Tanzania Food, Drugs and Cosmetics (Food Fortification) Regulation, 2011, National Biofortification Guidelines, 2020., and the National Guidelines for the Provision of Food and Nutrition Services for Basic Education Level Learners, 2023. On programmatic intervention level, Tanzania is currently implementing the Second National Multisectoral Nutrition Action Plan (NMNAP II) -2022/22-20252/26.

Early Childhood Education (ECE)

The Education and Training Policy (ETP) of 2014 R.E. 2023, direct that mandatory pre-primary education should be offered for 1 year and a child should be enrolled at age of 5 years. However, the National Education Act, No. 25 of 1978 does not recognise preprimary education, and define primary school as entailing grade one and complete at grade seven. Furthermore, the Law of the Child Act [Cap. 13 R.E. 2019] does not declare ECE a right although provides for creches and day-care centres. In that ECE is recognised by not legislatively mandatory on Tanzania.

Nevertheless there are instruments to support ECE in the country, including Day Care Centres Regulations, National Guidelines for Establishment and Management of Day Care Centers, 2020 and National Guidelines for Establishment and Management of Community-Based Day Care Centres. Furthermore, the Persons With Disabilities Act (PWDA) No. 9 of 2010, Section 27, (1) gives persons with disabilities of all ages and gender the same right to education in inclusive settings as other citizens, and Section 27(2) gives every child with disability an equal rights in relation to admission to the public of private schools. Relatedly, the 'Guidelines for Educational Support, Resources and Assessment Services (ESRAC) or 2013 were revised in 2023 and renamed. National Guidelines for the Screening, Identification, and Assessment of Children/Learners with Special Educational Needs, i.e., *Mwongozo wa Kitaifa wa Ubainishaji na Upimaji wa Watoto/Wanafunzi Wenye Mahitaji Maalum ya Kielimu*.'

Early Childhood Health (ECH)

The child's right to health is provided in the Law of the Child Act [Cap. 13 R.E. 2019], Sections 8 and 9. However, there is no legislative declaration that in public health facilities healthcare for children in free. The policy position and practice is that for children under five years of age, health services are free in all public health facilities. The under five years old health services are provided under the auspices of Maternal and Child Health MCH) services.. However, for those who are above 5 years old, there is a cost implication to accessing health services. At the moment health insurance coverage is mandatory for those who have formal employment but voluntary to other sectors.

Again, the HIV and AIDS (Prevention and Control) Act, 2008, Section 25(1) obliges the Ministry responsible for health to regulate measures to reduce HIV transmission from mother to child. And paediatric HIV medical care is free in all relevant health facilities. Towards attainment of ECH goals, of significance is also that the Government has in place the Maternal and Perinatal Death Surveillance and Response Guideline of 2015, the Antenatal Care Guidelines of 2018 and the National Guideline for Neonatal Care and Establishment of Neonatal Care Unit of 2019. Furthermore, since 2016 the Government has in place the National Guideline for Water, Sanitation and Hygiene for Tanzania Schools and in 2018 the Government developed "Policy Guidelines in School Health Services in Tanzania," which anchor the National School Health Program.

There are numerous instruments relevant in issues of child protection. These include the Constitution of the United Republic of Tanzania, 1977, Article 14, and Tanzania Penal Code [CAP. 16 R.E. 2022], Sections 150, 151 and 219 protect right to life. Law of the Child Act (LCA), Section 9 (3) (a) obligate parents to protect the child from neglect, discrimination, violence, abuse, exposure to physical and moral hazards and oppression. Law of the Child Act (LCA), Section 13(1) protect children from torture, cruel treatment, inhuman punishment or degrading treatment, i.e., done with the intention of humiliating or lowering the dignity of a child. The Sexual Offences Special Provisions Act (SOSPA) Act, No 4 of 1998, also protects children from sexual abuse and female genital mutilation. Again, in 2022, the Government further developed, the National Guidelines for In-School and Out of School Child Protection and Safety Desk, i.e., *"Mwongozo wa Taifa wa Dawati la Ulinzi na Usalama wa Mtoto Ndani na Nje ya Shule."*

On social protection, LCA, Section 9(3)(b) obligate parents to provide good guidance, care, assistance and maintenance for the child and assurance of the child's survival and development. Furthermore, LCA Section 41 obligates a parent in respect of whom an order of parentage has been made, to contribute towards the welfare and maintenance of the child to supply the necessities for survival and development of the child. Further, the Penal Code under Sections 166 and 167 criminalises parents, guardians or other persons who are having lawful care or charge of children whose apparent ages are not more than fourteen years and unable to provide for themselves, refuses or neglects to maintain the child, provide (those able to do so) sufficient food, clothes, bedding and other necessaries of life for the child, so as to insure the health of the child. LCA Section 51(b) declare to be an offence punishable by law failure to supply the necessities for child survival and development by anyone who is legally liable to do so.

In 2009 the Government developed National Guidelines for Improving Quality of Care, Support, and Protection for Most Vulnerable Children in Tanzania. In 2017, the Government developed the National Guidelines for Identification of Most Vulnerable Children and Linkage to Care, Support and Protection. In relation to that since 2017, the Government has in place the 'National Intergrated Case Management System (NICMS) Framework.' Furthermore, in 2017 the Government also developed the National Guidelines on Integrated Child Care Management Training for Community Level Child Care Managers, i.e., *"Mwongozo wa Kitaifa Kuhusu Mafunzo ya Usimamizi Jumuishi wa Mashauri ya Watoto kwa Wasimamizi wa Mashauri ya Watoto Ngazi ya Jamii"*. Again, in 2019 the Government developed the National Guidelines on Children's Reintegration With Families. Again in 2024 the Government prepare a Reference Book for Fit Persons, i.e., *'Kitabu cha Rejea kwa Mlezi wa Kuaminika'*.

2. The Integration of 'Inclusion' in Early Childhood Education (IECE)

While NSIE identified 13 special education needs categories, the study focused only on the integration of children with disabilities (CWDs) in ECE. The study learnt that majority of CWDs access to IECE is through the mandatory pre-standard one class. **BEST (2022)**, indicate that a total of 6120 pupils with disabilities were enrolled in pre-primary in Tanzania. Of these 92.9% were enrolled in government schools while only 7.1% were enrolled in private schools.

Table 1: CWDs enrolled for Pre-primary in 2022

	BLIND		LOW VISION		DEAF		HARD OF HEARING		DEAF BLIND		ALBINO		PHYSICAL IMPAIREMENT		INTELLECTUAL IMPAIRMENT		AUTISM		MULTI IMPAIREMENT		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
GOV	132	125	270	227	396	290	102	96	6	0	171	138	971	604	901	592	157	122	235	153	5688
PRIVATE	9	6	11	7	46	31	7	3	0	0	35	45	63	48	22	18	22	12	19	28	432
TOTAL	141	131	281	234	442	321	109	99	6	0	206	183	1034	452	923	610	179	132	254	181	6120

SOURCE: BEST, 2022

Regarding the availability of adequate ECE teachers trained to facilitate inclusive classes, out of 16 periphery DEO's 8 were of the opinion that such teachers were adequately available, while 7 stated that they were not adequately available and 1 was uncertain. Similarly 10 DEO's out of 16 in urban settings stated that such teachers were adequately available while 6 stated that they were not adequately available. It is therefore clearly, that while in some LGAs there are adequate teachers trained in IECE in others they are inadequate.

Regarding inclusivity of ECE infrastructure in their respective LGAs, out of 16 DEO's in periphery LGAs, 9 stated that most of the school infrastructure did not follow universal design for learning and were not easily accessible for children with disabilities, while 7 stated that they were accessible. Similarly, for DEO's in urban settings, 8 stated that most infrastructure was not accessible for learners with disabilities, while 8 were of the opinion that most of the ECE facilities were accessible to children with disabilities.

Regarding availability of braille story books and text books for ECE learners with visual disabilities, Out of 16 DEO's of urban LGAs, 6 stated that pre-school braille story books were available and 10 stated that they were not available.

Furthermore, 7 stated that ECE braille text books were available for learners with visual impairment and 9 stated that they were not available. On the other hand, out of 16 DEO's from periphery LGAs, 15 stated that there were braille pre-school story books for learners with visual disabilities, while only 1 stated that they were not available. Again, 7 stated that pre-school braille text books were available, while 9 stated they were not available.

Overall, there are divided perceptions regarding basic issue related to integration of inclusion in ECE. These indicate that there is high disparity across LGAs regarding the extent IECE has been attained, at the pre-school level. Furthermore, the LGAs do not conduct or keep inclusivity assessment records to determine the progress they have made and the remaining gap.

Some of identified obstructions to enrolment and participation of CWDs in ECE include:

a) Negative perceptions on CWDs - Community members, including parents and guardians do not believe CWDs have any significant potential or prospects in education and employment.

b) Distance: Distance from home to school deter some parents/ guardians from enrolling CWDs.

c) Other challenges identified are Inaccessible infrastructure, limited assistive devices, poverty, lack/inadequate specialised teacher, lack of personal assistants, lack of support from family members, and insecurity.

3. Early Childhood Development Investment

The study learnt that there are substantial ECD investments and resources from outside the country, These come through numerous multilateral organisations, several bilateral funds/ agencies, diverse philanthropic organisations and various international NGOs. It is therefore very complex to disaggregate IOs, Bilateral Relationships; Philanthropic Organisations; and INGOs ECD directed resources and their diverse investment pathways e.g., funding government budget, funding research, INGOs, variously supporting local NGOs, implementing or financing different programmes, projects and interventions etc

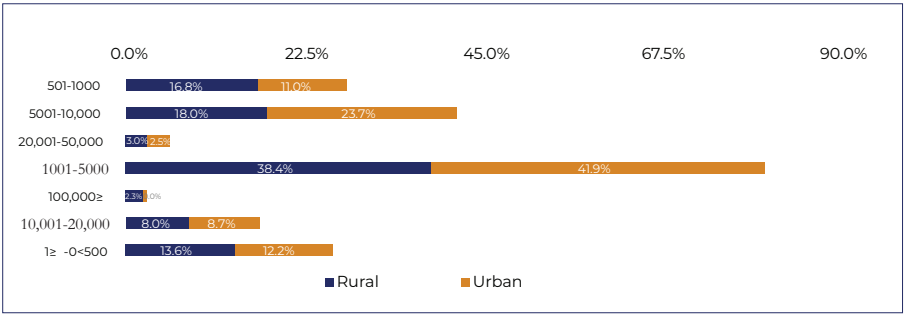
Furthermore, mapping where and what ECD investment has been made is inevitably a complex maze which needs a through investigation. UNICEF & GENESIS (forthcoming) provide an insightful analysis of ECD investment landscape in Tanzania. This is an important study in the right direction, and set an important precedent in studying ECD investment in the country. Although in Tanzania there is the Development Partners Group (DPG), and various technical working groups such as Nutrition, Health, Education, Agriculture, HIV/AIDS, and Water Sanitation and Hygiene, it has been a challenge to achieve a coordinated

ECD investment strategy. Part of the challenge is lack of clarity regarding the priority ECD investment areas, unclear pattern of ECD investment, limited assessment of the state of ECD services at the community level, and lack of clarity regarding current investment gaps towards attaining national ECD targets.

The study focused on ECD investment/financing at LGAs and household level. It was learnt that the Government is the principal funder of a majority of ECD related programs and interventions across all ECD sectors. This is done through direct Government disbursement and through funding of LGAs budgets. Furthermore, LGAs, also funds several ECD related interventions and initiatives through own source. However, overall direct responsibility of ECD services financing is with parents/guardians. For example 'fee free' education is a policy position and political commitment but is not a legislative responsibility of the Government. Similarly, day care centres are privately run while the financing of community daycare centres is the responsibility of community members.

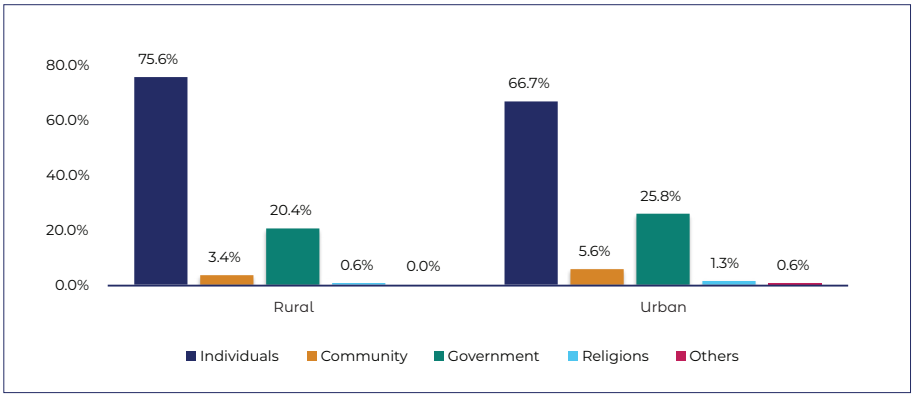
As indicated in Figure 2, the study learnt that the average daily income of 68.8% of rural HoH and 64.8% of urban HoH, is below the proposed threshold of U.S $1.9 a day and therefore living in extreme poverty. Inevitably, this makes it practically challenging for them to be able to prioritise and adequately invest in ECD. Majority of both urban (57.3%) and rural residents (63.1%) are of the opinion that it is the Government which is responsible to establish ECE facilities in their localities. However, as indicated in Figure 3, both rural based (75.6%) and urban based (66.7%) parents/guardians are of the opinion that the responsibility to finance ECE for their children is of the individuals, i.e., parents/guardians of those children.

Figure 2: HoH Average Daily Income



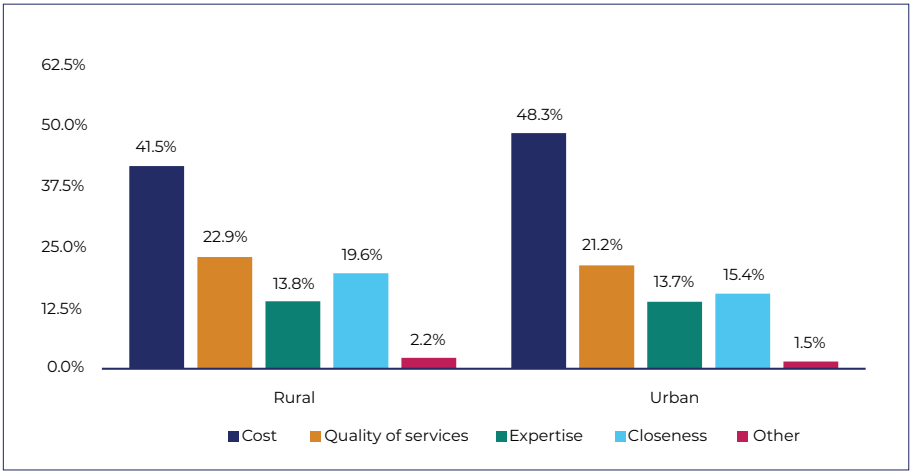
The study also learnt that 86% of rural based and 91% of urban based parents/guardians preferred public over private health facilities maternal and child health services. Furthermore the study learnt the leading reason for preferring public facilities is affordability.

Figure 3: Responsibility to Finance ECE



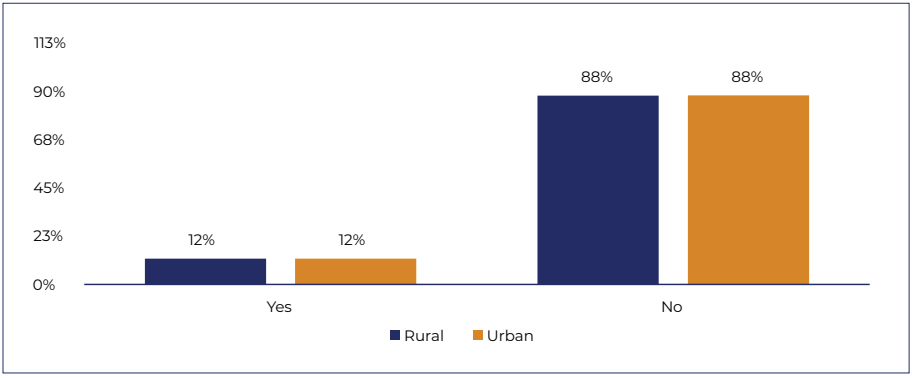
As indicated in Figure 4, 41,5% of rural based and 48.3% of urban based parents/guardians preferred public over private health facilities because they are more affordable. Other reasons include quality of service, availability of expertise and proximity to people residences.

Figure 4: Reasons for Preferring 'Public' over 'Private' Health Facilities



The Study also learnt that 31.8% of rural based and 34.2% of urban based parents/guardians have at some time failed to meet medical costs and access health services needed for their children who are in the early childhood phase. Parents/guardians are more likely to fail to afford health care services of their children when they need them because of the out-of-pocket (OOP) payment practice. As indicted in Figure 5, majority of HoH , 88% of both rural and urban based parents do not have health insurance cover for their young children.

Figure 5: Having Health Insurance Cover for Children



The study also learnt that 50% of rural based and 59.6% of urban based parents/guardians do not consider their household as being food secure throughout the year. This means that more than half of households in rural and urban settings are at the risk of experience periodic food insecurity. Similarly, 56.36% of urban based and 48.41% or rural based parents/guardians, stated that there times when they are unable to to ensure that young children in their households get the balanced diet they need.

The study learnt that although all ECD components are delivered at LGAs level, most LGAs do not have specific ECD budget lines. For example in ECE budgets are supposed to appear in the respective schools and are taken on board the 'capitation grants 'paid by the Government directly to schools. Due the 'fee free basic education policy ' most of the resources are coming from the central government.

Furthermore, out of 32 DEOs, 12 indicated that they do not have a specific budget for ECE. While the study was not able to identify a basic criteria for ECN budget, the margins are too huge to ignore. For periphery LGAs the difference in FY2022/23 is TZS 1,800,000 lowest, and TZS 68,589,855 highest; and for FY2023/24 is TZS 2,500,000 lowest and TZS 178,005, 000 highest. For urban LGAs in the FY2022/23 the difference was TZS 2,400,000 lowest and TZS 56,798,004 highest, while for the FY2023/24 the difference is TZS 5,160,000 lowest and TZS 96,654,840 highest. There is a need to further investigate the determinants for such variation.

ECN was the most budgeted for ECD component in LGAs. Mostly budget is allocated for routine ECD related activities such as Promotion of exclusive breast feeding; Maternal nutrition; Complementary feeding training; improvement of multisectoral nutrition services; early childhood stimulation; Pregnant mothers stimulation; Promotion of balanced diet; Vitamin A supplementation deworming campaigns, celebration of breastfeeding week; Therapeutic foods trainings;

Nutrition education to mothers of malnourished children etc. Furthermore, the study learnt there is strong variation between LGAs regarding budgeting for ECD.

In Early Childhood Security and Safety, the study learnt that there are ECD services providers, such the Police Department Gender Desk who do not budget for ECD interventions at all. The study also learnt that most DSWO did not have specific ECD budgets. For example, except for Uyui, Mkinga, Kishapu, Kilolo, Itilima, Sumbawanga MC, and Bariadi, who have activities on under 5 years birth registration and certification, the rest covers all children in general. Issues such establishment of community daycare centres, parenting programs, inclusion of children with disability in early learning, or community sensitisation of health insurance for children did not feature at all in DSWOs budgets.

Overall, looking at LGAs budgets, it is clear that an ECD lens is missing in the budgeting process. The budgets do not indicate that they target specific ECD outcomes. Lack of specific budget lines and limited capacity for ECD budgeting can be part of the problem. However, lack of a comprehensive essential ECD covering basic ECD rights across sectors may also contribute to this challenge.

4. ECD Services Availability, Access and Related Services

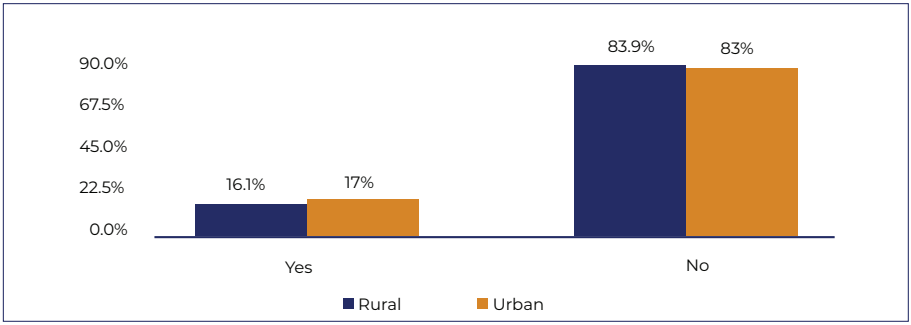
Currently in Tanzania there are 4,263 mitaa, and a total of 12,319 villages, hence a total of 16,582 grassroots institutions of governance. Overall, there are 3389 daycare centres and 206 community day-care centres (CDCs) in the country. Across the country, an average of only 25.7% and 1.2% of the villages/mitaa have at least one daycare centre and/or a CDC. Of the 32 villages/mitaa involved in the study, only 1 had a CDC. There study also learned that there is very low awareness on the CDC Guidelines, particularly among ward, village and mitaa officials. There is therefore a huge gap with regards to availability of ECE facilities in the country.

In terms of distance from home to school for children aged 3-5 years, 63.1% of urban based HoHs, and 59.3% rural based HoHs said children can walk comfortably, while 36.9% of HoHs of urban areas and 40.7% HoHs of rural areas said the distance was long and children of that age cannot walk comfortably. However, for children of age 4-5 years old, only 17.7 HoHs from urban areas and 21.8 from rural areas said children of that age group can walk to and from school comfortably. Again for age group 5-8 years children, 14.5% and 13.5% HoHs from rural and urban respectively said the distance was too long for children of that age to walk to and from comfortably. These findings shows that distance between home and school is still a thorny issues for majority of children who are supposed to attend ECE facilities and might affect enrolment and attendance, or become too tasking for young children.

ECH facilities are most readily available services at community level. The study learnt that majority of respondents (74% urban & 61% rural) walk to the nearest health facility. Furthermore, 74.8% of rural and 80.3% of urban respondents, were of the opinion that in case of a medical emergency at home, in an ideal situation it is possible/convenient to quickly rush someone to the nearest health facility.

However, availability does not always mean utilisation For example, although the Registration Insolvency and Trusteeship Agency (RITA) has cascaded services to health facility and community level, thereby removing substantial barriers in registration of children and attainment of birth certificates service utilisation is still low. As indicated in Figure 6., majority of HoHs, (83.9% of from rural settings and 83% from urban) have not attained birth certificates for their children.

Figure 6: Percent of HoH Who Have Processed Birth Certificates for their Children aged 0-8 years



The study also learnt that majority of child abuse incidences go unreported, as 52% of PGCD are of the view that sometimes child abuse incidences go unreported; while 20% see it as often. Again, there is a discrepancy regarding the perceived prevalence of child abuses. While PGCD flagged issues such as unnatural offence, child battering/cruelty, rape, sexual abuse/ harassment to be prevalence in their LGAs, yet except for the district courts of Bariadi, Singida, Kilolo, Geita and Iringa, where there are notable number of cases, in other district courts there is minuscule number of such cases. Findings from the district courts in the respective LGAs, show that in 5 years, i.e., 2018-2023, 6 had not registered for determination any such criminal case, and 3 had register only one case each.

Reporting of child abused incidences might be affected by accessibility. On the checklist of availability of services, only 29 respondents were in a position to provide information, while 3 could not. Therefore out of the 29 villages/mitaa, involved in the study only 6 had a police station, while 23 did not have. Furthermore, only five (5) had a PGCD, while 24 did not have. The police department should babe further supported in the Government policy and initiative to further cascade the services of the police force to the community level.

5. ECD Coordination and Accountability Mechanisms

Coordination entail alignment of early childhood interventions, intervention services,, and community resources to support a collaborative, cross-disciplinary, and cross-agency service delivery process.. The National Multi-sectoral Early Childhood Development Programme (NM – ECDP) has outlined a clear Leadership, Management and Coordination structure. Furthermore, the Guideline for the Coordination National Multi-sectoral Early Childhood Development Programme (NM – ECDP) 2021/22 to 2025/26, i.e. "Mwongozo wa Uratibu wa Programu Jumuishi ya Taifa ya Malezi Makuzi na Maendeleo ya Awali ya Mtoto, 2021/22-25/26, task clear responsibilities at all levels. Furthermore, the National ECD dashboard has been developed and is in place to facilitate monitoring progress in the implementation of ECD policies. Again, progress is made in developing the National ECD scorecard. Currently Ifakara Health Institute (IHI) and Tanzania Early Childhood Development Network (TECDEN) are developing indicators to be included in the National Multisectoral ECD Scorecard.

However, ECD services delivery continue to be dominantly sectoral rather than integrated or complementarily. There is little evidence of the coordination of the delivery of early childhood intervention services, resources, and supports with service providers and agencies, particularly at LGAs, wards and villages/mitaa levels. There is also little evidence of collaboration among and between service providers and agencies to facilitate a team approach to early childhood interventions. Furthermore, there is very limited information, guidance, and education provided to HoHs about early childhood intervention and inclusive service delivery models.

Conclusion

The study learned that Tanzania has a rich ECD policy environment, across an array of all ECD sectors. There are numerous policies, legislations, regulations, guidelines, and programmatic documents variously providing for ECD. However, early childhood is blanketed within the larger childhood concept. In that regard, it is challenging to decipher the specific early childhood rights and mandatory early childhood services. The study also learnt that the state of the integration of 'inclusion' in Early Childhood Education leaves a lot to be desired. There are hardly any statistics at LGAs and community levels regarding young children with disabilities. Most ECE infrastructure is not inclusive, and there are limited teachers adequately trained to facilitate IECE. Furthermore, there are limited and uneven distribution of accessible teaching and learning materials across LGAs. The study also learned that cultural/attitudinal barriers persist particularly at the household/community level obstructing the enrolment and attendance of learners with disabilities in ECE facilities.

Regarding financing of ECD programs and services, principal funders of ECDs services and programs are: the Government of the URT, DPs (IOs and Bilateral Partners), Philanthropic Organisations, NSAs (particularly INGOs, NGOs,) and Parents/ Guardians. The study learnt that majority of respondents are low income earners with very limited means to financially contribute towards accessing of ECD services. For that reason, most HoHs rely on public funded ECD services. However, most HoHs acknowledge that it is their responsibly to finance ECE services and are willing to collaborate with all actors towards the attainment of quality ECD services.

Majority of HoHs affirmed that they can access most ECD services, although the quality of services is still wanting. Services provided at the household levels, such as nutrition is determined to be the most challenging of the services.

Overall however, ECD services however are still not universal with some localities accessing while others are not. Furthermore, there is a clear unevenness with regards to the distribution and access across ECD sectors. Optimum impact will not be attained when a child gets one or two while missing on several others. Delivery of each ECD domain needs to be equable to each child. The study learnt that currently, the ECD coordination structure from the national to the grassroots level is in place, but discrete sector-wise delivery seem persist. There is little complementarity between ECD sectors which lead to uneven delivery and access to ECD services.

Recommendations

Policy Recommendations

i) The review of Child Development Policy be undertaken imminently and ECD be specifically be incorporated in the policy.

ii) A review/amendment of Law of the Child Act be undertaken to enable the accommodation of specific ECD rights, services and obligations.

iii) Revising the Food and Nutrition Policy for Tanzania, 1992 (NFPT) to recognise and provide for early childhood nutrition.

iv) Development of the national guidelines for early childhood food and nutrition security

v) Development of specific regulations and guidelines be adopted to unpack policy directions, technical recommendations and legislative provisions and cater for ECD age-specific needs. For example, TFNC need to pioneer the development of early childhood nutrition guidelines.

vi) Amendment of the TFNC Act to ensure it legislate on specific issues of nutrition. Currently it does not ensure production and utilisation of food in a manner that achieve and maintain adequate national levels of nutrition.

vii) There is need for the development of a compendium of ECD policies, legislations and regulations in Tanzania. This should be one document that summarise all they key policy documents related to ECD.

viii) There is a need for delineation of specific essential ECD services package in Tanzania. It is recognised that Tanzania has adopted and localised the Care for Child Development (CCD) package. However, the package can be revisited and broaden to ensure that it constitute the basic mandatory ECD services in Tanzania. The Table below indicate the preliminary recommendation for such a package:

Coordination Recommendations

i) Prioritisation of adequate dissemination of priority ECD guidelines, plans and action points particularly to LGAs, and community levels.

ii) Undertaking of specific ECD coordination capacity building of ECD coordinators at all levels, particularly at regional, LGAs and community levels is essential.

iii) Approximation of a programmatic approach towards ECD services delivery, through cross-sector aligned prioritisation, planning, budgeting and implementation

iv) Documentation of the role of the private sector in ECD and systematic, concrete engagement of the sector, in partnership with NSAs and the public sector, both at the national and local government level is recommended.

v) Development of a national ECD investment portfolio and a costed plan based on essential interventions across ECE, ECH, ECN, Child Protection and Social Protection - as will be indicated in the ECD compendium.

Programmatic Recommendations

i) A project designed to model effective provision of Inclusive Early Childhood Education is essential.

ii) Development of an ideal community daycare centre model to ensure there is consistency in establishment of community daycare centres.

iii) Coordinate a multi-stakeholder approach to upscale the establishment of community daycare centres across the country.

iv) Undertake ECD awareness creation and capacity building at LGAs, Ward and Village/Mtaa level.

v) Undertake a thorough assessment of IECE in the country.

vi) Advocacy for ECD to be in the MTR Framework, and for ECN and ECE to be declared specific child rights.

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