

The Political Economy of Early Childhood Development in Tanzania Mainland

Status, Practices, Challenges and Opportunities

April 2024

hakielimu

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Abbreviations and Acronyms

AU	African Union
BEmOC	Basic Emergency Obstetric Care
CBOs	Community Based Organisations
CCD	Care for Child Development
CCWs	Community Case Workers
CDP	Child Development Policy
CDSC	Community Driven System Change
CFTs	Council Facilitators Teams
CHWs	Community Health Workers
CJFs	Community Justice Facilitators
CSO	Civil Society Organisation
CSW	Commissioner of Social Welfare
CWDs	Children with Disabilities
DEOs	District Education Officers
DFID	Department for International Development
DNuOs	District Nutrition Officers
DRC	Declaration of the Rights of the Child
DWCPT	District/Council Women and Children Protection Team
EAC	East African Community
ECD	Early Childhood Development
ECE	Early Childhood Education
ECSS	Early Childhood Security and Safety
ECH	Early Childhood Health
ECN	Early Childhood Nutrition

EIB	The European Investment Bank
EPES	Essential Package of ECD Services and Support
ETP	Education and Training Policy
FAO	The Food and Agriculture Organization of the United Nations
FBOs	Faith Based Organisations
FGM	Female Genital Mutilation
FNPT	Food and Nutrition Policy for Tanzania
GFSI	Global Food Security Index
HCs	Health Centers
HPCs	Health Care Professionals
IECE	Inclusive Early Childhood Education
IEP	Individualised Education Plan
IFC	International Finance Corporation
IFSP	Individualised Family Service Plan
INGOs	International Non-Governmental Organisations
LCA	Law of the Child Act
LEA	Local Education Authority
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MIYCAN	Maternal, Infant, Young Child and Adolescent Nutrition
MoA	Ministry of Agriculture
MoFP	Ministry of Finance and Planning
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSA	Multi-Sectoral Approach
MVC	Most Vulnerable Child/Children

MVCCs	Most Vulnerable Children Committees
NDF	The Nordic Development Fund
NEA	National Education Act
NHP	National Health Policy
NIB	The Nordic Investment Bank
NM-ECDP	National Multi-Sectoral Early Childhood Development Programme
NPA-VAWC	National Plan of Action to End Violence Against Women and Children in Tanzania
NPSC	National Protection Steering Committee
NPTC	National Protection Technical Committee
NRCIM	National Research Council and Institute of Medicine
NSAs	Non State Actors
NSIE	National Strategy for Inclusive Education
OCDs	Officers Commanding Districts
OFSP	Orange Fleshed Sweet Potato
PAs	Professional Associations
PGCD	Police Gender and Children's Desk
PHA	Public Health Act
PMTCT	Prevention of Mother to Child Transmission
PO-PSMGG	President's Office Public Service Management and Good Governance
PPE	Pre-Primary Education
PWDA	Persons With Disabilities Act
RPCs	Regional Police Officers
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SOSPA	Sexual Offences Special Provisions Act
TAHEA	Tanzania Home Economics Organization

TASAF	Tanzania Social Action Fund
TGEP	Tanzania Generation Equality Programme
TWGs	Thematic Working Groups
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	The United Nations Development Programme
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNGA	United Nations General Assembly
UNICEF	The United Nations Children's Fund
URT	United Republic of Tanzania
VHND	Village Health and Nutrition Day
VHP	Village Health Post
VHWS	Village Health Workers
WB	The World Bank
WFTs	Ward Facilitators Teams
WHO	The World Health Organization

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Introduction

1. Background

In Tanzania, early childhood development refers to the optimal development of a child from conception to eight (8) years (MoHCDGEC, 2020). Overall, in 2020, Tanzania Mainland had 16,204,920 children, (i.e., 27.07% of its total population) in the early childhood phase (MoFP, et al. op cit). The majority of them 11,376,763 (70.20%) i.e., 5,681,430 male and 5,695,333 females, reside in rural settings and 4,828,157 (29.80%), i.e., 2,403,254 male and 2,424,903 females reside in urban settings (ibid.)

Historically, childcare was a matter of cursory concern to the Government or employers because it was considered a private matter provided through informal care (Baker, 2011). The informal childcare system constitutes immediate family and community members, i.e., parents, relatives, friends and neighbours (Brady, 2018). Under this system, children 'belong' to the family and there is little state interference regarding their overall treatment (Hart, 1991). In this context, children's best interests are synonymous with those of their parents. Ideal childhood is therefore essentially defined by the interplay of context specific social, cultural (traditions, norms, customs, and taboos) and economic practices and religious values. These constitute the understructure of the informal childcare system because they underpin the practices, feelings, attitudes, values, beliefs and interactions related to child rearing.

The child rights movement has overseen the shift from children as the 'property' of parents to children as a discrete group in its own right. Recognition of child rights has transferred the family's absolute power over children and conferred it upon the state. Under the doctrine of child rights, the state has the mandate to intervene in family life where necessary to promote, provide, and/or protect the best interests of the child towards the attainment of the children's delineated rights (Rodham, 1973).

Consistent with global norms, in 1992, Tanzania adopted a national 'Child Development Policy' (CDP), which for the first time placed 'child development' per se on the national policy agenda. This development had two critical implications. First, childcare captured Government attention and ceased to be an exclusive private/family affair. The policy thereby recognized and concretized a dual system of informal and formal childcare. The latter includes public funded/provided child development services, care purchased via the market, community or family-based day-care, center-based care and nannies (Brady, op cit.: 242). Secondly, by setting the benchmark regarding what constitutes 'child development' for the entire country, the measure universalized child rearing practices, values and standards.

In this regard practices, values and standards in the informal care domain, have to be consistent with or at least not antithetical to national standards. The case for universal ECD services has been made, it is strong, and it is unequivocal (see for instance, Naudeau, et al., 2011). The international community has integrated ECD as a priority development agenda. Similarly, Tanzania, has demonstrated strong policy commitment towards ECD. Therefore, as a contribution towards attaining universal ECD services in Tanzania, this report explores the political economy of early childhood development in the country.

1.1. A Synopsis of the Political Economy of Early Childhood Development

A political economy approach to ECD moves beyond the concrete and observable to look at the societal structures and processes that distribute the material and social resources to families and children that can either support or threaten children's development (Bryant & Raphael, 2015). It examines the interaction between the state, the market and civil society through political, economic, and societal institutions and actors and how that interplay frames deliverable outcomes, such as public goods (Reis, 2012).

In this context, public goods are understood to be goods and services readily provided without profit to all members of the society, either by the state, or by private individuals or organizations (Reiss, 2021). While early childhood development services are indisputably perceived as universal 'child rights', it is important to establish whether they are codified as a public good in the country, and whether they are available and accessible. This is essential because the crucial thesis of a political economy analysis is to relate political and policy domains to conditions on the ground (Sharma, 2021).

Universal rights are viewed as the common concern of states and therefore codified in international law through binding written agreements (Charney, 1993). These agreements therefore promote the coordination of uniform state behavior, particularly on specific issues agreed upon, such as common standards of achievement for all peoples and all nations (Hannum, 1996). Thus, international agreements are prominent in the analysis of the political economy of child rights, and ECD in particular. This is because, by ratifying an international agreement, a country accepts its legal obligations under that agreement and will adopt implementing legislation. In this way an international agreement is domesticated into national policy and anchored in national law.

In the context of international law, international organisations (IOs), also known as multilateral organizations are also important, because they are established by treaty, and/or are instruments governed by international law and possessing their own legal personality (Potter, 1935). International organisations constitute the system of institutions and practices for the creation and enforcement of the rules of international law which govern the body of international intercourse (Potter, 1922:5). These organisations develop international standards, oversee compliance, and support implementation and attainment of these standards at international and national levels. Thus, they play a key role in the setting of international ECD standards, resource mobilisation and dissemination, and programmatic interventions. In that respect, they are an indispensable component of the political economy of ECD. In addition, there are bilateral funds and agencies which play a pivotal role in ECD through financial resource mobilisation and funding, capacity building and knowledge brokering, institutional development, and various forms of programmatic interventions.

Furthermore, philanthropic organisations play a crucial role in providing, soliciting and/or distributing donations from private individuals and for-profit companies to support ECD programmes. They are a significant source of financial, technological and technical

resources for ECD. They fund policy development, capacity building, research, and numerous programmatic interventions. Furthermore, the role of Non State Actors (NSAs) in the advancement of ECD is indispensable. NSAs pioneer ECD advocacy, build capacities, forge strategic partnerships, conduct studies, and undertake programmatic interventions towards the attainment of universal ECD services. NSAs include International Non-Governmental Organisations (INGOs), local Non-Governmental Organisations, Community Based Organisations (CBOs), Faith Based Organisations (FBOs), Professional Associations (PAs), and other forms of organised civil society. Overtime, the relationship between civil society and the Government has evolved. In particular CSOs that focus on development activities have attained the status of partnership in delivery of services to the people, especially vulnerable groups and marginalised populations.

From a political economy perspective therefore, the international dimension contributes three important elements to the international and national ECD agenda. First, it creates a global ECD momentum through strategic networks, partnerships, advocacy and pressure. Second, it sets the international ECD standards through international law and goals through global consensus. Global consensus entails forging a global partnerships for common agendas articulated through a common language aiming to achieve specific global targets such as the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs). Third, it provides a range of strategic resources through diverse avenues towards the attainment of ECD standards and goals. Resources among others include direct and indirect financial investments, and scientific evidence, expertise, technology, and technical know how.

Under international law, universal rights are domesticated and attained through two important mechanisms, first, Governments are obligated to enact relevant legislation that domesticate those rights, thereby codifying them as national and/or citizenship rights; and second, Governments are obligated to create administrative systems, to deliver, promote and protect those rights (**Sloss, 1999; Raustiala, 1995**). In that sense, under the auspices of the 'Government,' these complementary mechanisms, i.e., legislations and the administrative systems, constitute the epicentre of the political economy of any human rights, and in this particular context the right to early childhood development services.

The role of legislation is specifically to itemise the rights. This is is crucial because it distinguishes right from favour. As a cardinal principle, a legal right refers to an interest accepted and protected by law, i.e., bestowed by legal rules or judicial decisions (**Herstein, 2023**). In that respect, a legal right to a public good constitutes a government obligation to provide it to its citizens and/or ensure that they access or attain it regardless of their ability to pay. The right to early childhood development therefore requires the state to develop policies, legislation and action plans to achieve accessible early childhood development services. The first fundamental question that legislation answers is therefore, what are early child development rights? Without rights being clearly provided by the law, they cannot be claimed as a right. They are favours which can be withdrawn or sustained on paternalistic attitudes rather than lawful obligation.

Legislation also delineates the obligations of specific actors responsible for delivering those rights, and specifies sanctions for failing to adhere to stated obligations. In the context of early childhood development, this is expressed in two questions, Who does the law recognise as the primary custodian of early childhood development rights; and who does the law hold accountable and what are the appropriate penalties should children be found not to access early childhood development services.

On the other hand, administrative systems constitute the actors, processes, procedures and resources in place (i.e, developed, established and/or mandated) to actualize legislative provisions. These are concrete manifestation of two fundamental questions. First, who has to do what to ensure that the right to early childhood development services is a universally lived reality in the country. Second, what mechanisms are in place to oversee the delivery of these services including their quality standards.

Of importance to note is that parents and/or guardians are legal entities recognised as important actors in children's lives. In the family institution, they have legal obligations and identifiable processes, procedures and resources related early childhood development services. It is in this respect that they are considered as political institutions. According to Ochs & Taylor (1992:301), "...families are political in that certain members review, judge, formulate codes of conduct, make decisions and impose sanctions that evaluate and impact the actions, conditions, thoughts and feelings of other members." In that context, parenting is viewed as having a political or rather legal dimension. This is because being a parent is a legal status codified by law, conferred with legislative obligations and can be sanctioned. It is therefore an institutionalised position, that is based on a value system which inform practices, prioritisation, administration of power, and allocation of resources.

It is the administrative system that enables actors to operate and deliver on early childhood development services based on the legislative mandate. This include the role of the Government, i.e. central and LGAs, as well as its various key institutional actors. We will also be able to see key institutional actors at the community level, i.e., at the ward and village level. The role of the family as an institution, and parents, guardians, or those who have custody of a child as its key institutional actors will also be examined. Within the administrative system, key actors, processes and procedures related to aspects of early childhood development i.e., early childhood health, nutrition, education, protection and social protection.

On the basis of the foregoing, it is evident that early childhood development services are held as inalienable child rights in international law and the global child rights movement. The major question this study set itself to address is whether they are a public good in Tanzania, and what specifically does or will it take to deliver quality, universal early childhood development services in the country. To respond to this question from a political economy stance, the study examined whether early childhood development services are codified as a right in Tanzania. Furthermore, through exploring availability and access, the study appraises the functionality of the administrative system towards the attainment of quality, universal early childhood development services in the country.

1.2. Objectives of the Study

Through the Political Economy lens, this study aims to build an understanding of the state of Early Childhood Development (ECD) services in Tanzania mainland. 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 examine 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.

1.3. Location of the Study

Across the seven geographical zones of the country, i.e., Southern, Southern Highlands, Central, West Lake, Lake, Coastal, and Northern zones, out of a total of 26 regions, the study covered 16 regions. In each of the geographical zones 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, 16 were purposively selected to represent urban settings. The LGAs that hosted the regional headquarters was considered ideal representatives 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. Table 1 and Map 1 below indicate the location of the study.

Table 1: Location of the Study

SN	REGION	URBAN LGA	WARD	MTAA	PERIPHERY LGA	WARD	VILLAGE
1	Geita	Geita	Mgusu	Machinjioni	Mbogwe	Nyakafulu	Shinyanga B
2	Iringa	Iringa MC	Mkwawa	DonBosco A	Kilolo	Role	Kitelewasi
3	Kilimanjaro	Moshi MC	Soweto	Wireless	Mwanga DC	Shighatini	Mfinga
4	Manyara	Babati TC	Babati	Kwewe	Simanjiro DC	Naberera	Madukani
5	Mara	Musoma MC	Nyakato	Mlimani	Serengeti DC	Natta	Mbisso
6	Morogoro	Morogoro MC	Mazimbu	Boma A	Malinyi DC	Malinyi	Makerere
7	Mtwara	Mtwara MC	Naliendele	Pachoto A	Newala DC	Malatu	Mtanda
8	Pwani	Kibaha DC	Kilangala	Kilangala	Kibiti	Mchukwi	Mchukwi B
9	Rukwa	Sumbawanga DC	Mtowisa	Ng'ongo	Kalambo	Lioa	Santa Maria
10	Ruvuma	Songea MC	Mjimwema	Misufini	Namtumbo	Luchili	Kilangalanga
11	Shinyanga	Shinyanga	Ibadakuli	Bugweto B	Kishapu	Mwakipoya	Iboja
12	Simiyu	Bariadi DC	Nyangokolwa	Bipyai	Itilima	Lengambili	Lengambili
13	Singida	Singida Urban	Majengo	Ukombozi	Mkalama DC	Mwangeza	Dominiki
14	Songwe	Songwe DC	Mkwajuni	Mkwajuni	Mbozi	Igamba	Mbuga
15	Tabora	Tabora MC	Mapambano	Makongoro	Uyui DC	Miyenze	Miyenze
16	Tanga	Tanga CC	Maweni	Kichangani	Mkinga	Duga	Duga Maforoni

1.4. Methodology

The study is strongly 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 contexts to help orient practice reasoning (**Hunt, 2009**). Furthermore, this methodology interrogates complex experiential questions through explicit field/subject/ context specific philosophical underpinnings (**Burdine, et al. 2021**).

In this study, the growing field and practice of the early childhood development is at the centre stage. ID extends qualitative descriptions into the realm of interpretation and explanation in the context of qualitative credibility criteria. The '*descriptive*' dimension seeks to portray various issues related to perception, nature, access and impact of ECDs services. The '*interpretive*' dimension seeks to unearth the underlying structures, determining the perceptible nature of ECDs services. This study therefore mixes secondary research with quantitative and qualitative primary data. Consistent with interpretive description, the aim is to generate knowledge relevant for early childhood development practice in the Tanzanian context.

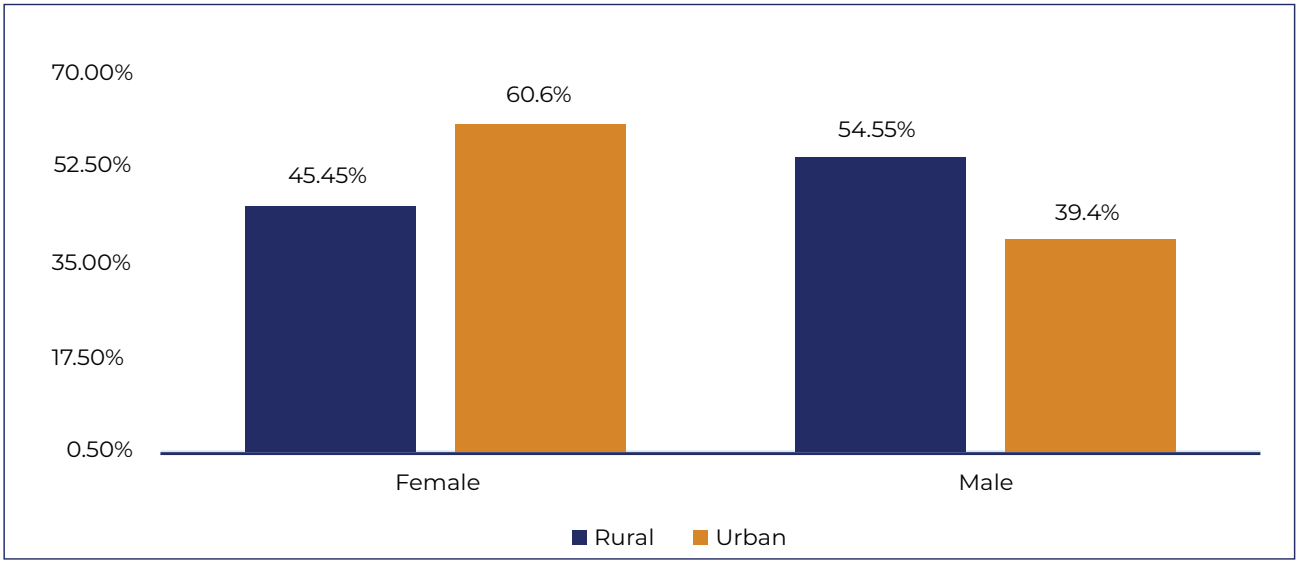
1.4.1. Conceptual Framework

The study is guided by the "Child Protection Systems: Actors, Context, and Components" conceptual framework developed by **Wulczyn et al. (2010)**. This Framework recognises that child protection system constitutes an interplay of actors and in a variety of a hierarchy of institutional settings. This study views child protection system as consistent with early childhood development system. This system is viewed as constituting certain formal and informal structures, functions and capacities that have been assembled to deliver early childhood development services towards the attainment of national early childhood development goals. Optimum attainment of early childhood development goals will therefore rely on seamless efforts of these actors. On the other hand, intermittent actors' efforts will result in imbalanced provision and access to child early childhood development services. Furthermore, coordination of these actors is seen as fundamental towards ensuring complementarity off their otherwise discrete efforts. The Political Economy of early childhood development in Tanzania is therefore studied through examining systems components (i.e., human resources, finance, laws and policies, and the governance) as we as the actions or inactions of various institutional actors in the child protection system.

1.4.2. Data Collection Techniques, Sample Selection and Description

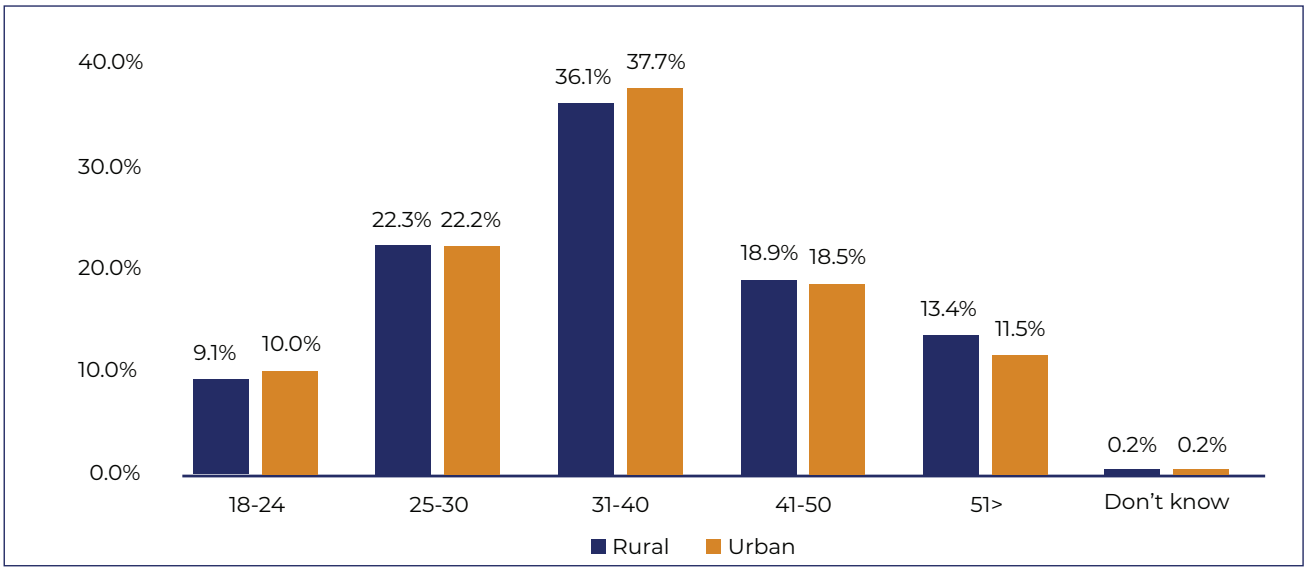
A survey tool was administered to HoHs with children in the early childhood phase, i.e., 0-8 years old in the villages/mitaa involved in the study. A sampling frame was prepared entailing all eligible HoHs in each locality. A total of 4,205 eligible respondents (1,990 male and 2,215 female) were identified across the localities of the study. Among them 2,200, (1,200 male and 1000 female) were identified in rural areas; and 2005, (790 male and 1,215 female) were identified in urban areas. 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. Overall, the study involved a total of 841 Heads of Households (HoH), of whom 398 were male and 443 were female. As indicated in Figure 1.1, of the 398 male respondents, 240 reside in rural areas and 158 reside in urban areas, while of the 443 female respondents, 200 reside in rural areas and 243 reside in urban areas. The analysis however will be based more on the rural-urban desegregation rather than male-female.

Figure 1.1: HoH Sex by Residence Category



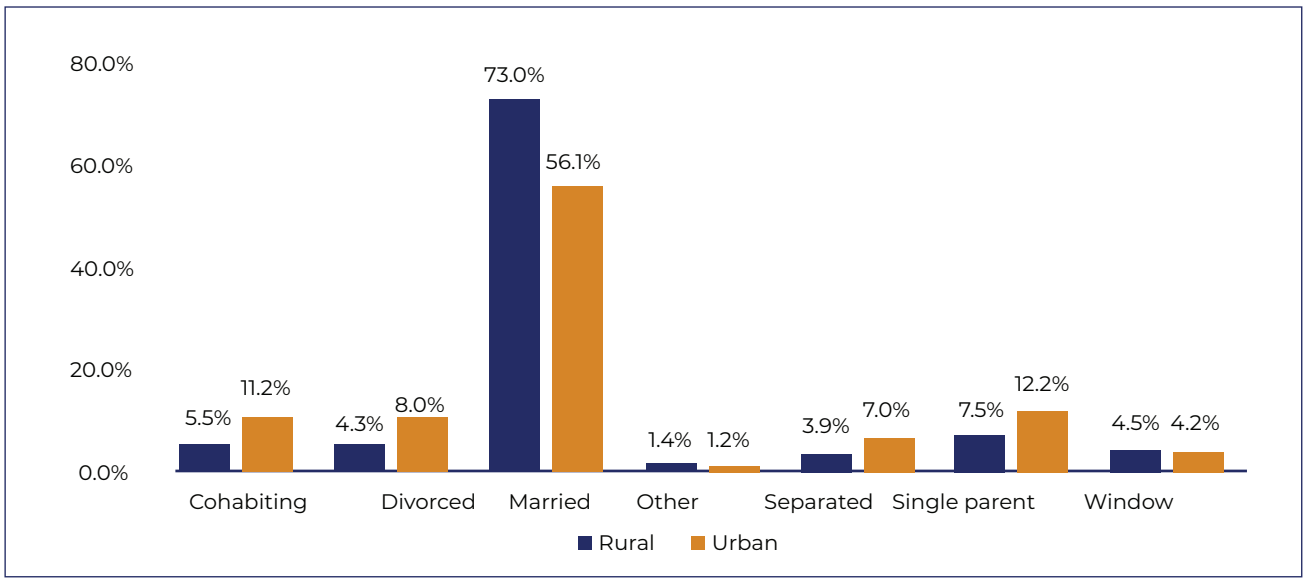
Furthermore, the age of the respondents varied, with some being in the 18-24 age category, while some were above 51 years old. However, as shown in Figure 1.2, the majority of the respondents were in the age category 31-40, followed by 25-30 and 41-50.

Figure 1.2: HoH Age Cohort by Residence Category



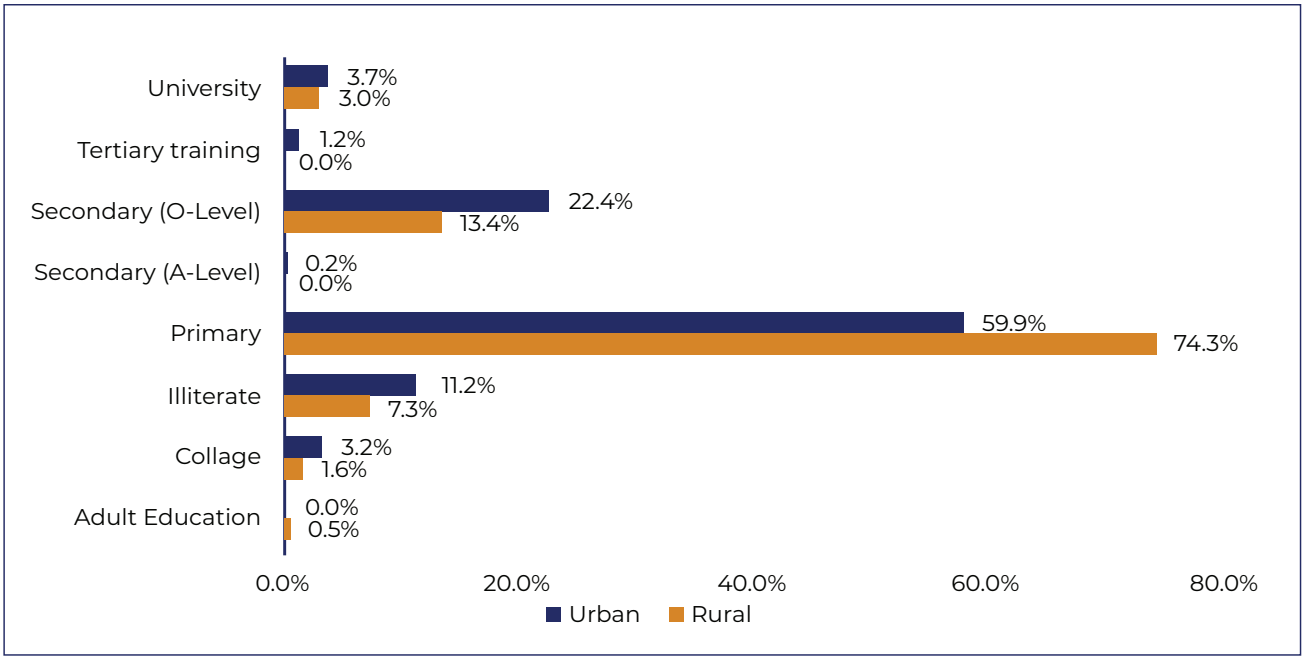
As Figure 1.3 indicates, the marital status of the majority of respondents, i.e, 73.% for rural residents and 56.1% for urban residents were married. Urban areas have a slightly higher percentage of HoHs who are either single parents, i.e., 12.2% compared to 7.5% of their rural counterparts, and cohabiting, 11.2% compared to 5.5% of rural residents. A few other HOHs were divorced, separated, and widow/widower. Such information is important it helps to understand the family arrangements of children and their social circumstances. However, in this paper the correlation between marital status and ECD was not sought. .

Figure 1.3: HoH Marital status by Residence Category



Furthermore, as indicated in Figure 1.4, the majority of respondents, i.e., 74.3% (rural) and 57.9% (urban), had a maximum of primary level education, followed by ordinary level secondary education, 22.4% (rural) and 13.4% (urban).

Figure 1.4: HoH Education Level by Residence Category



Regarding their economic activities, at the time of the study, the majority of the respondents from rural areas (69.5%) were involved in agriculture. Respondents from urban areas however, were involved in a variety of activities, with some doing small business (27.4%), farming (25.9%), self-employed in the informal sector (17. %) among others. Moreover, 16.7% of urban HoHs stated that they were unemployed, compared to only 6.1% of the rural HoHs. Again, an insight into the economic status of the HoH is important in the context of ECD, because of the responsibility they have in the maintenance of the child, provision of basic needs and ensuring access to social services.

The combination of education level and economic activities, indicates that majority of the respondents are low income earners. In the context of child rights, this is an appropriate population to study with regard to ensuring equitable access to universal ECD services. On the basis of the max-min principle, establishing and analyzing the low-income populations, helps in determining the basic minimum that is available, and setting minimum acceptable standards.

At the community level, FGDs were conducted with purposefully identified 11 categories of actors in the child protection and child social protection system at ward and village/mtaa levels. Respondents were Ward Executive Officers, Ward Education Officers, Ward Community Development Officers, Ward Health Officers, Ward Social Welfare Officers, Village/Mtaa Executive Officers, Medical Officers in-Charge at ward/village level, Police Officers in-Charge at ward/village level, Community Health Workers, Chairpersons of village/mtaa vulnerable children committees, two mtaa/village council members. An average of 8 respondents participated in 31 FGDs, a total of 248 respondents.

Furthermore, a semi-structured and self-administered questionnaire was used to collect data from purposefully identified key institutional actors across ECD sectors at the LGA level. Thus, data was collected from DMOs (19), DEOs (31), DSWOs (31), DNuOs (29), District Police Officer Gender Desk in-Charge (25), and District Courts. A checklist administered to village/mtaa executive officers was developed to determine the availability of basic ECDs facilities at community level. A total of 29 checklists were filled out. In addition, various sources of secondary data were used as acknowledged throughout the report.

1.4.3. Data Analysis and Presentation

Data analysis entailed triangulation, open and reflexive engagement with diverse sources of data, including primary data, secondary data, and, to a small extent existing literature in order to enable the emergence of clear arguments and coherence of the narrative. For quantitative data, a clean dataset was exported to SPSS V20 for analysis. The analysis involved cross tabulation and finding percentages for specific variables of interest. Findings are presented in figures with concise supporting descriptive narrative. For qualitative data, synthesising of findings across themes of interest was mainly used.

1.5. Ethical Considerations

Although this study concerns children, it did not involve them as respondents therefore it did not face an ethical dilemma related to involving children in research. Nevertheless, the study took very seriously ethical issues and strongly considered ethical responsibilities of all parties that were involved. 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.

Study Findings

2. The Tanzania Early Childhood Development Policy Environment

2.1. International Policy on Early Childhood Development

In international law, the universal right to child development was first recognized by the Geneva Declaration of the Rights of the Child adopted by the League of Nations on 26th September 1924 which stated that "The Child must be given the means requisite for its normal development, both materially and spiritually." On 10 December 1948, the United Nations General Assembly (UNGA) adopted the Universal Declaration of Human Rights which proclaimed, in Article 25 (2) 'childhood' to be entitled to special care and assistance.

This was followed in 1959 by the adoption by the United Nations of the Declaration of the Rights of the Child (DRC). In this declaration the right to child care and support to attain optimal development was elaborated in its second principle, which stated that "The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration." Exactly 30 years later, on 20th November 1989, UNGA adopted the United Nations Convention on the Rights of the Child (UNCRC) replacing the DRC. Article 6 of the UNCRC obligates countries to ensure to the maximum extent possible the survival and development of the child. It is this article which led to an serious uptake of 'child survival and development' policies and programs across the world from the early 1990s.

In the context of international law, the UNCRC is a legally-binding international agreement setting out the rights of every child, regardless of their race, religion or abilities. The legal implications of ratifying the Convention is that the country accepts its legal obligations under the Convention and commits to implementing it unreservedly. Thus, the country is legally bound to domesticate the Convention unequivocally. Important areas of domestication are twofold, as indicated in Article 4 of the UNCRC, which obligates the Government to pass relevant legislation and create administrative systems, to promote and protect child rights.

2.2. National Policy on Early Childhood Development

The United Republic of Tanzania (URT) ratified the UNCRC in 1991. Accordingly, it is obligated to embed its core provisions, fundamental principles and stated child rights, in national policies and legislation. This was done in the Child Development Policy (CDP), 1996 and the Law of the Child Act [Cap. 13 R.E. 2019]. The CDP clearly stipulates child development as a right, and states that "...the development of a child is related to his/her physical, intellectual, moral, and spiritual growth (CDP, 1996:12, 24). Among other things, the policy posits that pre-schools and day-care centres should be established and their services improved. It also stated that a system of educating parents on the importance of pre-school education

should be established. The policy further stated that communities and relevant institutions should be mobilised and educated on their responsibilities in child development.

The Law of the Child Act (LCA) [Cap. 13 R.E. 2019] is the principal act for the promotion, protection and maintenance of the welfare and rights of the child in Mainland Tanzania. The Act codifies child rights in the country. It also establishes and/or mandates an institutional and administrative system to oversee/actualize those provisions, principles and rights and ensure they become the lived experience of every child.

Responsive care giving is a crosscutting issue essential for ensuring children's health, nutrition, safety and security and vital for early learning. Thus, in 2018 the Government adopted 'A National Agenda for Responsible Parenting and Family Care.' The Agenda aim to engage parents in child care, child protection, and communication with children across the entire childhood cycle, i.e., from conception to 18 years. Overall, the Agenda stipulates measures that should be taken to establish a society where both male and female parents, caregivers and communities confidently provide optimum nurturing care, stimulation, support, encouragement, guidance and protection for children throughout their childhood to enable them to reach their full potential in adulthood.

Relatedly, in 2022 the Government developed the National Guide for Caregivers of Children Under Five Years of Age, i.e.,"*Kiongozi cha Kitaifa cha Mlezi wa Watoto Wenye Umri Chini ya Miaka Mitano.*" This Guide is designed to help all those who have the responsibility of parenting, caregiving and living with children under five years of age, to provide integrated services with quality standards that are compatible with the age of children under the age of five years. Below is an analysis of the national policy environment on various sectors of early childhood development.

2.2.1. Legal Recognition of Early Childhood Development

LCA Section 4 defines the child as a person below the age of 18 years. This definition covers children in the early childhood development phase, but does not single out this or any other childhood phase for specific legislative provisions. Similarly, LCA defines 'child development' but the concept 'early childhood development' is not mentioned or defined. It is clear that the blanket definition in the LCA does not recognise the significance of the early childhood phase.

2.2.2. Early Childhood Development Bundle of Rights

The Constitution of the United Republic of Tanzania, 1977, Article 14 provides that every person has the right to life and to the protection of their life to society in accordance with the law. This right also extends to unborn children, because The Tanzania Penal Code [CAP. 16 R.E. 2022], Sections 150 and 151 criminalises abortions; and Section 219 criminalises the destruction of the life of a child capable of being born alive. Furthermore, LCA sections 8 and 9, codify the rights of each child to include the right to life; food; shelter; dignity, clothing; health, including medical care and immunization; education respect; guidance; liberty; play and leisure. Let us examine these rights through the ECD lens.

i. Early Childhood Nutrition

The LCA Section 8 and 9, gives children the right to food, but does not define what constitutes that right. The puzzle therefore is, does the right to food mean the right to nutritious food? Does more food necessarily mean better nutrition? This is a contentious issue. Most commonly, food security refers to the ability to consistently access adequate food (MoH, 1992, Gibson, 2012; Pinstrup-Andersen, 2009). Nutrition security on the other hand refers to the ability to consistently access and consume adequate, safe, nutrient-dense food comprised of a variety of food groups to satisfy individuals' dietary needs and choices for an active and healthy life (Simelane & Worth, 2020).

In the context of early childhood nutritional requirements, apart from abiding by the WHO (2002) recommendation for early initiation of breastfeeding within 1 hour of birth to protect the newborn from acquiring infection and reduce newborn mortality, Tanzania developed the 'Food, Drugs and Cosmetics (Marketing of Foods and Designated Products for Infants and Young Children) Regulations, 2013 which, among other things, prohibits advertising of breast-milk substitutes, complementary foods and designated products. The Regulations are consistent with the WHO's International Code of Marketing of Breast-Milk Substitutes adopted in 1981 which aims to stop the aggressive and inappropriate marketing of breast-milk substitutes and contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

The Tanzania Food and Nutrition Act, No. 24 of 1973, established the Tanzania Food and Nutrition Center (TFNC). TFNC is the technical arm of the Government under the auspices of the Ministry of Health (MoH), established to spearhead the national food and nutrition programme, and ensure a coordinated, effective and efficient approach to tackling malnutrition. It is therefore within the mandate of TFNC or any other institutions upon which the national nutrition mandate will be bestowed, to pioneer the development of the currently non-existent national guideline on early childhood food and nutrition security.

Notably the Food and Nutrition Policy for Tanzania, 1992 (NFPT), does not recognise either 'early childhood' or early childhood nutrition, but variously use the terms 'child' 'children', 'small children' and 'young children', but does not define any of them. NFPT is however responsive to some nutrition challenges for children within the early childhood phase. E.g., Vitamin A Deficiency (VAD), affecting mostly children aged 6 months - 6 years; Nutritional Anemia, children below 5 years; and, Protein Malnutrition, children from 6 months -3 years/5 years. It does not however, have any policy statement targeting the attainment of ideal early childhood nutrition. In 2023, the Government developed the National Guidelines for the Provision of Food and Nutrition Services for Basic Education Level Learners, i.e., '*Mwongozo wa Kitaifa wa Utoaji wa Huduma ya Chakula na Lishe kwa Wanafunzi wa Elimumsingi*'. Among other things the Guidelines provides basic information for food and nutrition needs for children beginning from age 3 years and above.

On programmatic intervention level, Tanzania's Second National Multisectoral Nutrition Action Plan (NMNAP II) tackles malnutrition in children under five years old. The plan recognizes two main forms of malnutrition: deficiency of nutrients and deficiency of vitamins and minerals. For the first, the plan aims to reduce stunting from 32% to 24% by 2025. It also targets reducing thinness and low birth weight. For the second form, the plan focuses on reducing deficiencies in iron, folic acid, iodine, and Vitamin A.

The plan prioritizes interventions such as promoting proper feeding, treating malnutrition, monitoring growth, and delivering nutrients to children under five. Similar interventions are planned for children aged 5-9, with the addition of nutrition education and counselling. Surprisingly, the plan doesn't mention promoting fortified foods, which raises questions about whether this approach is still considered a priority.

ii. Early Childhood Education

LCA does not mention or define ECE, although it defines and regulates the administration of creches and day-care centres. Furthermore, LCA does not declare ECE a right. However, the basic question is, 'does the right to education mean the right to early childhood education (ECE)? The National Education Act (NEA), No. 25 of 1978 does not recognise pre-primary education, and defines primary school education as starting in grade one and complete at grade seven. Therefore, in the context of ECE, it will cover grade 1 up to 3. Furthermore, Section 35 (1) of NEA, makes it compulsory for children who have attained the age of seven years to be enrolled for primary education, which in principle imply that legislatively, compulsory ECE is only for 1 year.

The Education and Training Policy (ETP) of 2014 R.E. 2023, on the other hand directs that pre-primary education should be offered for 1 year and a child should be enrolled at age of 5 years. Accordingly, each public primary school is obligated to have a pre-primary education (PPE) class to prepare children for starting primary school, at age 6 years. Subsequently, the Tanzania Institute of Education has revised the 'Curriculum and Syllabus for Pre-primary Education 2023, i.e., '*Mtaala na Muhtasari wa Elimu ya Awali, 2023*,' to be used from the beginning of the academic year 2024. There is also in place the Teacher's Guide for Pre-Primary Education, 2016 and Primary Education Syllabus Standards I-II of 2023

In relation to ECE, LCA section 147-151 provides for creches and day-care centres. Essentially creches are obligated to cater for children from 3 months to 2 years old, while day-care centres are obligated to cater for children aged 2-5 years. Already Day Care Centres Regulations have been revised and announced through Government Notice No. 167 of 13/05/2016. Furthermore, in 2020 the Government developed the National Guidelines for Establishment and Management of Day Care Centers, and the National Guidelines for Establishment and Management of Community-Based Day Care Centres. LCA Section 149(2) which grant the Commissioner of Social Welfare the power to register day-care centres and crèches. Moreover, in 2020 the Government developed the National Guidelines for Development of Play and Learning Materials for Children Under Five Years.

On the integration of 'inclusion' in ECE, 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. Furthermore, the PWDA Section 27(2) gives every child with disability an equal right to admission to public or private schools. The Government has demonstrated its commitment to the inclusive education approach, particularly through the development of the National Strategy for Inclusive Education (NSIE) at all educational levels.

In 2013, the Government developed 'Guidelines for Educational Support, Resources and Assessment Services (ESRAC), to institutionalise and cascade support services for children with special educational needs. These Guidelines were revised in 2023, and re-named the 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*.' These Guidelines were developed to strengthen the identification and assessment system for these children/students in order to provide equal opportunities and suitable interventions inside and outside the formal education system.

On the basis of the above, to a large extent in Tanzania the policy environment for ECE is positive. However, early childhood education is not categorically declared as a child's right because it is neither included on NEA, or stated as such in the LCA. This leaves room for choice to enrol or not to enrol a child, without consequence. It also does not give legal power to institutional actors to enforce the establishment of ECE facilities such as community day-care centres, or enrolment of children by their parents and guardians.

iii. Early Childhood Health

Children's health is the extent to which individual children or groups of children are able or enabled to develop and realise their potential, satisfy their needs, and develop the capacities that allow them to interact successfully with their biological, physical, and social environments" (NRCIM, 2004:33). In that respect early childhood health promotion aims to keep children healthy with a focus on early interventions and programs for these children.

On the other hand, the right to health is a government obligation to provide, or ensure that its citizens access necessary medical services regardless of their ability to pay. The right to health requires the state to develop policies and action plans to provide accessible health care. (Tengiz, 2021). Children's right to health is provided for in LCA, Sections 8 and 9. In addition, the National Health Policy (NHP) (2007) and the subsequent Public Health Act (PHA) No. 1 of 2009 are principal instruments that inform availability of and access to early childhood health in Tanzania.

The NHP indicate that child health services will be provided under the auspices of Maternal and Child Health MCH) services. 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. Accordingly, in Tanzania it is mandatory for all pregnant women to be tested for HIV and, if found to be infected, they are offered free treatment for themselves to improve their health and to prevent passing of the virus to their infant.

As far as MCH services are concerned, the NHP provide a clear structure of health care delivery in the country, starting with Village Health Posts (VHP) in the rural areas. The target is for each village to have a VHP. These are expected to provide preventive services, provide health education about diseases in the village, clean and safe water, hygiene and environmental sanitation. They are also expected to advise on maternal and child health and food and nutrition. Furthermore, they are expected to collect statistics on diseases and immunisations, treat minor ailments and identify referral cases. Village Health and Nutrition Days (VHND), are particularly relevant for these activities. The VHP are for villages which do not have dispensaries.

Above the VHP are dispensaries which are earmarked to serve between 6,000 and 10,000 people. The plan is to have a dispensary for each village in the country. These are supposed to undertake all the duties of VHPs and provide all primary health care services, including Maternal and Child Health (MCH). Above the dispensary, are Health Centers (HCs), which are anchored at the Administrative Division level and are supposed to cater for approximately 50,000 people. These are expected to handle especially referral cases from VHPs/dispensaries. Above HCs are District Hospitals, Regional Hospitals and Referral/ Consultant Hospitals. Thus, according to NHP, basic early childhood health services are provided at VHPs and dispensaries, and HCs are regarded as referral level one.

Also of significance in attaining ECH goals, are the Maternal and Perinatal Death Surveillance and Response Guidelines of 2015, the Antenatal Care Guidelines of 2018 and the National Guideline for Neonatal Care and Establishment of Neonatal Care Unit of 2019. Section IV of the latter for instance is dedicated specifically to care for Child Development. Furthermore, since 2016 the Government has in place the National Guideline for Water, Sanitation and Hygiene for Tanzania Schools. The Guidelines specify essential sanitary conditions and facilities in schools compounds, as well as school community activities aimed to prevent water and sanitation related diseases. Furthermore in 2018 the Government developed "Policy Guidelines on School Health Services in Tanzania," which anchor the National School Health Program. These Guidelines focus particularly on school health services, a healthy school environment, and health education.

iv. Early Childhood Security and Safety

Early Childhood Security and Safety (ECSS) is an umbrella term encompassing child protection and child social protection. Child protection refers to the safeguarding of children from violence, exploitation, abuse, and neglect (Katz, at al. 2021). On the other hand, Social Protection "is a set of interventions whose objective is to reduce social and economic risk and vulnerability, and to alleviate extreme poverty and deprivation" (FAO: 2017). Social protection therefore helps increase access to food, nutrition, education and healthcare (ILO & UNICEF, 2023). Child-sensitive social protection refers to "the objective of ensuring that social protection systems and interventions are designed with the rights and needs of children at their core" (DFID UK et al. 2009).

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 the right to life. LCA, Section 9

(3) (a) obligates parents to protect the child from neglect, discrimination, violence, abuse, exposure to physical and moral hazards and oppression. LCA, Section 13(1) protects 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. This includes cultural practices which dehumanise or are injurious to the physical and mental well-being of a child. Again, LCA, Section 17(1) protects children from entering into discotheques, bar or night clubs; while 17(2) protects children from accessing cigarettes, alcohol, spirits, drugs or any intoxicating substance. This makes it unlawful for adults to go with young children in such places or to send children to collect these items.

In the Sexual Offences Special Provisions Act (SOSPA) Act, No 4 of 1998 which has been incorporated into the Penal Code Cap. 16 among others prohibits female genital mutilation (FGM). This is particularly relevant because, according to Ehiane at al. (2024), in some regions, such as Manyara and Kilimanjaro, the 'FGM' is conducted on infant girls of one month to one year old to avoid being arrested by police. Again, Section 169 (A) prohibits cruelty to children. It stipulates that any person having custody, charge or care of a child who ill-treats, neglects or abandons that child or causes female genital mutilation or procure that child to be assaulted, ill treated or abandoned in a manner likely to cause the child suffering or injury to health, commits the offence of cruelty to children and is liable on conviction to imprisonment for up to fifteen years or a fine of about three hundred thousand Tanzanian Shillings or both.

The Government has also focused policy attention on prevention of violence against children in school settings. The Education (Corporal Punishment) Regulations, 2002 are in place for to guide the administering of corporal punishment to students guilty of serious breaches of school disciple or of grave offences. Furthermore, in 2020 the Government developed the Guidance on Education, Counseling and Child Protection for Schools and Teachers Colleges in Tanzania, i.e., "*Mwongozo wa Malezi, Unasihi na Ulinzi wa Mtoto kwa Shule na Vyuo vya Ualimu Tanzania,*" to ensure that teachers and schools are well equipped with tools for child protection. 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.*" which provides specific guidance on establishment of such desks. It however should also be noted that, the Directorate of Community Development of the MoCDGWSG, also has Guidelines for the Responsibilities of Community Development Experts in Regional Secretariats and Local Government Authorities, i.e., "*Mwongozo wa Majukumu ya Wataalam wa Maendeleo ya Jamii Katika Sekretarieti za Mikoa na Mamlaka za Serikali za Mitaa*" of 2019. The Guidelines provide for the 'Child Development Desk,' and among its responsibilities is to ensure eradication of cruelty against children. The desk is also tasked to introduce a register for child rights abuses and monitor how they are addressed at village, ward and council levels.

Furthermore, the Government has prepared a booklet for children on online safety. (MoCDGWSG, 2022a). This booklet posits that many children, (~67%), in Tanzania who are between the ages of 12–17-years use the internet every day. However, increasingly children who in the early childhood phase use gadgets and access internet. If unprotected or

unguided children can access child harmful content. The be 'safe online' initiative should therefore consider these much younger children. In relation to that, the Government has also prepared Education Materials for Parents, Guardians, and Teachers on Child Online Safety (MoCDGWSG, 2022b). The Guide provide important information, tips, and pathways for parents, guardians and teachers to protect children online.

On social protection, LCA, Section 9(3)(b) obligates 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. Further, the Penal Code under Sections 166 and 167 criminalises parents, guardians or other persons who having lawful care or charge of children whose apparent ages are not more than fourteen years and are unable to provide for themselves, refuse or neglect 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 its health. LCA Section 51(b) declares failure to supply the necessities for child survival and development by anyone who is legally liable to do so to be an offence punishable by law.

With specific reference to vulnerable children LCA, Section 16 (1) (a)-(q) specifies the conditions under which a child can be considered to be vulnerable and in need of care and protection. In addition, in 2009 the Government developed National Guidelines for Improving Quality of Care, Support, and Protection for Most Vulnerable Children in Tanzania. Furthermore, in 2019 the Government developed the National Guidelines on Children's Reintegration With Families. Most recently, in 2024 the Government has prepared a Reference Book for Fit Persons, i.e., '*Kitabu cha Rejea kwa Mlezi wa Kuaminika' (WMJJWMM, 2024a)*. This Reference Book has been prepared to help Social Workers and other stakeholders providing services to vulnerable children, to enable them build capacities of community level Fit Persons towards provision of quality parenting services to the children who will be entrusted in their care. Alongside the Reference Book, in 2024 the Government developed a Facilitators Guide for Fit Persons, i.e., '*Kiongozi cha Mwezeshaji kwa Mlezi wa Kuaminika.' (WMJJWMM, 2024b*). The Guide is meant to enhance the abilities of Fit Persons in the parenting of children with particular emphasis on child protection and safety, provision of psychological and social support to children, early childhood development, and child behavior modification.

In 2017, the Government developed the National Guidelines for Identification of Most Vulnerable Children and Linkage to Care, Support and Protection. These Guidelines were developed to enable LGAs and communities to take responsibility and be accountable for identification of MVC and linkage to care, support and protection services. In relation to that since 2017, the Government has in place the 'National Integrated Case Management System (NICMS) Framework' to respond to and support children in need of child protection or child social protection.

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". The Guidelines aim to prepare those responsible for overseeing children's safety and welfare at the community level to understand and properly follow the coordination steps in handling child protection or child protection cases starting from recognition, to providing support to children at risk in their communities.

3. The Integration of Inclusion in Early Childhood Education

NSIE has identified 13 special educational needs categories to be considered in the context of inclusive education. These include: Learners from Nomadic or Seminomadic families; Out of School Children; Refugee Learners; Working Children, Learners with Chronic Illnesses; Orphaned Children; Learners with Specific Learning Difficulties; Gifted and Talented Learners; Learners Living in Extreme Poverty; Children who Live Far from School; Learners With Disabilities; Girl Child; Boy Child; and, Children in Conflict With the Law. However, this study explored specifically the integration of children with disabilities (CWDs) in ECE. The study considered CWDs as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis.

3.1. Description of Inclusive Early Childhood Education

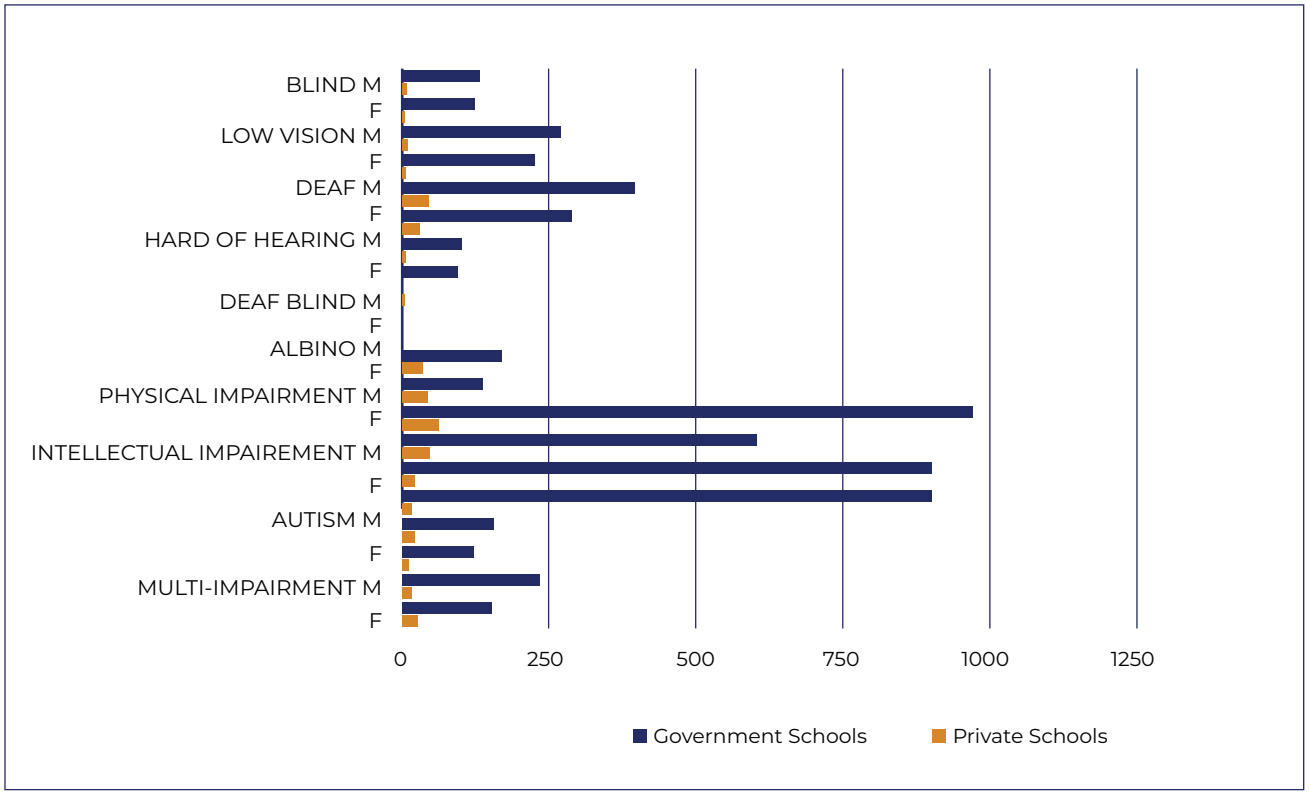
On most measures of child well-being such as health and education, CWDs are more disadvantaged compared to those without disabilities (UNICEF, 2022). Early childhood interventions for CWDs are crucial to ensure optimal development and preparation for primary education. Inclusive Early Childhood Education (IECE), is an essential foundation for ultimately achieving an education system that is truly inclusive in all its sub-sectors and at all levels. IECE "embodies the values, policies, and practices that support the right of every infant and young child and his or her family, regardless of ability, to participate in a broad range of activities and contexts as full members of families, communities, and society" (DEC & NAEYC, 2009: 2). An IECE, is one that supports the participation of all children in a continuum of early childhood settings, community-and school-based, with appropriate modifications and accommodations, in order to achieve school readiness and positive outcomes throughout their educational experience. Accordingly, NCERI defined IECE as one that provides each child with "the opportunities to receive effective education services, with the needed supplemental services and supports, in age appropriate classes in their neighbourhood schools, in order to prepare students for productive lives as full members of society" (NCERI , 1995:1).

Shaeffer, (2019) describe IECE as rights-based and child-centred and -friendly, constituting the following elements: all children are welcomed and equally valued; children develop on the basis of their individual strengths and are scaffolded to develop further; children's differences and diversity are celebrated rather than ignored or "cured"; teachers and other IECE facilitators have high expectations for all children; all facilities available to them are fully accessible; staff work together in ensuring that all children and their families participate; and, children's presence, participation, learning and development are constantly monitored and supported. The Tanzania education system has adopted an inclusive education approach at all levels. With regards to ECE, this include creches, day-care centres, pre-primary, and early primary levels. The study therefore explored the state of inclusion at the ECE level.

3.2. Enrolment of CWDs in IECE

BEST (2022), indicate that a total of 6120 pupils with disabilities were enrolled in pre-primary in Tanzania (See Figure 3.1). Of these 92.9% were enrolled in government schools while only 7.1% were enrolled in private schools. This clearly indicate that pupils with disabilities overwhelmingly rely on public schools to access education. At 27.5%, physical impairment is the type of disability with the largest number of pupils, followed by intellectual impairment 25.04% and then deafness, at 12.5%. Furthermore, statistics indicate that more (58.4%) male pupils with disabilities were enrolled at pre-primary school, compared to female pupils with disabilities (41.6%). The study learnt that for creches and day-care centres, DSWOs did not keep a register of children with disabilities enrolled. Accordingly, the data of how many were currently enrolled in formal ECE facilities was not readily available at the district, ward and mtaa/village levels.

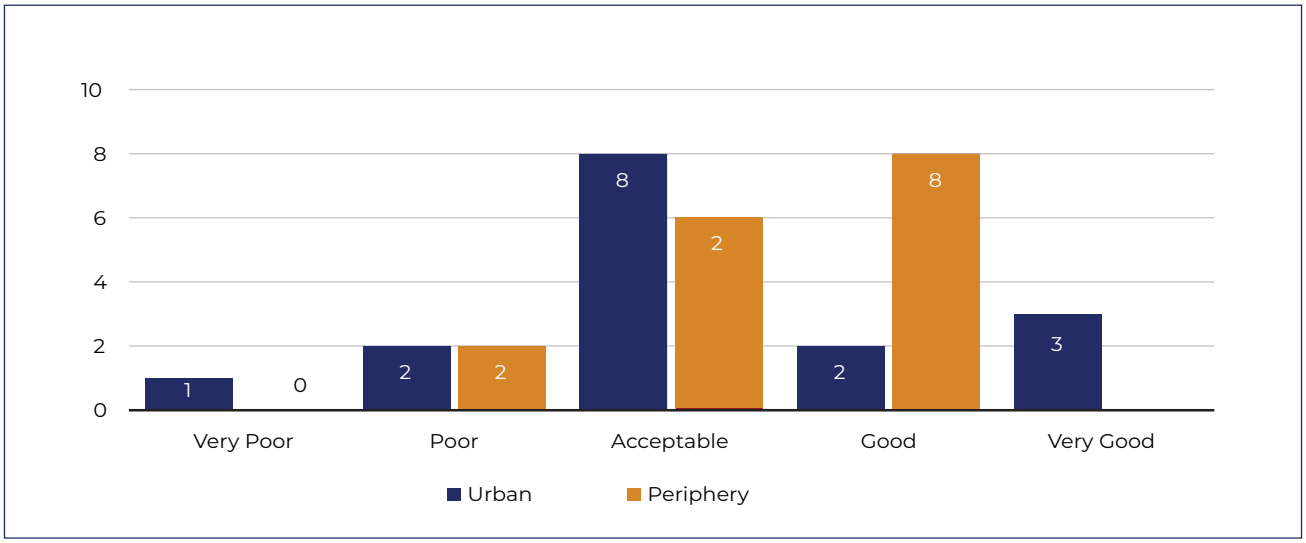
Figure 3.1: Enrolment of Pupils With Disabilities in Pre-Primary 2022



As indicated in Figure 3.2, most District Education Officer's (DEOs) in urban settings were of the opinion that in their LGAs, the enrolment of learners with disabilities in IECE was acceptable, (meaning it can be tolerated through should definitely improve), while the majority in periphery LGAs were of the opinion that it was good. However, these opinions are not based on evidence or statistics. The DEOs do not have the projected number of children with disabilities who are eligible to be enrolled in ECE facilities for a particular education year, and they do not have data of those who are actually enrolled in any educational year. Furthermore, the study learnt that most LGAs do not have a specific plan of action for identification, assessment and provision of support services for learners with disabilities in early pre-primary level and early grade primary level. This can also be contributed to by lack of awareness of the new 2023 National Guidelines for the Screening,

Identification, and Assessment of Children/Learners with Special Educational Needs. These Guidelines needs to be quickly and effectively disseminated.

Figure 3.2: Perceptions of DEO's on IECE Enrolment in the LGAs



3.3. Availability of ECE Teachers Trained in Inclusive Education

The study learnt that the Kisangara Institute of Social Welfare, a Campus of the Institute of Social Work (ISW), offers ECD special training programmes to cater for ECE teacher's needs. The Institute offers Early Child Care Development programme at Certificate level and produces ECD para-professionals to be employed in ECD Centres. It also offers Ordinary Diploma Early Child Care Development. Equally relevant for this level is Patandi Teachers' College of Special Needs Education which offers Certificate in Special Needs Education. One of Patandi's key focus is to train teachers on identification, assessment and placement of children with special educational needs.

The study explored DEOs' opinions 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 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.

The study learnt from DSWOs that they did not keep a register of pre-school teachers, because pre-school classes were under MoEST and not the Commissioner of Social Welfare (CSW). However, while creches, community day-care centres and day-care centres are under the administrative authority of CSW, the study learnt that DSWOs also did not keep a register of caregivers in the registered ECE facilities. It was not therefore possible to determine the number of teachers available, their qualifications, and thereby establish the adequacy or the current gap of ECE teachers in general and IECE teachers in particular.

The issue of adequate teachers trained in the facilitation of IECE is important because, ECE pedagogy entails the combination of instructional techniques and strategies

adapted to enable teaching and learning activities to occur and allow children to acquire knowledge, skills, attitudes, and dispositions (Shukia & Marobo, 2022). It requires a strong collaboration between children and teachers and interaction with the environment in a shared manner that allows learning to occur (Wall et al. 2015). Because in ECE, interaction is key to sharing knowledge and skills between teachers, children and the environment, and pedagogies are influenced differently from context to context and sometimes from child to child, specific consideration of the needs of children with special educational needs is paramount.

3.4. ECE Infrastructure and Children with Disabilities

The study further sought the assessment of DEOs regarding the inclusivity of ECE infrastructure in their respective LGAs. Out of 16 DEOs 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 DEOs 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. The study learnt that DEOs in the LGAs did not have school infrastructure assessment reports to accurately determine how many ECE facilities satisfy the requirements of universal design for learning and how many needed improvements and what specific improvements were required.

3.5. Availability of Braille Text and Story Books

The study explored whether, in the LGAs, braille story books and text books were available 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 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. However, the DEOs were not certain whether in those schools where braille text and story books were not available, there were learners with visual disabilities or not. Therefore, while the unevenness regarding availability of braille text and story books is strong across LGAs, the study could not readily conclude that, currently, there are ECE level children with visual disabilities who do not have access to these books.

Overall, there are divided perceptions regarding the basic issue of integration of inclusion in ECE. These indicate that there are great disparities 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. This inevitably will affect planning for inclusivity LGA levels.

3.6. Obstructions to Enrolment and Participation of Children with Disabilities

With regard to the most fundamental issues that hinder optimum enrolment and participation of learners with disabilities at the ECE level, the study learnt the following:

Negative perceptions on children with disabilities

The study learnt that most community members, including parents and guardians, have negative attitudes towards children with disabilities which also negatively affects their intention to enroll them in schools. Dominant community perceptions regarding children with disabilities and their enrolment in school include the belief that it is a waste of time and resources to educate them particularly because they will not get formal employment in the future. There were also perceptions that children with certain disabilities, for example visual and intellectual impairment cannot learn.

Distance

In some localities, schools are far from residential areas and satellite schools have not been established therefore it is a challenge for children with disabilities to be enrolled. This, coupled with lack of transport and absence of dormitories makes it difficult for children to regularly attend school. This was also related to high dropout among learners with disabilities.

Inaccessible infrastructure:

Some of the schools do not have accessible infrastructure which makes it a challenge for learners with disabilities.

Limited assistive devices:

Lack or inadequate assistive devices were also mentioned as a barrier to the enrolment and participation of children with disabilities in ECE.

Poverty

It was highlighted that although public schools had a fee-free policy, still many children with disabilities come from poor families which are unable to support their extra needs to be able to enroll and participate in school.

Inadequate number of specialized teachers

nadequate number of teachers trained to facilitate inclusive classes was highlighted as another reasons leading particularly to dropout of leaners with disabilities. This is because, due to ineffective facilitation methods, they are not involved in the activities of their peers.

4. Early Childhood Development Investment

4.1. Description

Return on investment is one of the most potent cases for investment in ECD. According to FTF (n.d.) investing in early childhood means 'funding proven programs and innovative strategies for children from birth to age 5 that: strengthen families in their role as their child's first teacher; improve the quality of early learning environments like preschool and child care and expand access to those programs; and, promote prevention and early identification of health problems that can impact learning later on.' This definition has a few limitations when applied to the Tanzania context. First, in Tanzania the early childhood phase is from conception to 8 years old. Second, priority ECD areas are not limited to ECE and ECH, but also include ECN, ECP and ECSP. However, its key word 'funding' underscores what investment is taken to mean. The assumption here is that 'funding' is critical towards attaining national ECD goals. UNICEF & GENESIS (forthcoming) provide an insightful analysis of the ECD investment landscape in Tanzania. This study therefore explored the investment in ECD at 'household' and LGA level.

4.2. Financing ECD in Tanzania; Who is Liable?

Financial liability for ECD services interrogates who has a legal responsibility to finance ECD and whether ECD services are or are not public goods. With regard to ECE financing, ETP states that, for public schools, basic education is free and compulsory, and caters for the period from pre-school to Form Four (age group 3–6 to 16). The National Education Act, (NEA) No. 25 of 1978 however, recognizes primary education, but not early childhood education or PPE. NEA Section 35 makes enrolment of a child in primary school compulsory, and Section 36 obligates parents/guardians to ensure the child regularly attends primary until she/he completes that level.

The NEA is silent on who is categorically responsible for paying of schools' fees in public schools. Section 10(1)(d) indicate that there should be written law relating to payment of schools' fees, and obligate the Local Education Authority (LEA) to collect and receive school fees. Section 60 (n) empower the Minister responsible for education to make regulation regarding the minimum payable fees in any public school, the manner of the payment and the recovery of those fees. Again, Section 57, obligates all private schools to get the approval of the Commissioner for Education regarding any fees, subscriptions, or contribution levied or collected as a condition of admission into the school or attendance. However, through the Commissioner of Education, in 2016 the Government issued Circular No. 3 guiding on the fee free basic education for all public schools. This Circular remain to be the seminal guidance in the financing of basic education in Tanzania.

In terms of health care financing, NHP identifies five sources of funds. These include central government funds, local government funds, funds from voluntary agencies and religious organizations, funds from donors, and people's contribution to health services. As far as

child health is concerned, the focus of PHA is primarily on vaccination and/or immunization against childhood diseases. Section 19 obligates parents or guardians to ensure that within 12 months from birth a child is immunised against polio, tuberculosis, diphtheria, pertussis, tetanus, measles, hepatitis 'B' and other diseases as may be announced by the Minister responsible for Health. Section 22, declares that there no fee will be charged to any Tanzanian child for any certification granted, immunisation or vaccination done in the country.

However, the overall responsibility for financing the health of children lies with parents/ guardians. Clauses 8, 9 and 41 of the LCA show that the LCA has squarely conferred the responsibility for the early development of the child, including health, medical care and immunisation on parents or guardians. On the other hand, Section 10 (1) of the HIV and AIDS (Prevention and Control) Act, 2008, requires the government to use available resources to ensure that vulnerable children and orphans are accorded basic health services.

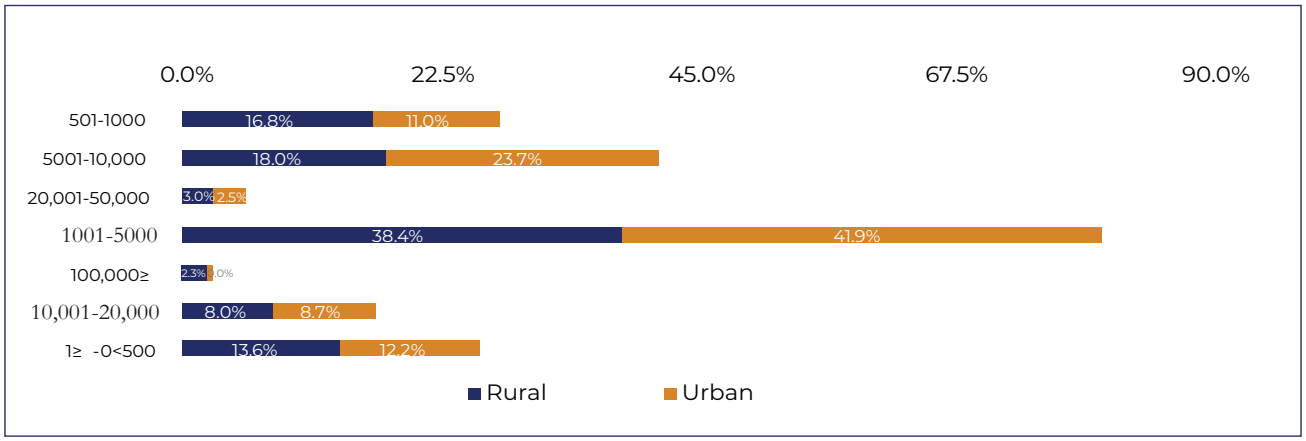
4.3. Household-level Financing of ECD Services

The maintenance and protection of a child is a legal obligation of a parent, guardian or person having legal custody of a child as shown above. In that respect the financial obligations related to the maintenance and protection of a child are the responsibility of a parent, guardian or person having custody of the child. Thus, this study explores household level financing of ECD service.

4.3.1. Relationship Between Income and ECE Expenditure

There is a clear relationship between income and patterns of consumption. According to **Cowling (2022)**, nearly 26 million people in Tanzania lived in extreme poverty, with the poverty threshold set at 1.90 U.S. dollars a day. The exchange rate at the time of writing this report, was US $ 1 equals TZS 2,580.00. As indicated in Figure 4.1, 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 which means these households are living in extreme poverty

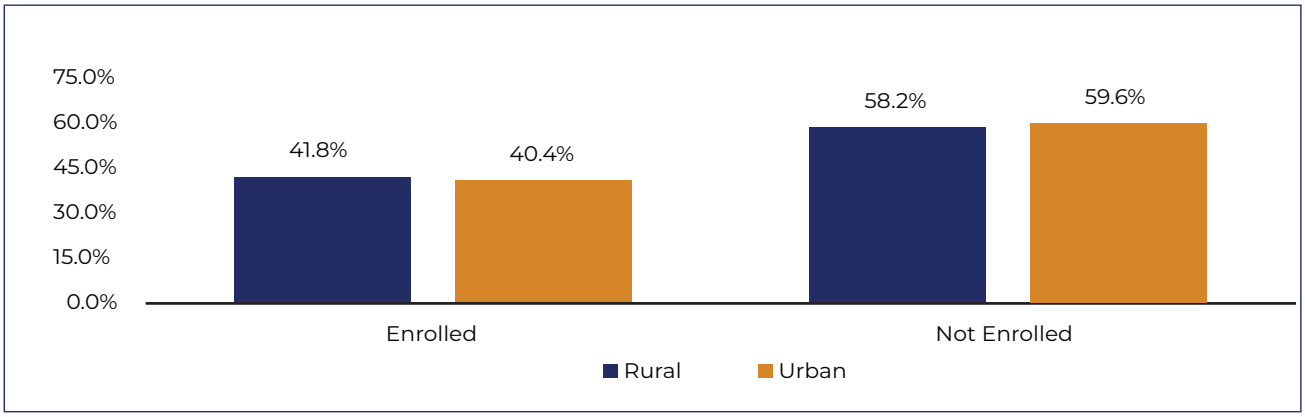
Figure 4.1: HoH Average Daily Income



As indicated in Figure 4.2 the difference between urban and rural parents/guardians as far as enrolling their children age 1> and< 2 years in ECE facilities is small. 58.2% of rural and

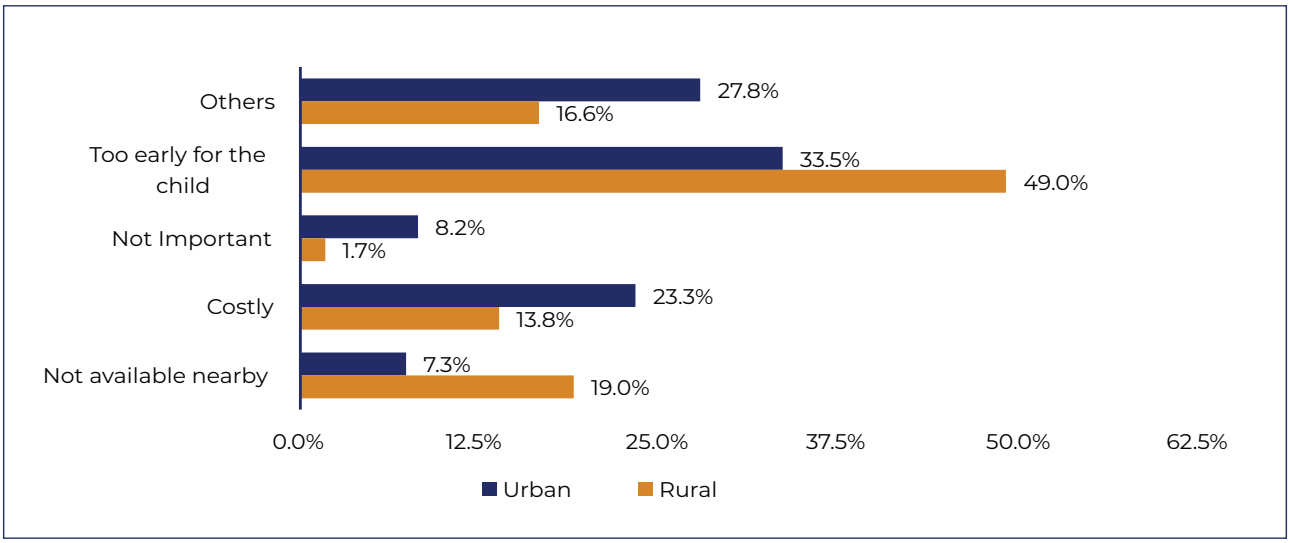
59.6% of urban parents/guardians have not enrolled their children of this age category in any ECE institution, while 41.8% (rural) and 40..4% (urban) have enrolled them. Of those who have not enrolled their children, 66.3% of rural and 45.8% of urban residents stated that it was because it was too early for the child. Furthermore, 13.9% of rural and 9.6% of urban parents/guardians stated that there was no facility available near their residence, while 5.2% of rural and 10.4% of urban parents/guardians stated that it was costly, and 3.8% rural and 10.0% urban residents were of the view that it was not important.

Figure 4.2: Children 1> year and < 2 years Enrolled / Not enrolled in ECE Institution



For children in age group 2> and <5 years, 57.9% of urban and 58% of rural children have not been registered in any ECE institution. 49.0% of rural and 33.5% of urban residents stated that it was too early for the child. This indicates a difference of perception between rural and urban residents regarding the appropriate time to enrol a child in an ECE institution. Again, 23.3% of urban and 13.8% of rural residents stated that it was because it is costly, while 19.0% of rural and 7.3% of urban residents stated that there was none in their neighbourhood. For rural residents availability is more of a concern, while for urban residents cost is more of a concern.

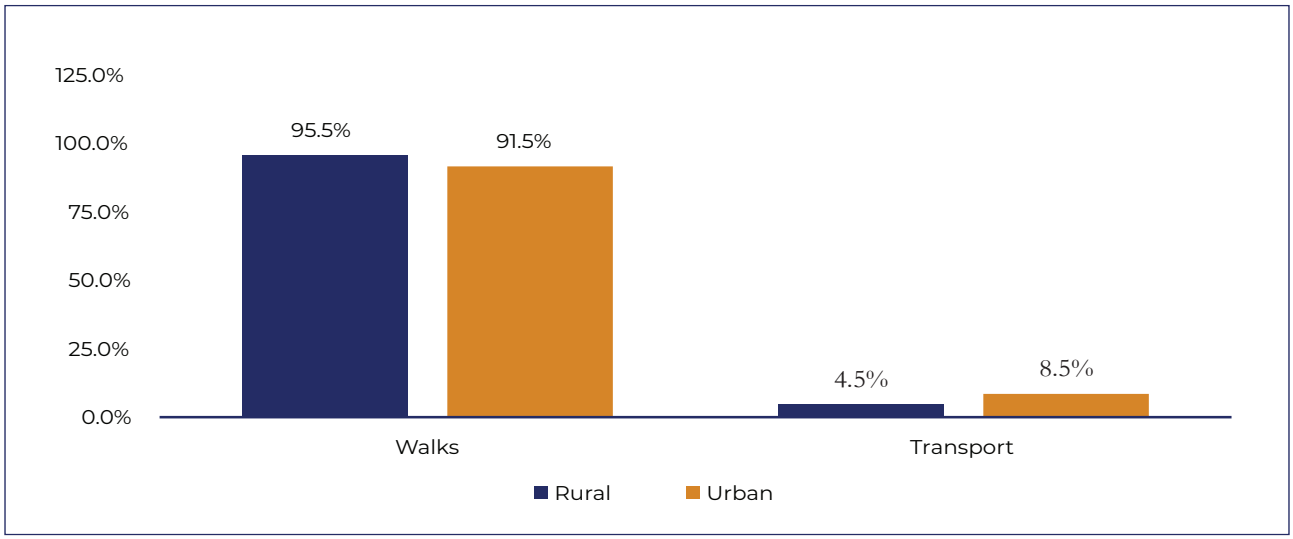
Figure 4.3: Reasons for Children 2> year and < 5 years not to be enrolled in ECE institutions



For children aged 5> and <8 years, the study found that 65.5% in rural areas and 64.3% in urban areas were enrolled in an ECE facility. While the difference is small, it is notable that

the enrolment rate is higher in rural areas. Of those not enrolled in any ECE facility, 20.7% of rural and 25% of urban residents stated that it was because of cost, urban residents once again indicating that cost is an important determinant. Furthermore, 11.5% of rural and 2% of urban residents stated that none was available near their residences, indicating nearby availability is another important factor. This is particularly significant because, as seen in Figure 4.4, 95.5% of rural based and 91.5% or urban based children walk to and from school.

Figure 4.4: Does your child walk or use transport to and from school?

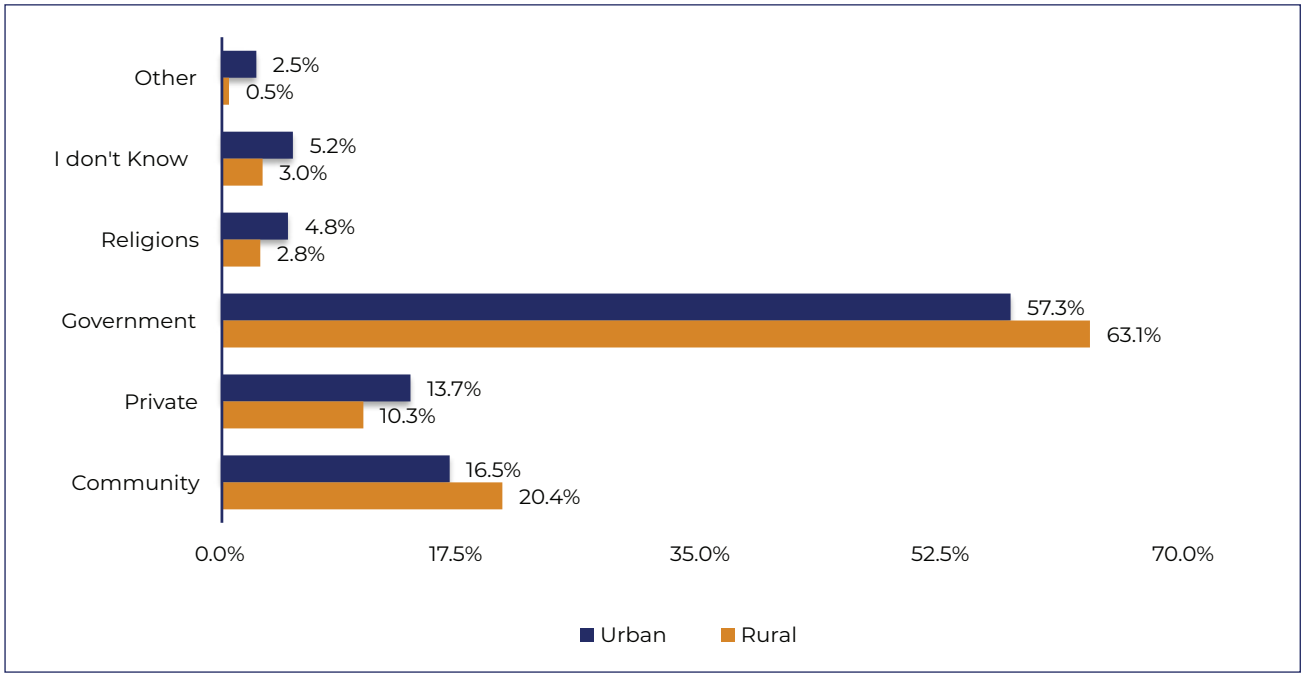


Of particular concern however is that, 66% of urban and 56.9% per cent of rural residents who have not enrolled their children stated that there are 'other' reasons for not enrolling their children who are above 5 and below 8 years old in ECE facilities. While the study could not immediately determine what those issues are, it is something that needs to be explored.

4.3.2. Perceptions on Financial Obligations to Invest in ECD

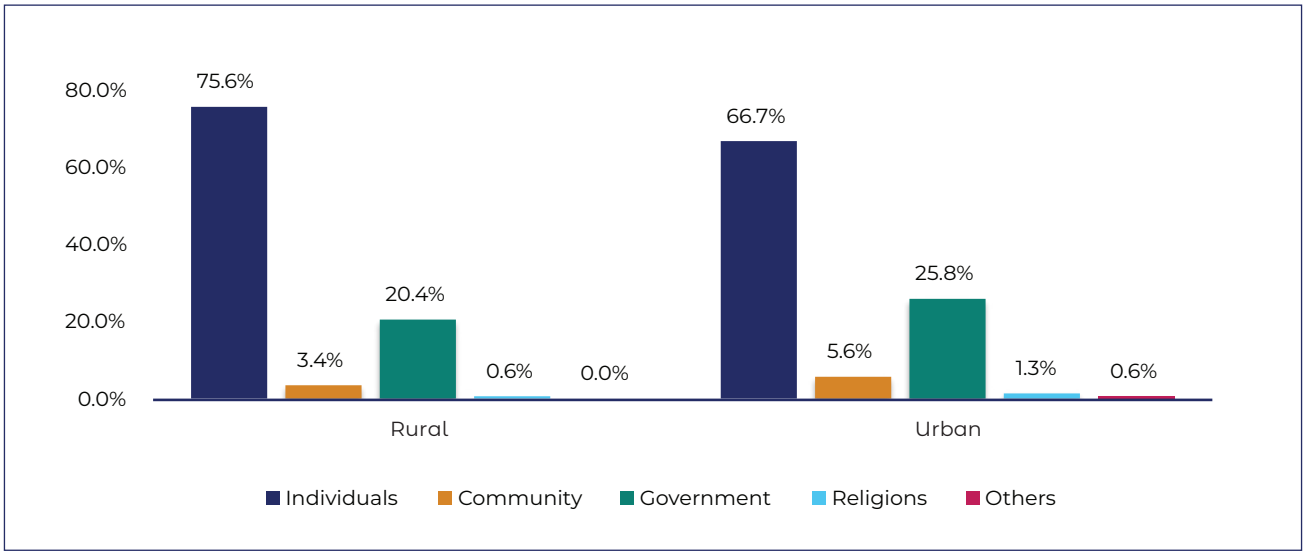
Figure 4.5 shows that majority of urban and rural residents are of the opinion that it is the responsibility of the Government to establish ECE facilities in their localities. This is erroneous especially as far as creches, day-care centres and community day-care centres are concerned. As per the respective guidelines, day-care centres are established and owned by the individuals/private service providers, while community day-care centres are established and owned by local communities. This misunderstanding might be contributing to the slow establishment of community day-care centres. At the time of this study, the office of the CSW has registered 3,389 day care centres across the country, and only 206 community day-care centres. The latter have been established with strong support from BRAC Maendeleo and Tanzania Home Economics Organization (TAHEA) - Mwanza.

Figure 4.5: Perception on Responsibility to establish ECE facilities in the Community



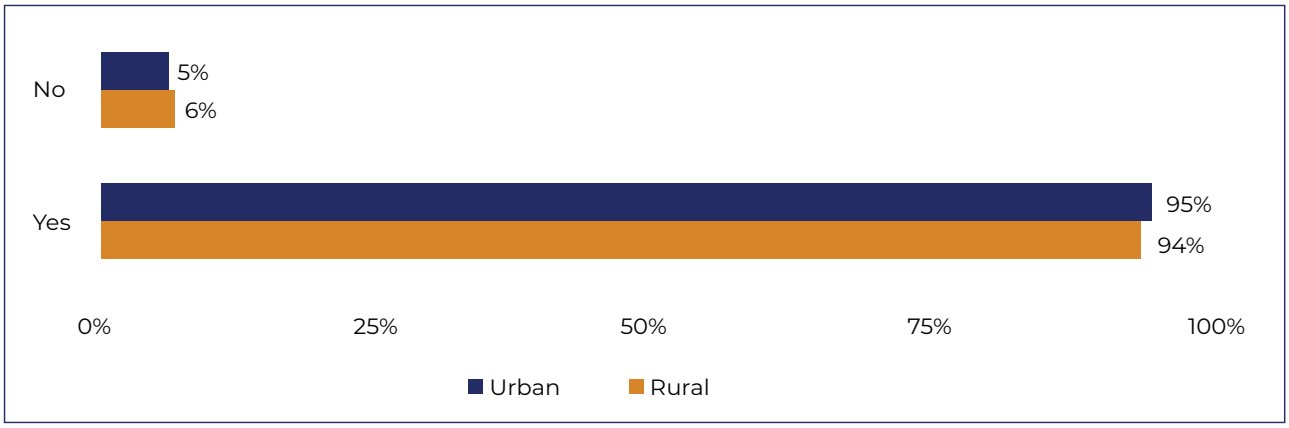
However, as Figure 4.6 indicate, more rural based (75.6%) than urban based (66.7%) parents/guardians are of the opinion that it iw the responsibility of individuals, i.e. parents/ guardians to finance ECE for their children It is also worth noting that more urban based parents/guardians, i.e., 25.8% believe it is the role of Government compared to 20.4% of their rural based counterparts.

Figure 4.6: Responsibility to Finance ECE



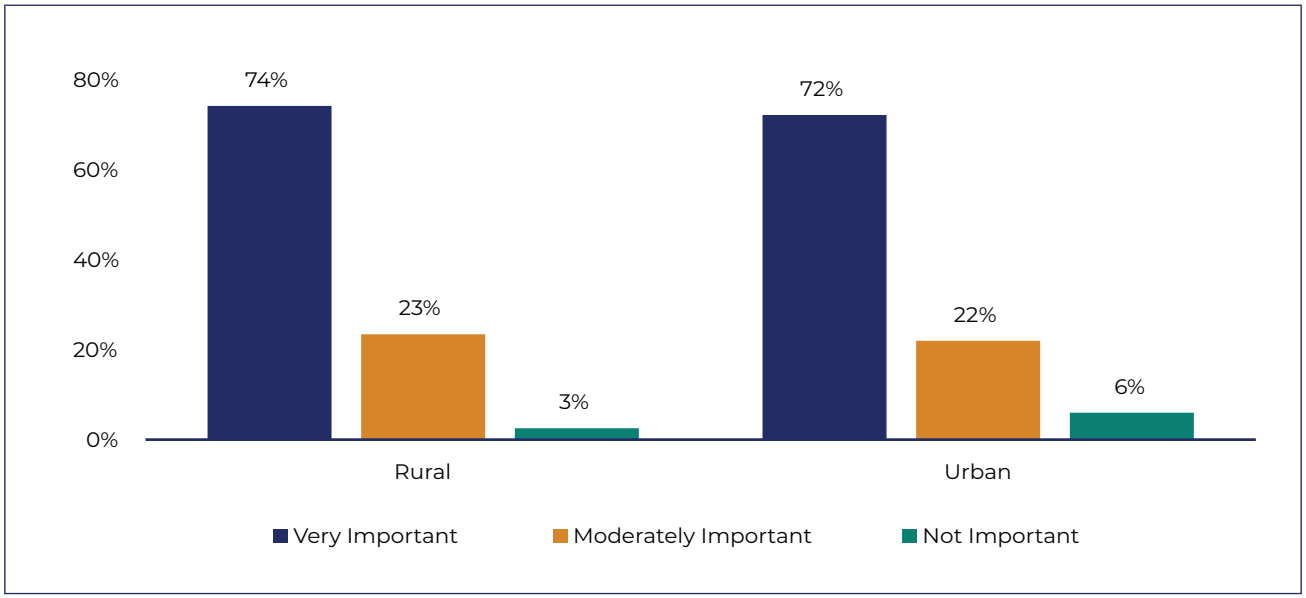
Furthermore, overall, as indicated in Figure 4.7, 95% of urban and 94% of rural parents/ guardians are of the opinion that it is the sole responsibility of parents to pay for the education costs of their children at beginner level. This flags an important question regarding the prevailing public attitude towards social service financing in the country. When the Government finances social services, does the public view it as the Government doing its citizens a favour, or as utilising national resources including taxes to provide services? The former attitude would not foster a sense of ownership and right, while the latter should.

Figure 4.7: Who is solely responsible for paying for educational costs of Children at the ECE level?



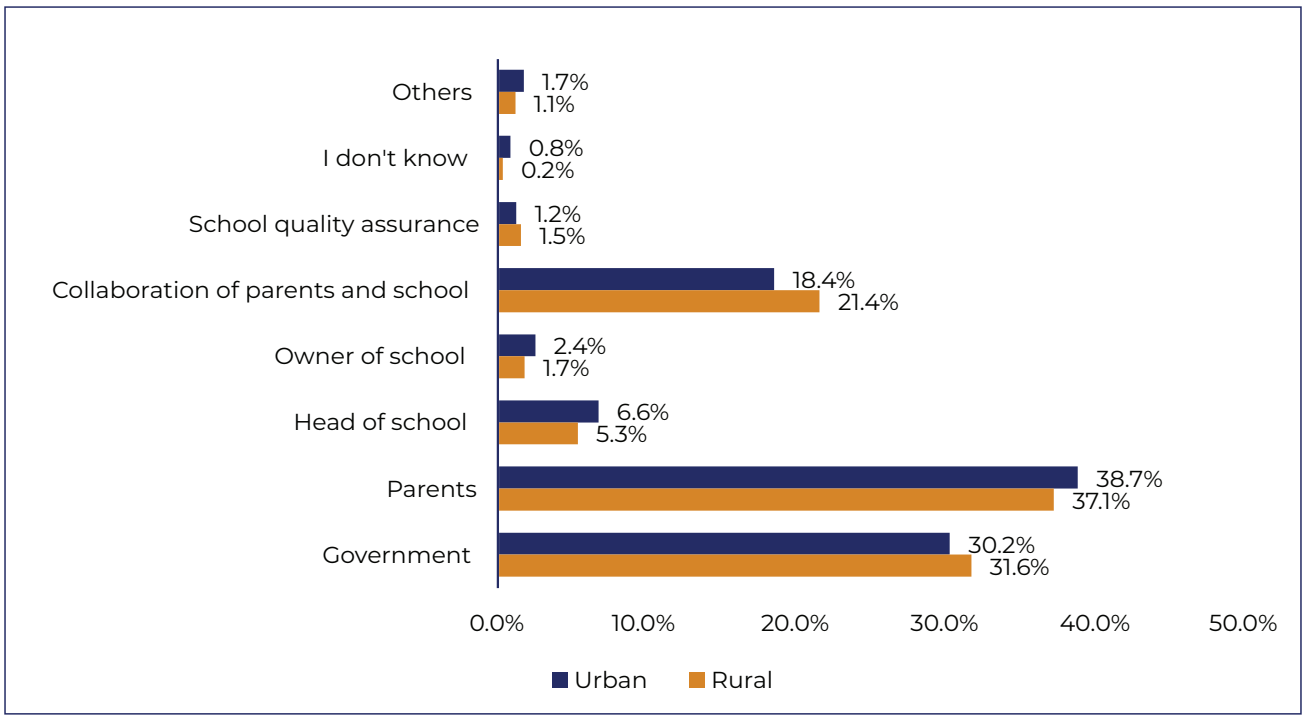
Again, as indicated in Figure 4.8, 74% or rural based and 72% of urban based parents/ guardians view financially investing in the ECE institutions where their children are enrolled as very important. However, when asked who they think is responsible to ensure children receive quality education there were varied opinions.

Figure 4.8: Perception on Importance of Investing on ECE



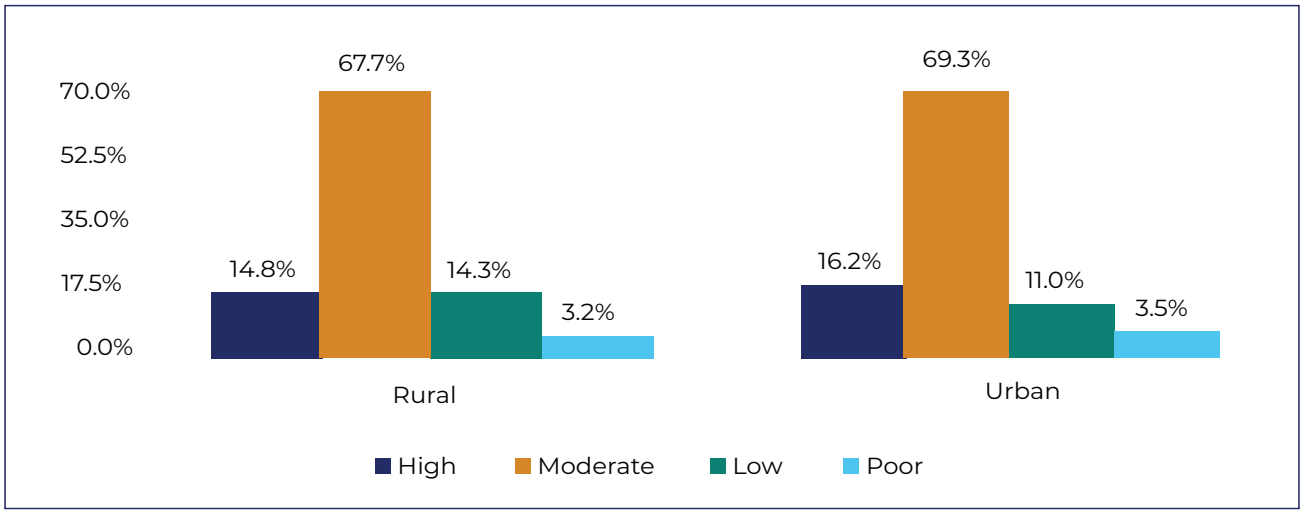
As shown in Figure 4.9, 38.7% of urban based and 37.1% of rural based parents/guardians believed that it is the role of parents; while, 30.2% of urban based and 31.6% of rural based parents/guardians were of the view that it is the role of the Government. However, 18.4% of urban based and 21.4% of rural based parents/guardians believed that there should be collaboration between parents and schools.

Figure 4.9: Responsibility to Ensure Quality ECE



Furthermore, only 14.8% of rural based and 16.2% of urban based parents/guardians were of thFurthermore, only 14.8% of rural based and 16.2% of urban based parents/guardians were of the view that ECE facilities were providing value for money with regard to the quality of services and education in ECE facilities. As indicated in Figure 4.10, 67.7% of rural based and 69.3% of urban based parents/guardians were the view that value for money is moderate, while 14.3% of rural based and 11.0% of urban based perceived value for money as poor. This indicates that, although most parents enrolled their children in public institutions, and although, in public schools there is a fee-free policy, parents/guardians still feel that there should be better return on investment.

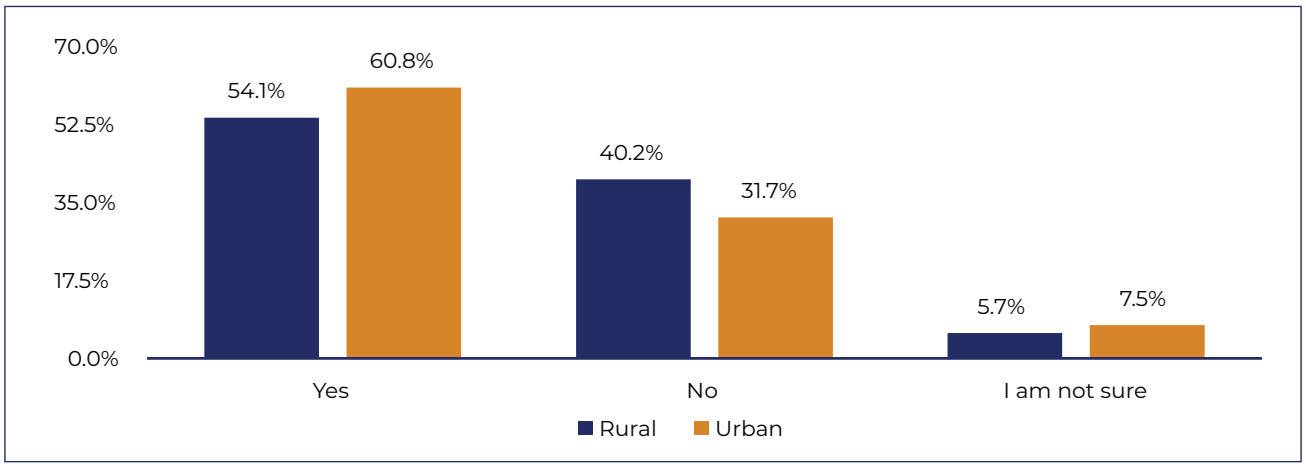
Figure 4:10: Perception on ECE Investment Value for Money



Further, with regard to family level ECE investment, as Figure 4.11 shows 54.1% of rural based and 60.8% of urban based parents/guardians stated that there are specific things they do and/or buy at home to help their children learn. However, 40.2% of rural based and 31.7% of

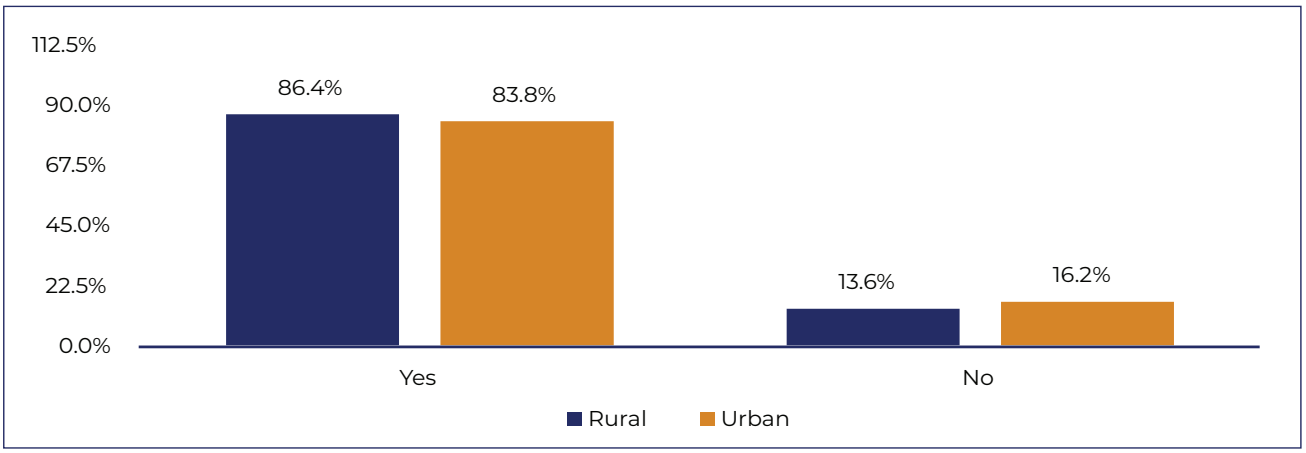
urban based parents/guardians stated that they do not, while the rest stated that they are not sure. The high percentage of those who do not buy/or do anything to help their young children learn is a serious concern and a red light regarding the appropriateness of the home environment for age-specific ECD services.

Figure 4.11: Purchasing/doing specific things at home to help child learn



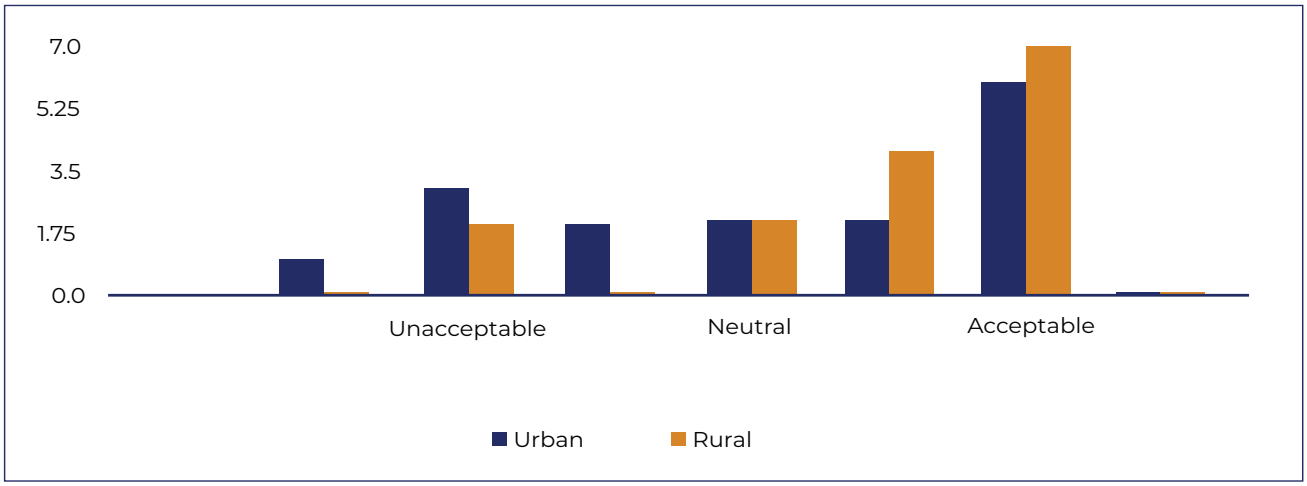
As shown in Figure 4.12, the study also learnt that 86.4% of rural based and 83,8% of urban based parents/guardians were of the view that they themselves, and their fellow community members are highly willing to be involved and cooperate with schools in the responsibility to improve the quality of education their children receive in ECE facilities.

Figure 4.12: HoH's Perceptions on Community Members' Willingness to Cooperate with Schools to Enhance the Quality of ECE



While DEOs perceptions on community members willingness to finance early childhood education varied, most corroborate the perceptions of HoHs. As indicated in Figure 4.13, the majority of DEOs believe that community members' willingness to finance ECE is acceptable.

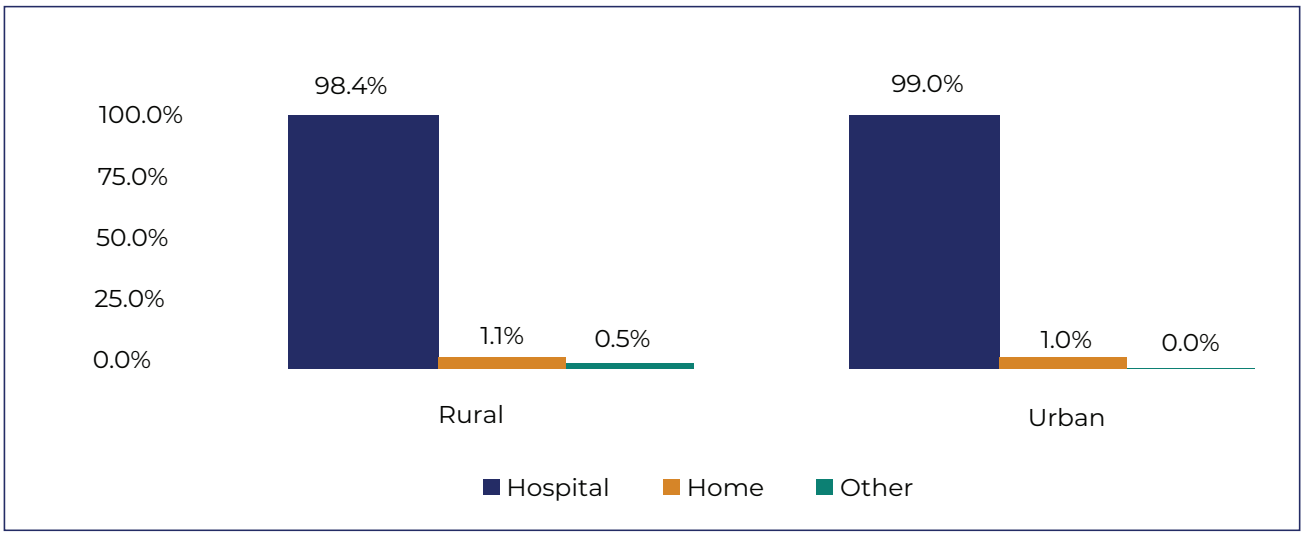
4.13: DEO's Perceptions on Community Members' Willingness to Finance ECE



Positive feedback regarding community members' willingness to finance ECE is particularly important because it indicates they will be open to the idea of making essential financial or material contribution towards establishing and operating community-based day care centres. This is also important because it means parents/guardians are willing to make investments at home to create a supportive ECE environment.

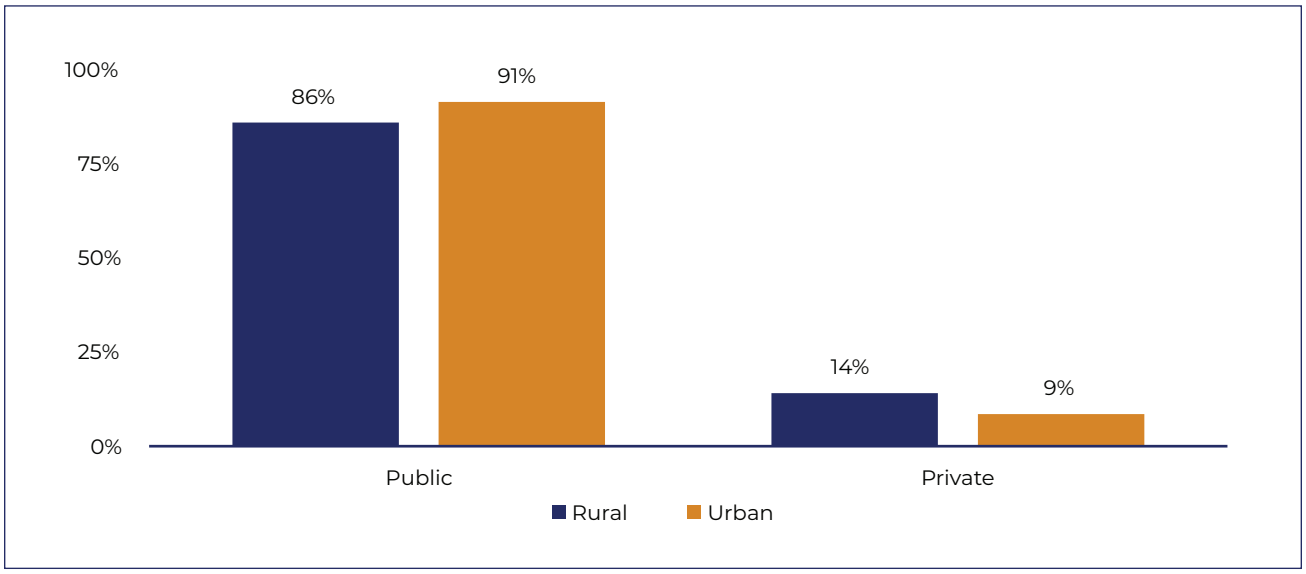
With regard to maternal health services, traditional birth attendants retain an important role in reproductive and maternal health in Tanzania (Pfeiffer & Mwaipopo, 2013). Although the Tanzanian Government promotes TBAs in order to provide maternal and neonatal health counselling and initiating timely referral, officially their role does not include delivery attendance although most TBAs still do handle deliveries (ibid.). However, as indicated in Figure 4.14, with regard to women's health-seeking behaviour particularly on giving birth, 98.4% of rural based and 99.0% of urban based parents/guardians preferred health facilities as the best place for women to give birth.

Figure 4.14: Preferred Child Delivery Services



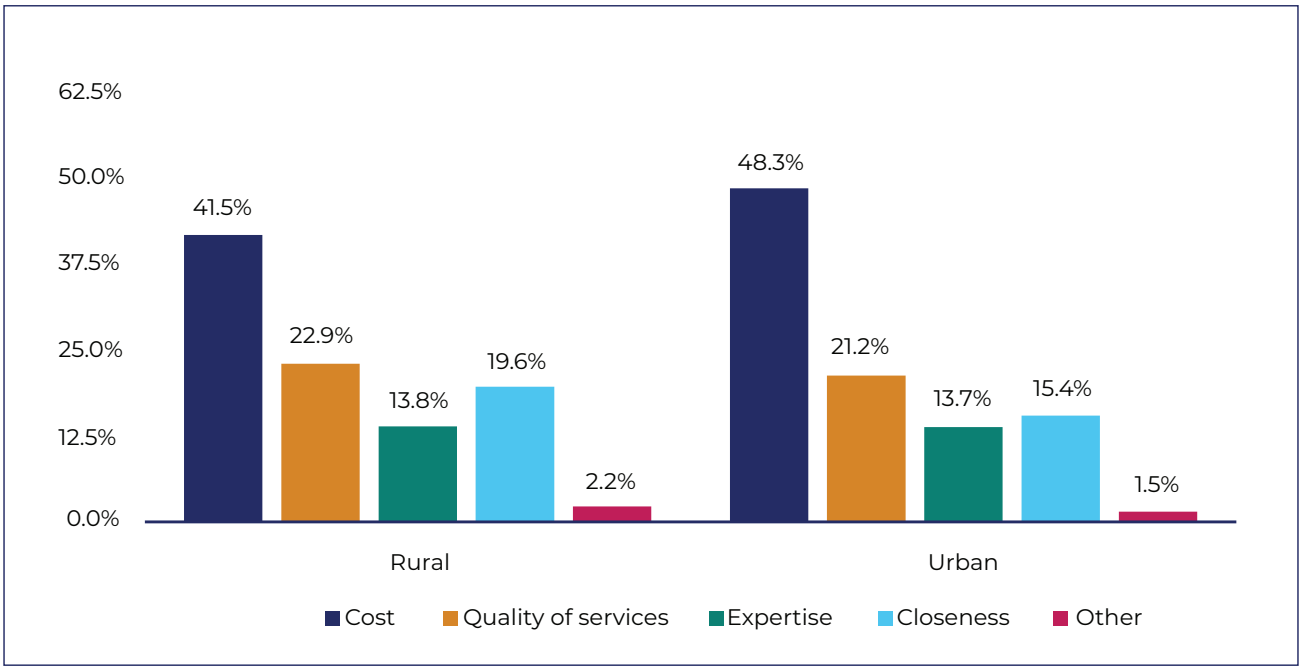
Again, as indicated in Figure 4.15, 86% of rural based and 91% of urban based parents/guardians preferred public over private health facilities providing maternal and child health services.

Figure 4.15: Private vis a Vis Public Health Facility Preference



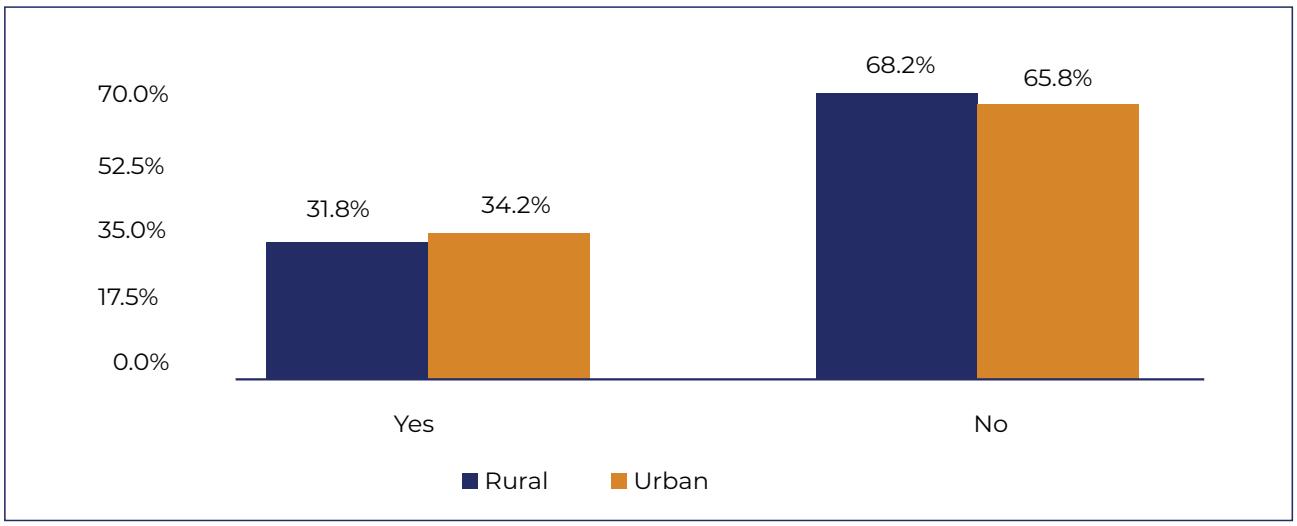
As indicated in Figure 4.16, 41,5% of rural based and 48.3% of urban based parents/guardians preferred public over private health facilities because they were more affordable. The reasons including quality of service, availability of expertise and proximity to people residences.

Figure 4.16: Reasons for Preferring 'Public' over 'Private' Health Facilities



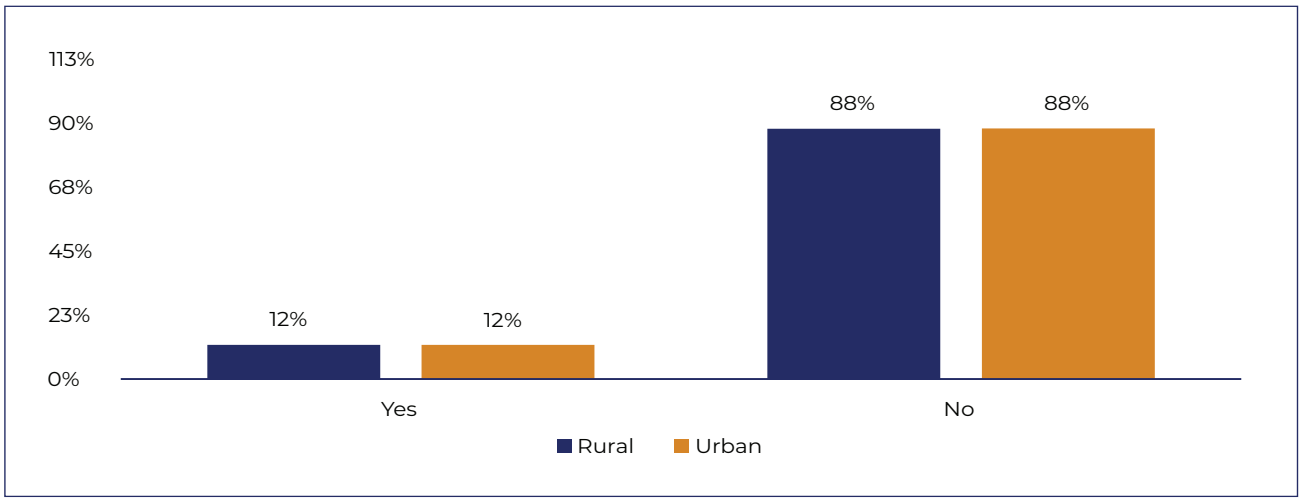
As shown in Figure 4.17, the study learnt that 31.8% of rural based and 34.2% of urban based parents/guardians have at some time failed to meet medical costs and access health services needed for their children in their early childhood. This indicate that a notable number of both urban and rural parents/guardians are at a risk of not being able to afford health care services for their young children when they need them.

Figure 4.17: Failing to Afford and Access Health Services for Young Children



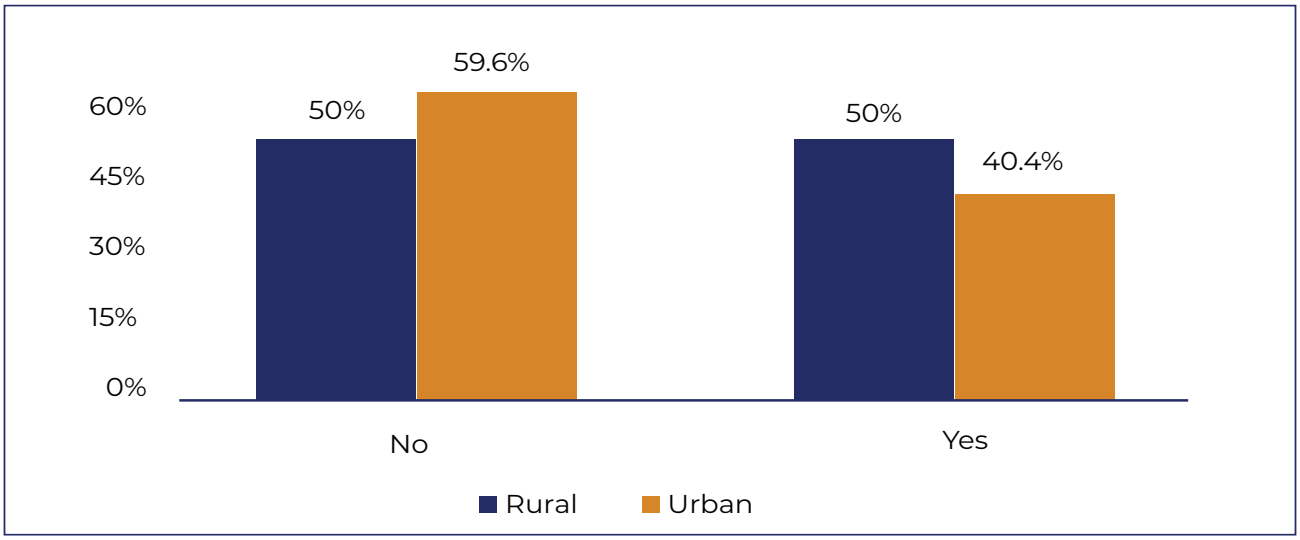
According to **Siraq & Mohamed (2021)**, there is a strong relationship between out-of-pocket health expenditure and poverty. Existing evidence also indicates that the poor are less likely to purchase health insurance (**Schneider, 2004**). Parents/guardians are therefore more likely to fail to afford health care services for their children when they need them because of the out-of-pocket (OOP) payment practice. As indicated in Figure 4.18, 88% of both rural and urban based parents do not have health insurance cover for their young children.

Figure 4.18: Having Health Insurance Cover for Children



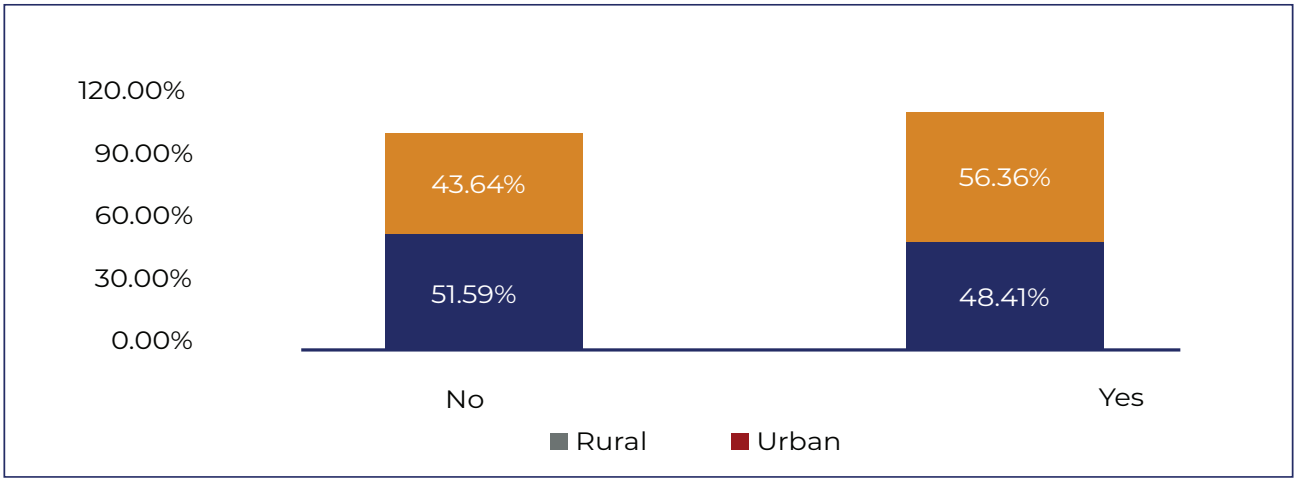
Although the global food security index score for Tanzania has improved from 37.8 in 2012 to 49.1 in 2022, overall the Global Food Security Index (GFSI) places Tanzania among countries with a relatively weak food security score (Rashid et al. 2024). Further, according to MoFP-PED et al., (2020), 8% of the Tanzania Mainland population are extremely food poor. Most of these are in rural areas (9.7%) compared to urban areas (4.4%). Consistent with the general national trend, in terms of food security as shown in Figure 4.19, the study found 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 experiencing periodic food insecurity. Such a situation may have negative implications for other ECD areas as well together with the overall household environment.

Figure 4.19: Perception on Food Security



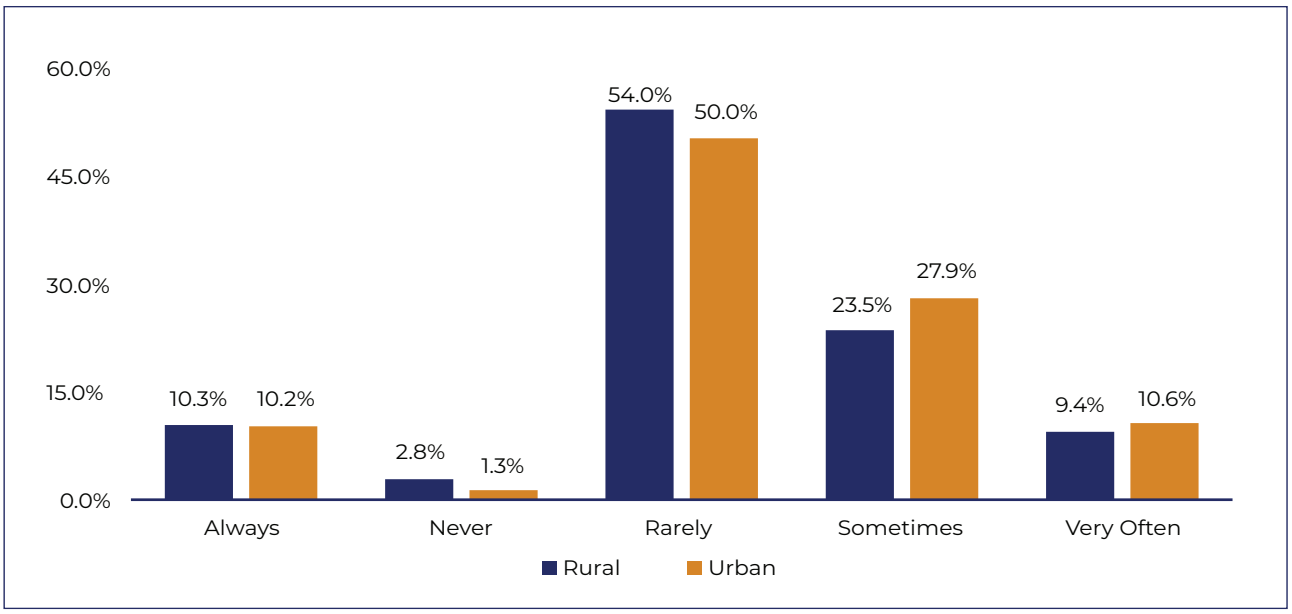
Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. The national trend indicates that the percentage of children under age 5 who are stunted has decreased steadily from 48% in the 1999 TDHS to 30% in the 2022 TDHS-MIS. Overall, 30% of children under age five are stunted (short for their age), and 9% are severely stunted (MoH, et al. 2023). While, there is a notable decrease, it is clear that Tanzania is still facing a heavy malnutrition burden. Similarly, as indicated in Figure 4.20, 56.36% of urban based and 48.41% or rural based parents/guardians, stated that there are times when they are unable to ensure that young children in their households get the balanced diet they need.

Figure 4.20: Consistence in Provision of Balanced Diet for Young Children



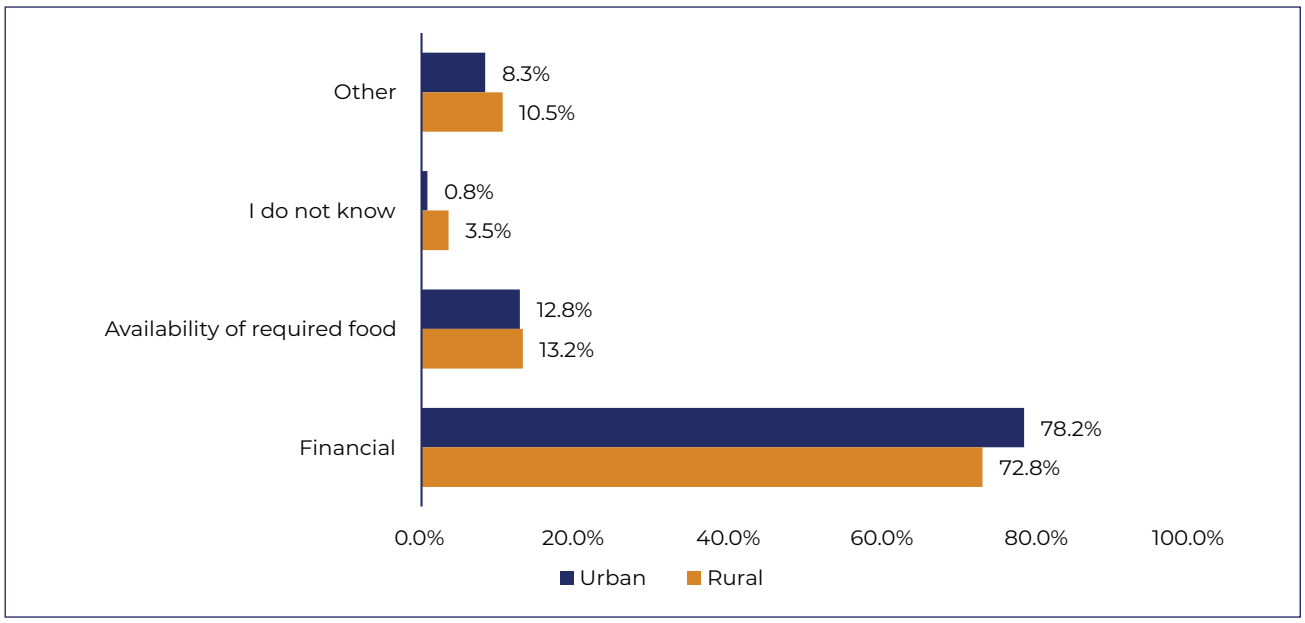
Furthermore, as shown in Figure 4.21, only 2.8% of rural based and 1.3% of urban based parents/guardians never have to struggle to provide a balanced diet for their young children.

Figure 4.21: Frequency in the Struggle to Provide Balanced Diet to Young Children



As shown in Figure 4.22, 78.2 of urban based and 72.8 of rural based parents/guardian flagged financial limitations as the main reason why they struggle to provide a balanced diet for their young children.

Figure 4.22: Reasons Related to Inconsistence in Provision of Balanced Diet to Young Children



In rural Tanzania, there are several opportunities regarding food and nutrition including; availability of arable land for cultivation of diverse crops, ownership of arable land by 75% of the population, and diverse crop production, where about 80% of households cultivate 2-3 food crops (Mbwana & Bundala, 2023). However, as shown in Figure 4.23, 65% of urban based and 46% of rural based parents/guardians believe that they have to buy and cannot grow most of the things their young children need to consume to get the balanced diet they need. A striking 40% of rural based and 21% of urban based parents/guardians stated that they believe they can grow essential food crops to provide a balanced diet for their young children, while the rest were not sure.

Furthermore, 54% of rural based and 52% of urban based parents/guardians are completely unaware of fortified food products. However, regardless of whether they are aware or not, the study found that 80% of rural based and 78% of urban based parents/guardians do not check if the salt they buy has any nutrients added. The study also learnt that only 16% of rural based and 21% of urban based parents/guardians buy fortified cooking oil, flour or other products, while 55% of rural based and 49% or urban based residents stated that they do not, and 29% of rural based and 21% of urban based residents said that they do not know. They study found that 77% of urban based and 80% of rural based parents/guardians would prefer their children to consumer fortified products, while 23% and 20% respectively, stated that they would not.

Findings indicate a clear relationship between income and ECD expenditure, in that the lower the income the less likely households would prioritise spending on ECD. Furthermore, findings indicate that parents/guardians perceive themselves as having the financial obligation to invest in ECD. Parents also indicate a strong willingness to be involved in enhancing the quality of ECD services. Low income and limited information/awareness/ knowledge seem to be the principal barrier for parents/guardians to appropriately invest in ECD.

The study therefore concludes that there are very limited effective efforts to enhance ECD investment at home. Apart from programs for vulnerable children/families, such as TASAF, which include ECD initiatives, there is a need to develop strategies and programs that can help families with low incomes and limited economic assets improve their financial stability. It is uncontested that every parent/guardian and every child needs a level of financial security to thrive and succeed. It is also uncontested that children are more likely to thrive if their family environment is economically stable.

Clearly, it is a challenge to ensure quality ECD services if family environment and circumstances do not improve. These include economic, social, attitudinal, cultural and behavioral home circumstances which are needed to provide the best ECD. Approaches that change and improve the entire household are most likely to have both short and long term impact within and beyond the family. For example helping an alcoholic father sober up, be present and be reliable for the family has the potential to uplift an entire household and even community. It is asserted therefore that programs targeting home environment are essential if we are to have a continuation and complementarity of experiences and services in all children's settings, in particular home, school, and health facilities.

On the basis of the above, this report proposes the expansion of items considered as resources to be invested in ECD to include financial, time, psychological and human capital resources. This is in agreement with Mistry, et al. (2022), who posited that young children are most directly influenced through diverse capacities, i.e. "resources that parents and other caregivers bring to the tasks of raising young children." These capacities include financial resources (economic ability to purchase material goods or services); time spent with or for children (opportunities for children and parents to interact (to enhance mentorship and social ties); psychological resources (physical and mental health and parenting style); and, human capital (knowledge and skills for decision-making acquired through education or

training, experience, or interactions with medical providers or others outside the immediate family). (Mistry, et al. 2022:1690)

4.4. LGAs Level Financing of ECD Services

4.4.1. An Overview of ECD Related LGAs Core Functions

Local Government Authorities (LGAs) are established under the Constitution of the United Republic of Tanzania of 1977 Articles 145. Article 146 of the Constitution states that the purpose of establishing LGAs i essentially to transfer authority to the people. Thus the Constitution confers on the LGAs the right and power to to involve the people in the planning and implementation of development programmes within their respective areas. LGAs are governed by two laws. First, the Local Government (District Authorities) Act, No. 7 of 1982. covers district authorities (including its division and wards), township councils, and village authorities. The general functions of these LGAs are stated in Section 111 of the Act. Second, the Local Government (Urban Authorities) Act. No. 8 of 1982 covers urban authorities and wards. The general functions of these LGAs are stated in Section 54 of the Act.

Among their key functions, LGAs in Tanzania are tasked to promote the social welfare and economic well-being of all persons within their respective areas of jurisdiction; and to further the social and economic development of its area of jurisdiction. Section 92 of the LCA, obliges Local Government Authorities to safeguard and promote the welfare of the child within its area of jurisdiction. Furthermore, the HIV and AIDS (Prevention and Control) Act, 1998, Section 34 directs Local Government Authorities to design, formulate, establish and coordinate mechanisms and strategic plans for ensuring that the most vulnerable children within its respective area are afforded the means to access education, basic health care and livelihood services.

Respectively, planning and management experts in the LGAs are obligated to allocate budgets in order to achieve ECD goals at their level. It is within the LGAs that specific and costed ECD programs should be available to meet their needs. As **Gustafsson-Wright & Boggild-Jones, (2018)** posited, standardised and accurate cost data are critical for the provision of quality ECD services at scale, in order to make the case for more and better investments. LGA financing for ECD is also important for ensuring sustainability and context specific prioritisation and customisation of services offered. The study therefore explored whether and how ECD is budgeted for at LGA level to achieve effective ECD service delivery at the community level.

4.4.2. The State of ECD Budgeting at the LGAs Level

a. Early Childhood Education

The study involved 32 District Education Officers (DEOs) in the areas of study to determine the state of ECE budgeting at the LGA level. The study learned that ECE budgets are mostly supposed to appear at school level through the 'capitation grants' paid by the Government directly to schools. Due to the 'fee free basic education policy' most of the resources come from the central government. Furthermore, out of 32 DEOs, 12 indicated that they do not have a specific budget for ECE. In addition, many other DEOs indicated that learners at ECE level benefitted from the general school budget and there has not been a need to categorically earmark funds for that level. For example, the infrastructure budget includes the entire school infrastructure needs, such as pre-primary classes or latrines, and therefore the budget would not show a specific ECE line but it would be included in the general school infrastructure. If there is provision of food for students with special needs, it will be for the whole school, and not just those who are in pre-primary. The same applies to books. Similarly, human resources will apply to the whole school and not just the pre-primary teachers. Thus, it is very difficult to disaggregate accurately what LGAs invest in ECE.

The study also learned that in the DEOs budget, the prime sources of funds were the Central Government, and Donor supported programme such as BOOST and Education Programme for Results (EPforR). Only 3 DEOs (Singida MC, Geita TC, and Uyui indicated 'own source' to mean the budget item is being funded by the LGA's own resources. However, except for Simanjiro, where they indicated that they have a flagship initiative targeting the pre and primary school children, and Mlakama where they budgeted for 'children's swing' none of the DEOs indicated that they have a specific ECE agenda.

To attain expected ECE outcomes, planning is indispensable. According to **Barnett & Belfield, (2006: op cit. p.80)** without planning, children activities, materials and interactions are haphazard and do not address effectively the interests and needs of the children. Therefore, there can be no optimal cognitive development. Clearly, in ECE planning for outcomes is critical and cannot be compromised given that the window of opportunity is narrow.

b. Early Childhood Nutrition

The study involved 32 District Nutrition Officers (DNuOs) to ascertain the state of ECN budgeting at LGA level. Of 32, only 10 were not in a position to share their nutrition budget. In the other 22 , the study found that, of all ECD areas, nutrition, focusing particularly on early childhood and pregnant mothers was an area most clearly and consistently budgeted for in almost all LGAs. Some of the most budgeted for include: promotion of exclusive breast feeding including celebration of breast feeding week; 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; therapeutic foods training; nutrition education to mothers of malnourished children; stakeholder meetings of child care centres

on provision of balanced diet for children; observation of Village Health and Nutrition Day (VHND); training of health care professionals (HPCs) on MIYCAN (Guidelines on maternal, infant, young child and adolescent nutrition); incentives to Community Health Workers (CHWs); nutrition screening for children; nutrition sensitisation campaigns; weaning supplementation trainings, particularly to women with malnourished children and Village Health Workers (VHWS); Active TB case identification for children under the age of 5.

The study also learnt that all LGA funded ECN interventions themselves through their own budgets. Additional sources of funds mentioned occasionally include NHIF, Improved Community Health Fund (ICHF), and User Fee. Only a few LGAs mentioned that together with 'own source' they have partners funding their respective budgets. This include Iringa MC (Health Basket Fund); Mtwara MC (Health Basket Fund & Nutrition International); Shinyanga MC (Health Basket Fund); Tabora MC (Nutrition International); Kilolo (Development Council); Malinyi (Health Basket Fund); Mkinga (Health Basket Fund); Newala (Health Basket Fund); Simanjiro (Health Basket Fund); and Uyui (Nutrition International). It is also noteworthy that although most of these LGAs have Non-State Actors, implementing nutrition projects in the LGA, only very few contribute to the LGA nutrition budget.

The study also noted that there is are wide variations in the total annual budgets of these LGAs. As indicated in Table 4.1 there are major differences in the amount each LGA is committing to nutritional intervention. This may indicate differing priorities or level of commitment of institutional actors with regard to nutrition or differing strategies and interventions. It may also reflect a lack of comprehension as to what constitutes early childhood nutrition budgeting. Nevertheless, the difference is too huge to ignore.

For example FY2022/23 in periphery districts, Mkinga budgeted a total of TZS 1,800,000/- while Mbozi budgeted TZS 183,678,000. For FY 2023/24 Mkinga budgeted TZS 2,500,000/- while Simanjiro budgeted TZS 406,555,124. For urban LGAs, in FY2022/23 the lowest was Kibaha which allocated TZS 2,400,000/- and the highest was Bariadi which allocated TZS 56,798,004. In FY2023/24 the lowest again is Kibaha which allocated TZS 5,160,000, and the highest is Mtwara MC which allocated TZS 96,654,840. In the interest of attaining universal quality ECN, it is important to know whether interventions are equitable and consistent across LGAs. It is recommended that a deeper sectoral analysis be conducted to explain the massive budget variations in across LGAs in ECD sectors, and their implication with regard to service delivery.

c. Early Childhood Health (ECH)

Measurements of child health are numerous but the mostly used proximate determinants are morbidity, vaccination coverage as well as dietary and growth patterns. (Megan et al., 2001). In ECH the principal concern is the availability and utilisation of health facilities and/or pioneering innovative approaches to improve access to health services for the safety and wellbeing of children. Priority issues are sequential: The initial stage is prenatal care which essentially focuses on standard health screenings for pregnant women, and maternal health overall. Currently, early stimulation of pregnant women is also considered an important early stage intervention. Subsequent to prenatal care is assisted delivery in

a conducive environment preferably in a health facility by adequately trained and skilled birth attendants. In this stage it is also crucial to have accessible and functional emergency obstetric care i.e., Basic Emergency Obstetric Care (BEmOC) in case of unexpected complications during pregnancy or child birth. These are in principal expected to be offered at primary health care facilities such as dispensaries and health centres (MOHSW, 2014). The standard requirement is that in each village there should be a dispensary and in each division there should be a health centre. The third stage is postnatal care which focuses primarily on mandatory childhood immunisations and child visits. Essentially this services are currently delivered through the National Plan for Reproductive, Maternal, New Born, Child and Adolescent Health and Nutrition (2021/22 - 2025/26), also known as One Plan III.

The study engaged 32 DMOs from the LGAs that were involved in the study. 11 LGAs were not in a position to share their ECH related budgets, and therefore the data available is for 21 LGAs only. The study learnt that ECH interventions and budget are within the respective health facilities in the LGAs, i.e., the district hospitals, health centres and dispensaries. However, the study could not readily ascertain accurately the strengths and gaps of the LGAs along the continuum from prenatal care assisted delivery to postnatal care.

LGA budgets show issues such as deworming, immunisation and vaccination campaigns, nutritional services and provision of Vitamin A Supplements (drops) are frequently budgeted for. The immunisation agenda seems to be strongly supported by Gavi, the Vaccine Alliance. The study noted that often where the is no donor support, immunisation is not reflected as budgeted for. The relationship between donor support and ECD budgeting at LGA level is definitely something that needs much through examination. Similarly issues related to Maternal and Perinatal Death Surveillance Reporting (MPDSR), breastfeeding week campaigns, MIYCAN training to HCPs are also reflected in the budgets. There are also issues of child protection such as birth registration and certification for under fives , which are supported by UNICEF in Bariadi TC. Issues of child welfare are also budgeted for, focusing on supporting vulnerable children with treatment and food in the health facilities. While, overall, there are clear efforts relating to ECH, the information is not synthesised at the LGA level. However, the budgets do not seem to put much emphasis on ECH. On the one hand, this may be due to the successes of MCH services, but on the other it may just be that budgeting does not prioritise or does not wear an ECH lens. Budgeting for ECH is inevitably an important intervention recommended by this study, preceded by LGA level ECH assessments.

According to the policy, health services are free in all public health facilities. for children under five years of age However, for those who are above 5 years old, there is a cost implication to accessing health services. While, the risks and challenges related to out-of-pocket payment for health services are well documented, none of the DMOs in the LGAs involved in the study promote health insurance as part of ECH interventions, particularly for those who are above 5 years old. This issue was also not taken up by District Social Welfare Officers (DSWOs), as a child social protection issue. Accordingly, health insurance for children above 5 years old does not feature as an ECD intervention.

d. Child Social Protection and Child Protection

On issues of child' safety and security, the study involved DSWOs in the 32 LGAs participating in the study and 25 Police Gender and Children's Desk (PGCD) at the LGA level. The study learnt that although PGCDs by nature of their roles should have community-based activities, none of them has a budget. At the moment the PGCD has to respond to cases of child abuse rather than be proactive in preventing them. Mostly, they have to wait for reporting of incidents that have happened.. Lack of budget limits their capacity to conduct outreach activities related to community awareness raising, and sensitisation to prevent child abuse. The study identified three key roles that PGCD need a budget for:

i) Conduct of community sensitisation and outreach programs: This is important because, on the one hand, community members are still not very conversant with the desk and how it works and fear of police stations is still dominant. Furthermore, there are many economic, social, cultural, and attitudinal barriers to reporting incidents of child abuse. The cumulative experience of PGCDs is that there are established practices at community level on how to handle incidents of abuse and violence which often do not culminate in justice to the victim. Sensitisation is essential to break down the barriers between PGCD and the community and to empower community members to come forward to attain justice, especially for young children thereby helping to prevent or reduce such incidents.

ii) Crime investigation: Usually issues of GBV and child abuse are complex social, cultural and community issues. Especially where children are involved, the investigation component is critical to get to the bottom of things in a timely manner. When PGCD is not proactive and relies on parents, guardians, or caregivers to come forward to demand justice for the child, many cases remain cold and unclosed as follow up ceases.

iii) Stakeholder engagement: There are numerous stakeholders that PGCD could potentially work with for the betterment of ensuring child protection. These include academic facilities, pre-schools, daycare centres; religions institutions, community members and leaders. Creating a working, sustainable relationship needs some investment. .

An examination of the DSWOs budgets show that there are hardly any discrete ECD allocations. Except for Uyui, Mkinga, Kishapu, Kilolo, Itilima, Sumbawanga MC, and Bariadi, which have specific budgets for birth registration and certification of under 5s, budgets cover all children in general. It is acknowledged that children in the early childhood phase do and can benefit from services to all other children. However, there are specific early childhood protection and social protection issues which need specific interventions. For example none of the DSWOs mentioned any activity related to sensitising communities on the establishment of community daycare centres which is crucial for ECE especially in rural settings, and none mentioned parenting programs. None of the DSWOs mentioned inclusion of children with disability in early learning, or community sensitisation of health insurance for children. There is a strong indication that issues that have donor funding

such as child registration and case management are budgeted for while some essential ECE issues are not. Furthermore, there is a strong indication of limited ECD budgeting capacity

In terms of sources of funding, there are three frequently highlighted sources. The most frequently mentioned is 'own source,' The second frequently mentioned source is UNICEF, while the Health Basket Fund (HBF) is the third frequently mentioned followed by the Central Government. The fact that 'own source' budget is the primary source is encouraging and positive because of its potential for sustainability and upscaling of interventions.

On overall examination of the budgets shows clearly that an ECD lens is missing in the budget process. The budgets do not indicate that they target specific ECD outcomes. One reason for this may be the lack of a comprehensive essential ECD package covering basic ECD rights across sectors. An Essential Package of ECD Services and Support (EPES) refers to the package of universal early childhood development services and support that the government is providing or is aspiring to provide in an equitable manner. However, as far as the study could tell, Tanzania has not developed and adopted any a comprehensive EPES package. The study learnt that the country did adapt the Care for Child Development (CCD) package developed by the WHO and UNICEF (**Ahun, et al., 2023**). However, this package mainly consists of materials to guide health providers to provide counselling on play and communication to parents/caregivers of children aged 0-3 during routine health services (**MoHCDGEC, 2021:16**).

The second notable issue in LGA level budgeting, is the non-utilisation of community resources. As indicated above, the URT Constitution conferred on LGAs the right and power to involve the people in the planning and implementation of development programmes within their respective areas. The budgets manifest that there are very limited efforts towards harnessing community capacities and investments. While there are varied levels of investments across communities, the most consistent challenge is lack of community ownership of initiatives. For example community daycare centres are meant to be established and run by communities. However, only a few have been established. As shown above, currently there are only 206 community day-care centres across the country out of a total of 3389 daycare centres. Some of the reasons mentioned include lack of or limited awareness of the Guidelines among key actors, particularly at the ward and village leadership levels; lack of coordination and guidance from the LGA; and lack of or limited community engagement. Again, currently there is no approved model for establishing community daycare centres. Each partner therefore has used their own approach and models. There is a strong likelihood that there are great disparities between established community daycare centres depending on the model used to establish them. It is important to have a community daycare centre model that can inform and harmonise all centres that will be established across the country.

Purposeful utilisation of community capacities within neighbourhoods is key to the positive development of children's well-being. These entail firstly, 'institutional resources' such as early education centres, playgrounds and public parks; and secondly, 'collective efficacy.' According to Mistry, et al. (2022:1691) such efficacy refers to "the ability of communities to

establish informal social structures and a broader sense of mutual trust and shared values." Collective efficacy emphasises not only the role of social connections within communities but also the function of social control mechanisms. These mechanisms include monitoring the behavior of others and supervising children (ibid.). Collective efficacy can give weight to by-laws, and activities concerning nutrition, early childhood protection and social protection.

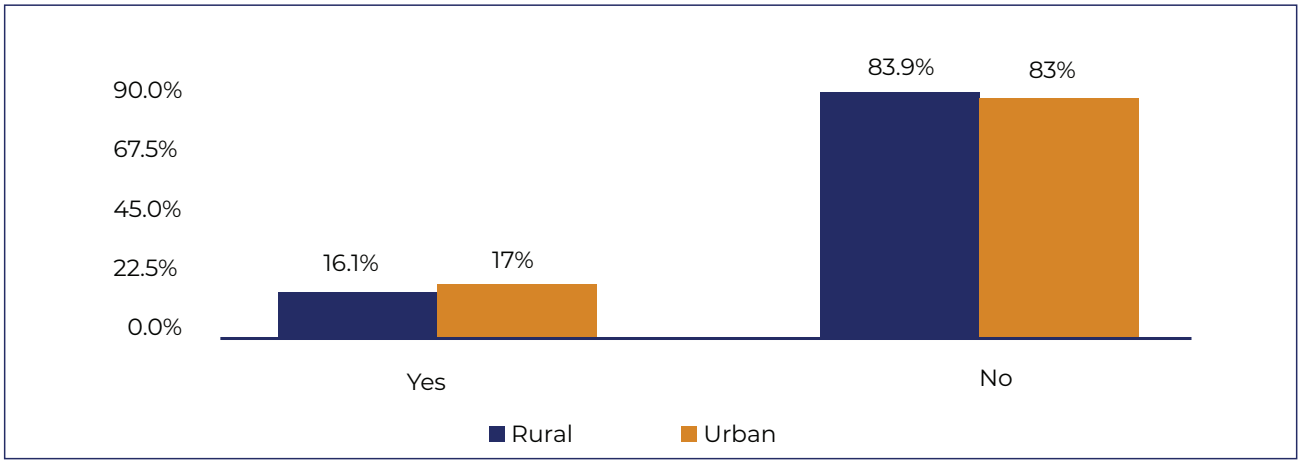
5. ECD Services Availability, Access and Related Services

5.1. Early Childhood Protection (ECP)

nterventions in Early Childhood Programs (ECP) aim to ensure children's citizenship rights and legal recognition through mandatory birth registration. This process involves obtaining a 'Notification of Birth' from the health facility or local authorities within 90 days of birth, which is then submitted to a District Registrar for processing. While the initial notification is free, a fee of TZS 3,500 is required for processing the birth certificate. Birth certificates serve as crucial proof of age and citizenship. Failure to register births poses risks such as denial of access to education, healthcare, and legal rights, along with hindrances in effective resource allocation and increased vulnerability to abuse and exploitation.

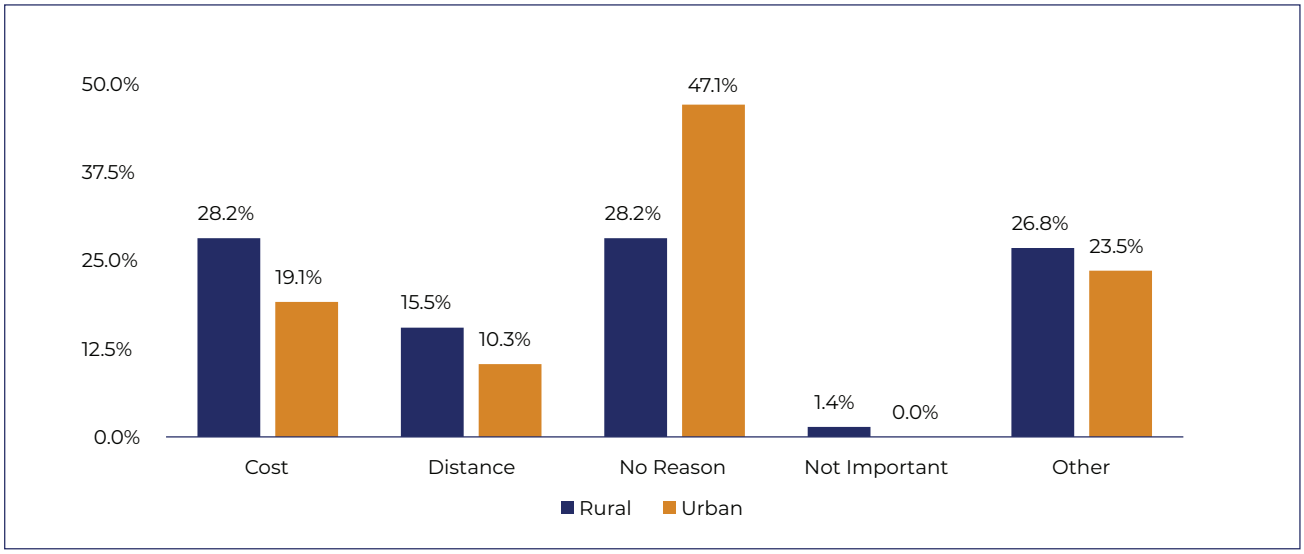
The Registration Insolvency and Trusteeship Agency (RITA), in collaboration with other stakeholders, is spearheading initiatives to enhance birth registration for Under 5s. These efforts focus on three strategic pillars: abolishing registration fees to make both registration and certificates free, decentralising registration services to local government offices and health facilities, and leveraging information and communication technology (ICT) to streamline registration processes. Despite these measures, 83.9% of households in rural areas and 83% in urban areas have yet to secure birth certificates for their children,. Such overwhelming percentages highlight persistent challenges in birth registration.

Figure 5.1: Percent of HoH Who Have Processed Birth Certificates for their Children aged 0-8 years



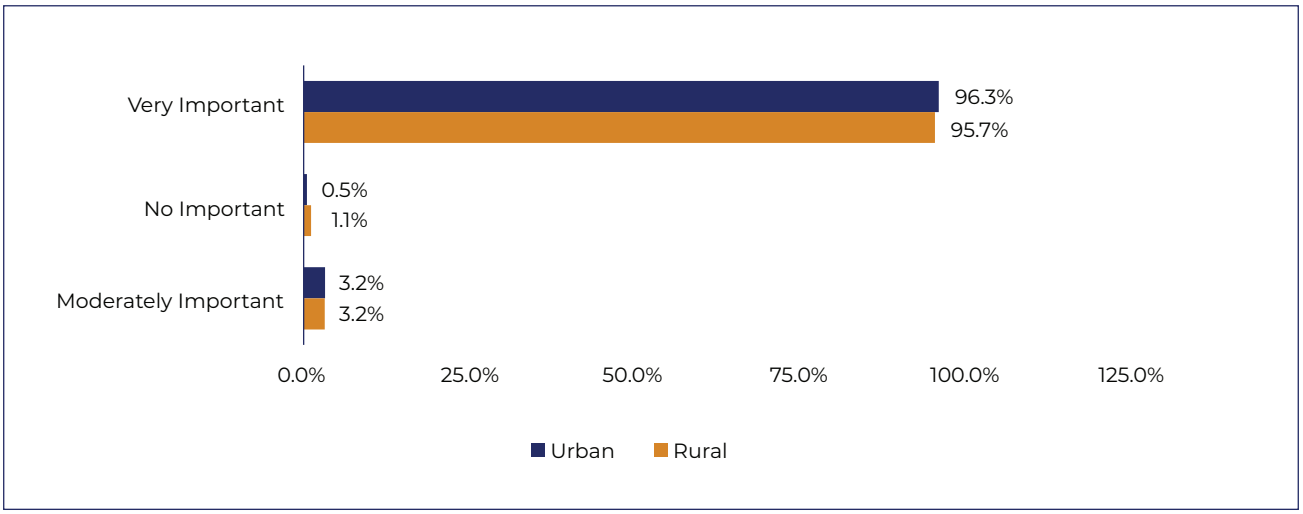
As indicated in Figure 5.2, 47.1% of urban HoHs and 28% of rural households stated that there was no good reason for not processing their children's birth certificates. Other reasons such as cost and distance were also given. But given the ongoing initiative as described above, particularly the availability of these services at health facilities level, these do not hold much water, unless there are hidden costs involved.

Figure 5.2: Reasons for HoHs Not to Have Processed their Children's Birth Certificates



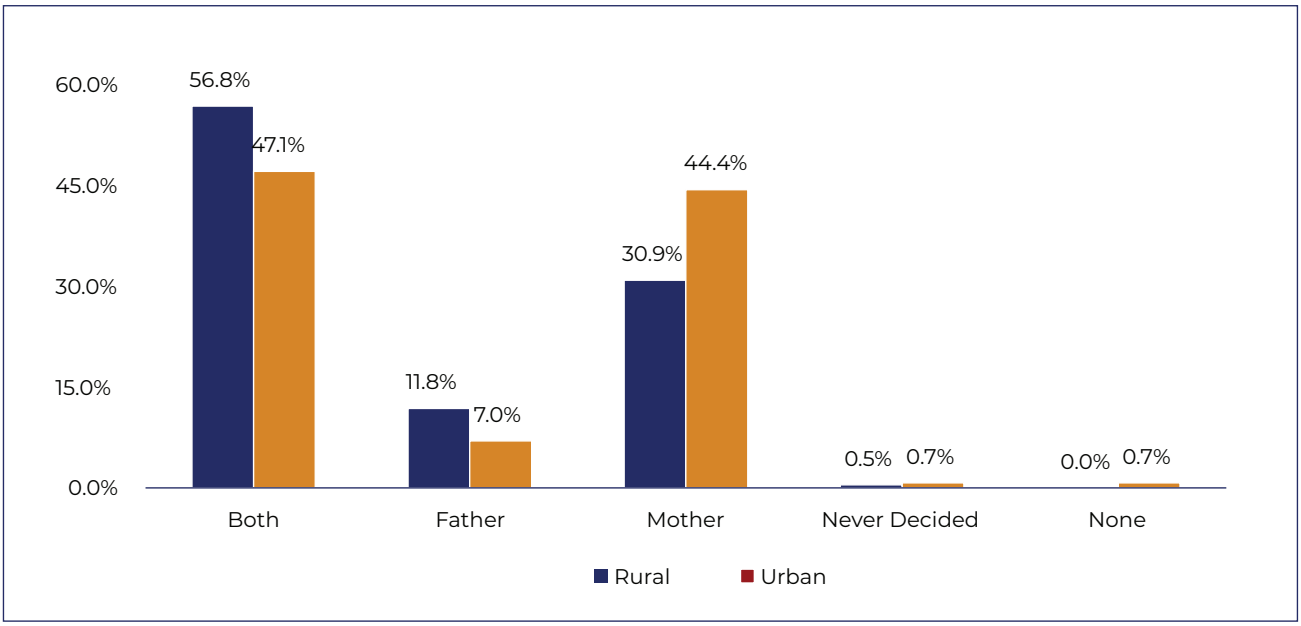
This report recommends more sensitisation, because under the circumstances, the attainment of birth certificates for children does not seem to be priority for most respondents, even though, as shown in figure 5.3, over 95% of HoHs from both urban and rural settings are of the opinion that it is very important for their children to have birth certificates. Perception that birth certificates are important does not necessarily propel HoHs in attaining them for their children. This indicate that for majority of HoHs there is no immediate incentive or sanction related to children attaining or not attaining birth certificates.

Figure 5.3: HoHs Perception About the Importance of Birth Certificates



The study further explored who has the primary responsibility for following up on children's birth certificates. As indicated in Figure 5.4, 56.8% of HoH in rural areas and 47.1% of those in urban areas, stated that it was the responsibility of both parents. However, 44.4% of urban HoHs, and 30.9% of rural HoHs stated that it was the role of the mother. This is an important finding because it indicates that if mothers were more sensitised it may bear more fruits, particularly because it is integrated with MCH services.

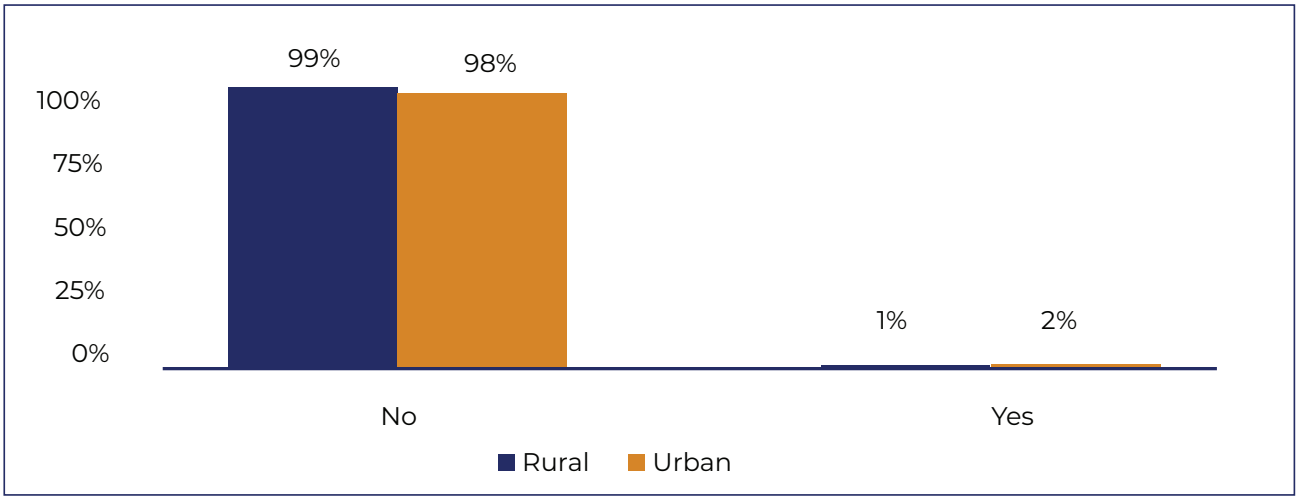
Figure 5.4: Who has the Responsibility to Follow Up on Children's Birth Certificates



According to the MoH, et al., (2022:15) in Tanzania registration of children under age 5 has increased substantially, from 26% in the 2015–16 TDHS-MIS to 68% in the 2022 TDHS-MIS. It should however be noted that TDHS-MIS, considered receiving birth notification form as constituting birth registration. This study however, investigated whether children's birth certificates have been processed. Therefore, while provision of birth notification forms has increased, it is clear that majority of parents/guardians have not proceeded with attainment of birth certificates for their children.

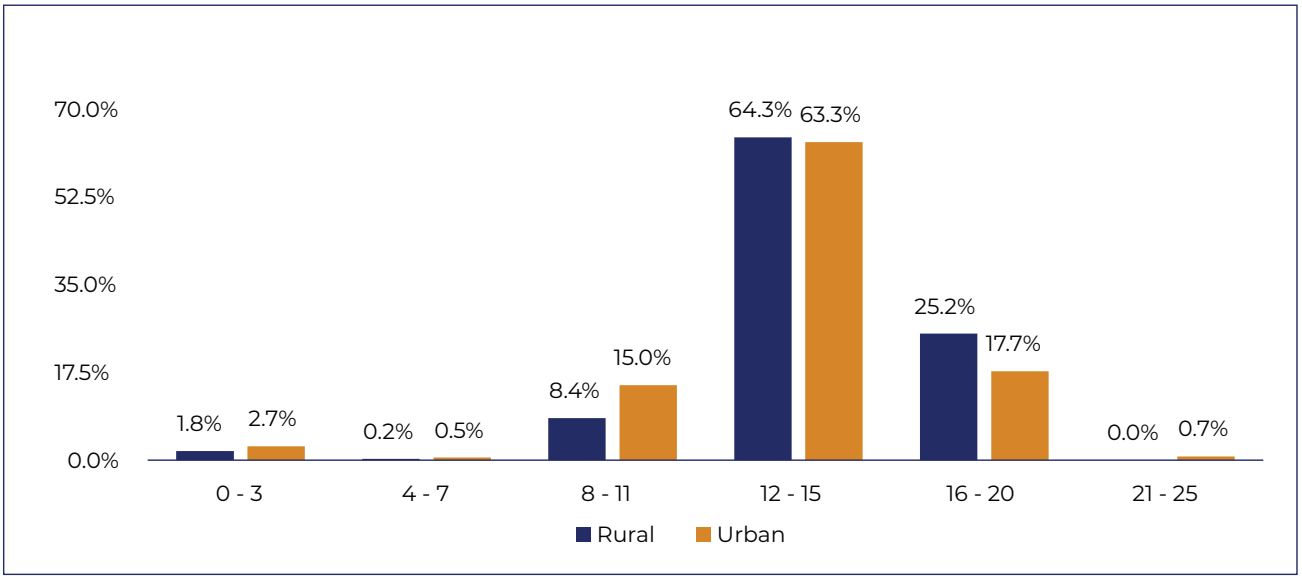
In addition, ECP, is also concerned with effectiveness and efficiency in tracking and intervening on child abuse. The case management system seems to work, but by design it is reactive than preventive. There is still not an effective mechanism for early detection of child abuse. Community sensitisation continues to remain the most effective deterrence mechanism. Furthermore, tracking shifts in community beliefs, especially those which entail harmful practices is critical. In that regard, when HoHs were asked whether in their community female genital mutilation/cutting is an important practice, as indicated in Figure 5.5, in both rural and urban settings, 98% and above stated that it is not.

Figure 5.5: HoH's Perceptions on Whether in Their Communities Female Circumcision is Important



In tracking and intervening child abuse, it is critical to identify and halt social practices, customs and traditions and any other condition that may prepare children for sexual exploitation. As indicated in Figure 5.6, HoHs in rural and urban settings are of the opinion that the majority of female children (64.3% rural and 63.3% urban), start being sexually active in the age group 12-15, while 8.4% (rural) and 15.0% (urban) believe it is as early as ages 8-11. The assumption here is that children do not just suddenly become sexually without pervasive grooming, way before they are 8 years old.

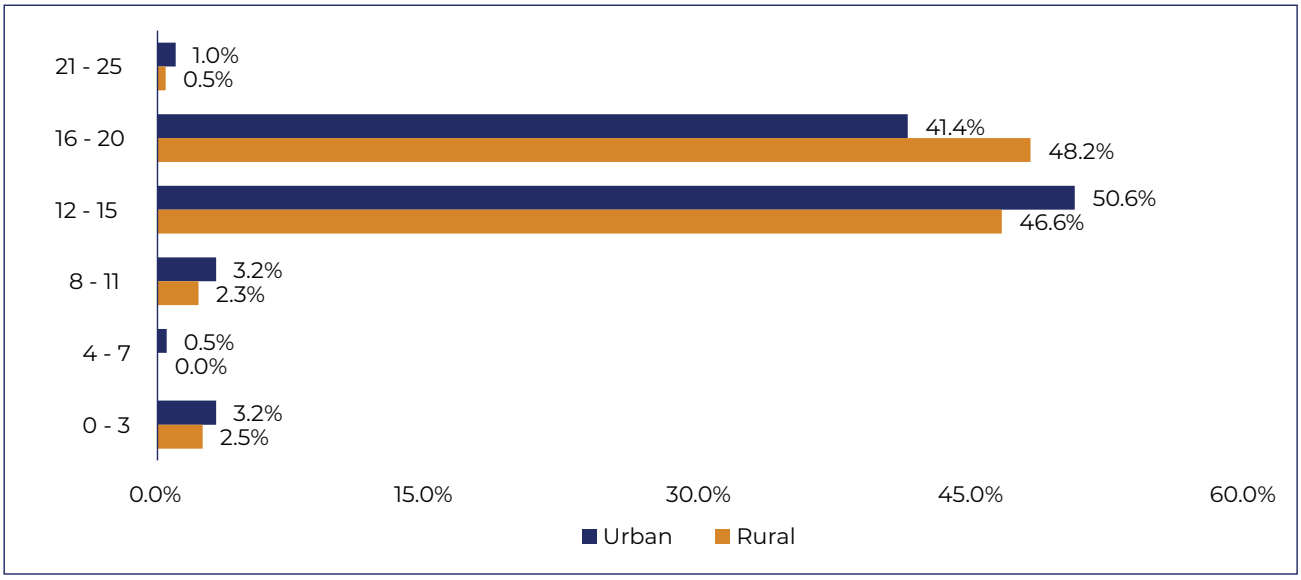
Figure 5.6: HoH's Perceptions on the Age Female Children Start Being Sexually Active



This age groups indicate pervasive sexual grooming environments. **Lamb & Plocha (2014),** posit that social environment is typically more telling than individual characteristics regarding sexually problematic behavior. It has been noted that environmental factors can conspire to introduce sexualised themes into a child's life too early (**Gunter, 2014**). In that regard interventions to examine environmental factors, and develop mechanisms to counter that social narrative are essential.

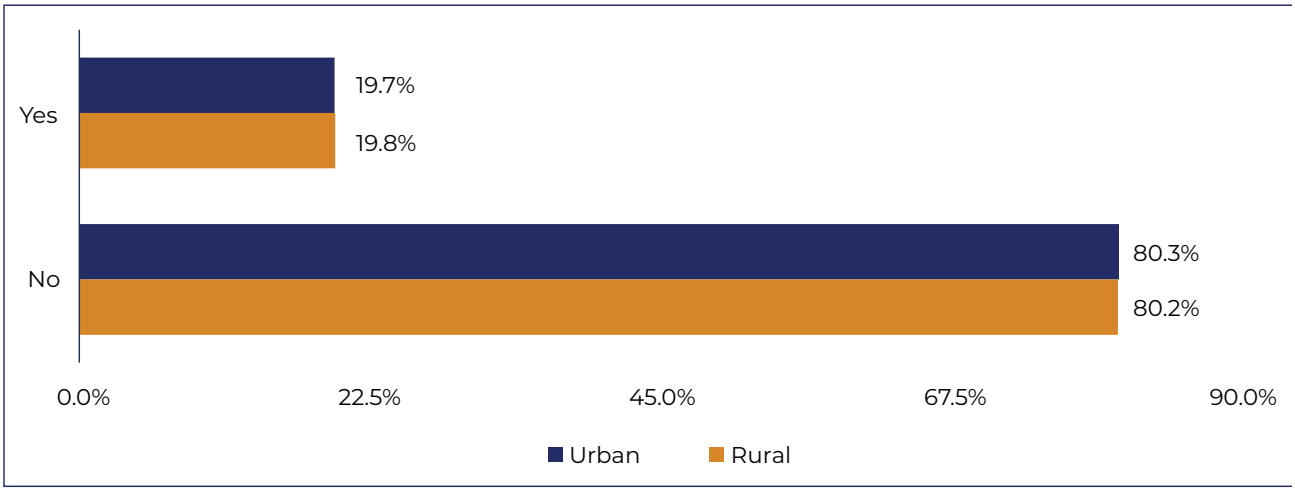
Equally problematic is that literature indicates tendencially boys show an earlier sexual initiation than girls (**Cueto & Leon, 2016**). However as shown in Figure 5.7, majority of respondents, both in rural and urban areas perceive male children to start sexual explorations later than girls. This indicate that girls are perceived to be particularly vulnerable and susceptible to sexual exploitation at a much younger age than boys.

Figure 5.7: HoH's Perceptions on the Age Male Children Start Being Sexually Active



On the other hand young boys are also at high risk of sexual violence. According to **LHRC (2023)**. Sexual violence, especially rape and sodomy, is the most common form of violence against children (VAC), and a quarter (25%) of the victims are under the age of 10 years, with boys (78%) constituting the majority of sodomy victims. Again, perpetrators of sexual violence against children, are usually individuals who have earned the trust of the child and of the family, including very close members of the family. (Ibid.). The study asked respondents whether their young children age 0-8 years sleep with post puberty members of the family, such as kin. As shown in Figure 5.8, more than 80% of HoHs in both urban and rural settings affirmed that to be the case. These are situations which underscore the critical importance of parenting programs as essential packages of ECD services.

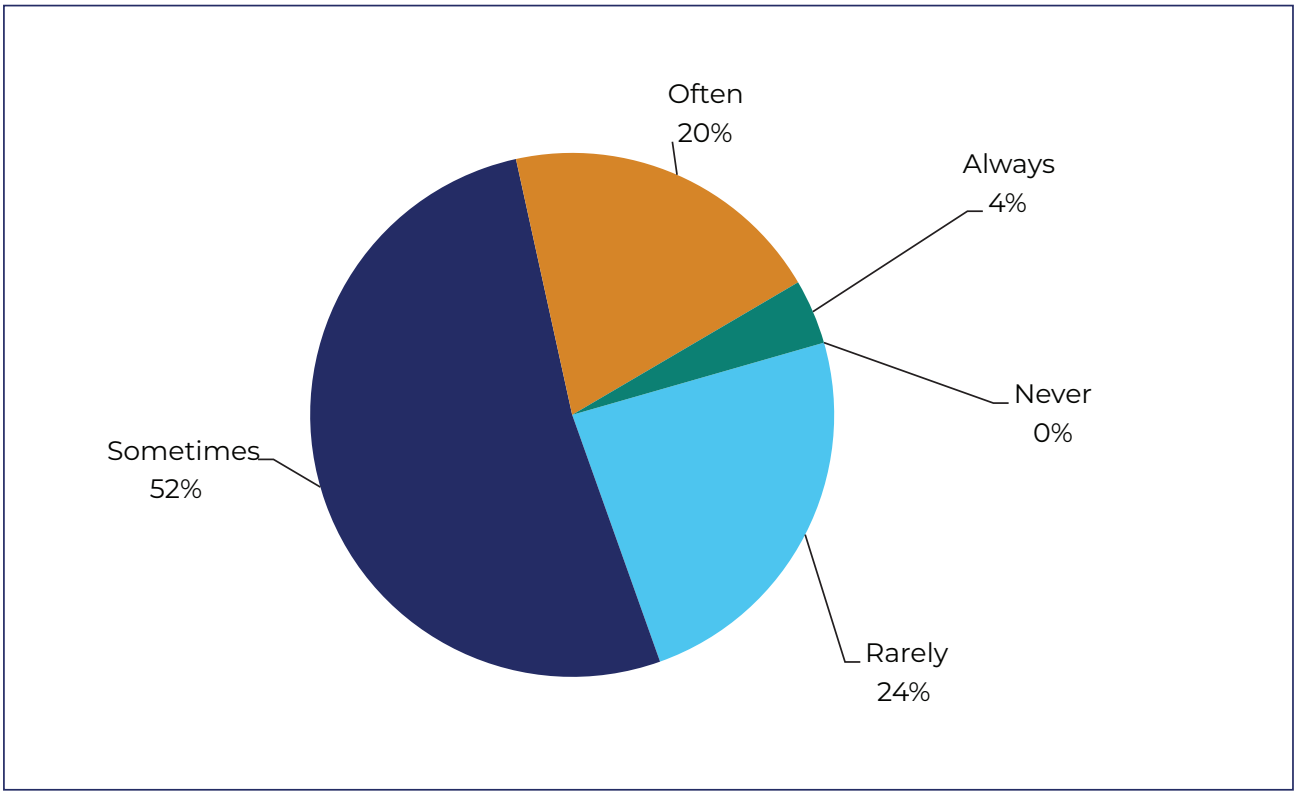
Figure 5.8: Do Young Children Sleep With Post- puberty Family Members including Relatives



Tracking and intervening on abuse of children who are in the early childhood phase become problematic when the circle of justice cannot be completed. For example as indicated in Figure 5.9, 52% of PGCD are of the view that sometimes child abuse incidents go unreported; while 20% see it as often. PGCD were divided on whether incidents of child abuse are increasing or decreasing This difference may be due to geographical differences,

meaning in some areas it is increasing and decreasing in others. In addition, due to unreliability of reporting statistics as many cases are not reported, it is not easy to make any firm conclusions based on reported cases alone.

Figure 5.9: PGCG Perception on How Often Child Abuse Cases Go Unreported



The study also found that while there is a strong perception that child abuse is pervasive, that situation is not reflected in the number of criminal proceedings in the courts. In the courts there are very few cases compared to the allegations. This can mean child abuse incidents are not reported, or when they are reported the do not get prosecuted, except for just a few. Further, even those which are prosecuted, there is no certainty that justice for the victim will be attained. For example, statistics from Shinyanga District Court show that in 2021, thirty (30) criminal proceedings involving children aged 0-8 years were conducted. Of those, twenty five (25) cases involved rape, and five (5) involved sodomy. Of those cases, 7 were found guilty, 9 not guilty and 14 cases were dismissed. In the same court, in 2022, thirty seven (37) proceedings were conducted. Thirty (30) involved rape, and seven (7) sodomy. Of those, eleven (11) were found guilty, six (6) not guilty and twenty cases were (20) dismissed. For the year 2023, there were 37 cases. Thirty (30) involved rape, and seven involved sodomy. 22 were found guilty and 7 cases were 7 dismissed. In these three years, of 104 cases heard by the court only forty (40) suspected perpetrators were found guilty.

Again, reporting, following up and processing offences might also be affected by accessibility issues. This study was conducted in 16 mitaa and 16 villages, 32 in all. 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. Furthermore, only five (5) had a PGCD, while 24 did not. The policy of further cascading services to the community level should therefore be supported.

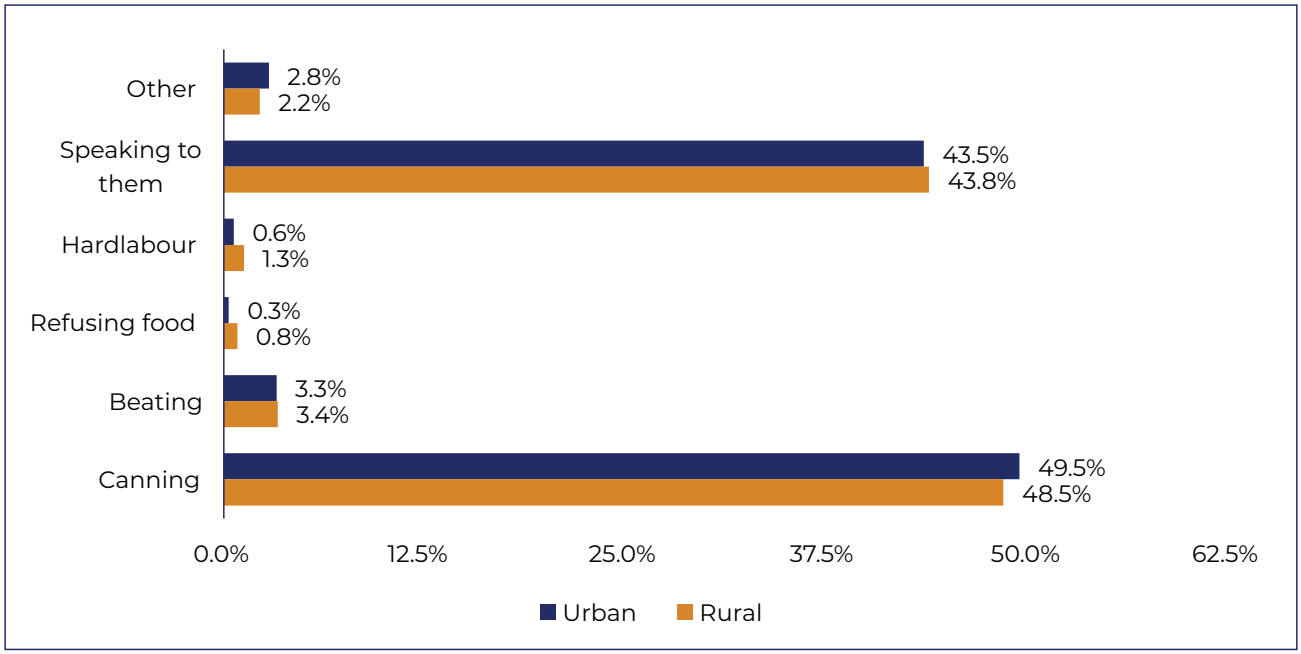
The study also learned that alignment between the PGCD perceptions and the court system with regard to criminal offences against children aged 0-8 is rare. As indicated in Table 5.1 below, the study inquired of the LGA level PGCDs what were the most common crimes committed against children in early childhood. The study also sought number and type of criminal offences against children aged 0-8 registered in the district courts of the respective LGAs.

In all the 15 LGAs, PGCDs mentioned criminal offences against children age 0-8 years in the respective LGAs. However, findings from the district courts in the respective LGAs, show that, over a 5 year period, i.e., 2018-2023, 6 had not registered any case of criminal offences against children in that age category, and 3 had registered only one case each in that period. However, there are substantial differences with some courts indicating to have registered a notable number of cases, such as Singida (49), Geita (421), and Iringa MC (95).

While this data does not help in reaching any specific conclusions, it is another indication of the circle of justice not being completed. PGCDs are a trusted source of information because they deal with child protection issues on a daily basis. It is also understood that the police department is obligated to conduct investigations leading to prosecution of cases. It is therefore worth a thorough investigation to determine the gap between what the police department knows to be the practice, and the cases being opened in the court system for prosecution. Whether procedural or technical issues are a hindrance to justice, or a culture of silence, or lack of cooperation from the victim's family, it is important to unveil prevailing barriers to justice. This will be an important step towards child protection.

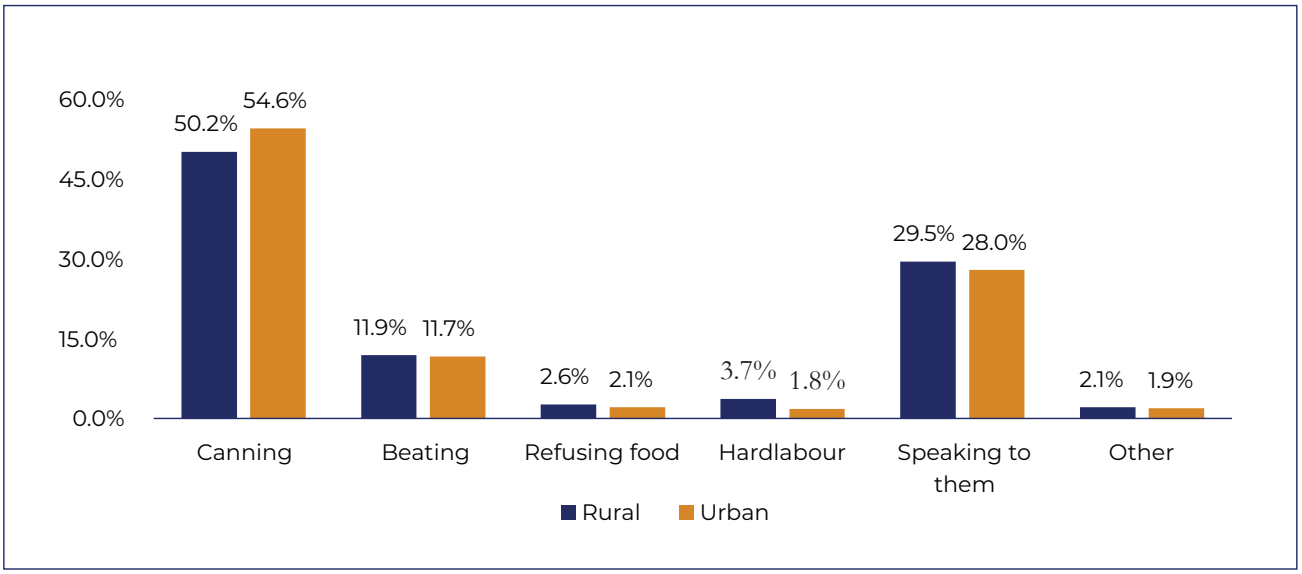
Furthermore, ECP is concerned the availability of domestic violence laws and their enforcement. The study found that although the laws are available, their enforcement is a tricky issue. Part of the challenge is that corporal punishment is a normalised practice in the community. Figure 5.10 for instance indicate that over 48% of HoHs in both rural and urban settings use caning as the main method of disciplining their children between ages 3-8 years.

Figure 5.10: The main ways HoHs use to disciple children between 3-8 years old



In correcting children's behaviours, the study learnt that generally majority of respondents do not differentiate between disciplining and punishing. In distinguishing the two Morin (2021) posits that while punishment focuses on making a child suffer for breaking the rules, discipline is about teaching him how to make a better choice next time. Most respondents perceived inflicting punishment as constituting disciplining. As shown in Figure 5.11, over 50% of HoH from both rural and urban settings identified caning as the main method that people in their areas use to discipline their children especially between the ages of 3 and 8.

Figure 5.11: HoHs Perceptions on the Main ways Community Members use to disciple children between 3-8 years old.



In addition, over 45% of HoHs, from both rural and urban settings think that in their communities there are people who punish children excessively. 50% of HoHs from both urban and rural settings, are also of the opinion that corporal punishment is the main method schools use to discipline pupils aged 3-8 years old. Thus, in all these settings it is clear that a culture of violence is institutionalized and normalized.

According to Mckenzie et al. (2013), punishment, particularly of children in their first decade of life does not teach them how to behave but often confuses them and sends unintended messages. On the other hand, disciplining helps children understand their behaviours, and teaches them skills related to managing their behavior, solving problems, dealing with uncomfortable situations, learning from their mistakes and adopting socially appropriate ways to deal with emotions (Morin op cit.). Tanzania has adopted and domesticated the Nurturing Care Framework, which clearly underscores positive discipline. Furthermore, 12 out 3 DMOs from periphery LGAs and 10 out of 4 from urban LGAs state that parenting programs are offered in all antenatal and postnatal care facilities.

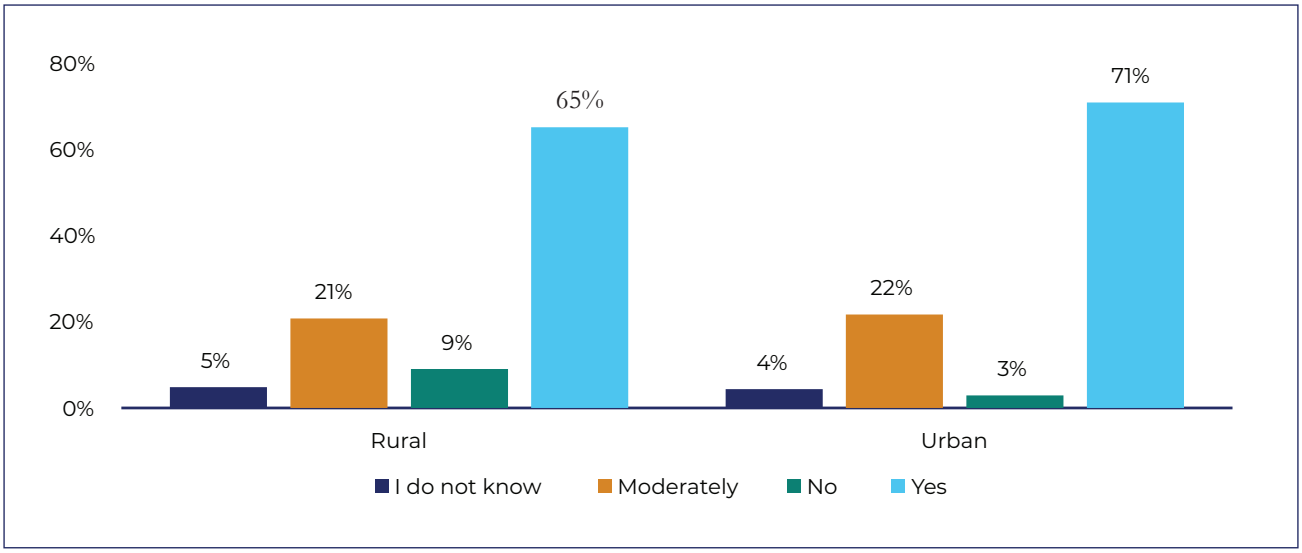
Most HoHs however, 90.2% in rural and 86.5% in urban areas were of the view that their community was a safe place for children to grow. However, 13.5%, (urban) and 9.8% (rural) were of the opinion that their community is not a safe place for their children. That percentage is high in the context of child rights, and it is very telling, for instance that parents/guardians are trapped in a situation they cannot escape. Living in a place that one knows is not safe either for themselves or their children indicates vulnerability or disempowerment.

Another critical component of ECP is the capability of law enforcement officers and actors in the child protection system. At the community level this includes the Child Protection Committee, Village/Mtaa Executive Officers, (V/MEO) who are the principal law enforcesr, Ward Social Welfare Officers, Community Health Workers, etc. They all need to be adequately and regularly trained on child protection issues, the laws, regulations, guidelines, innovative approaches, new skills etc. PGCD posits that they have received some trainings, but they are not adequate for purpose. Further, only afew officers have been trained. There is a need to train more police officers, including male polics officers to join the police gender desks.

At the mtaa/village level, especially in the grassroots institutions of governance there is very little capacity building on early childhood development in general, and issues of child protection in particular. In addition, on examining the DSWOs budget, the study did not see any item related to training of ward/village actors on issues of early childhood development, and building their capacities regarding the role they have to play. This is despite the fact that the mtaa/village executive officer is the ECD coordinator at that level; and is also tasked to oversee and support the Most Vulnerable Children Committee (MVCC).

HoHs were also asked whether in their village/mtaa, there was a 'child protection committee' (CPC). As shown in Figure 5.16, 38.6% of the HoHs from rural settings and 33.9% from urban settings stated that there is no such committee. This is supported by a verified checklist, which indicated that only 19 of the villages/mitaa involved in the study had Gender and Child Protection Committees. However, for those mitaa/villages which do have CPCs, as shown in Figure 5.12, most HoHs, i.e., 65%, from rural and 71% from urban areas were of the opinion that they are active, 21% and 22% respectively view their effectiveness as moderate.

Figure 5.12: HoH Perceptions on the Effectiveness of CPC



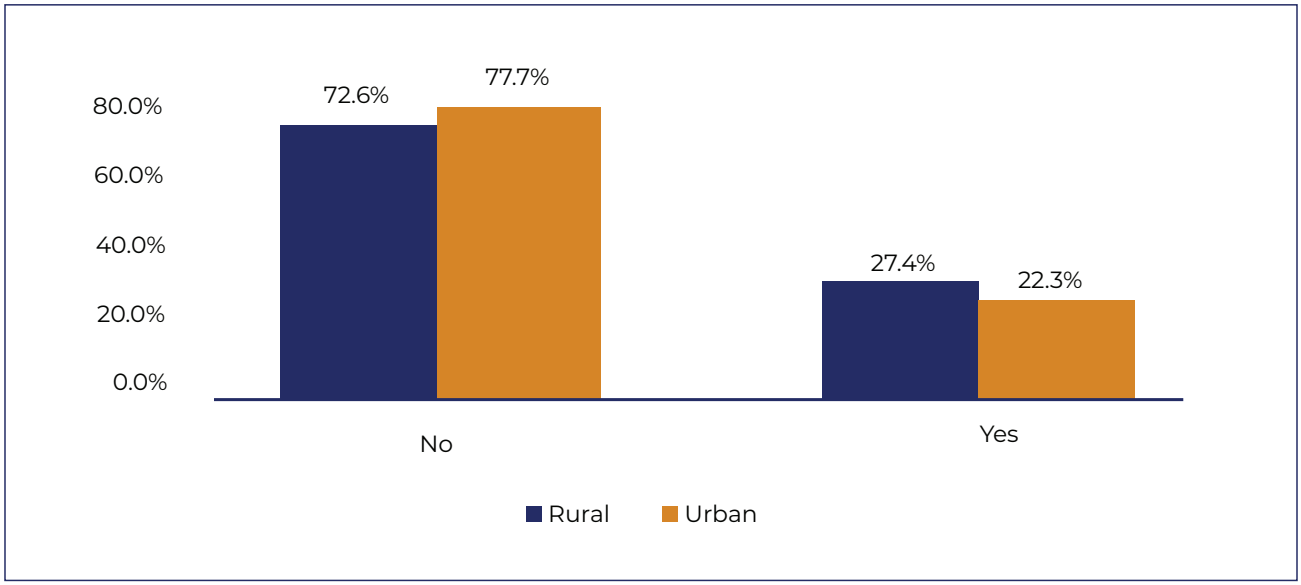
5.2. Early Childhood Social Protection

Naturally, exclusion undermines early childhood development (ECD). This is because it is strongly related to poverty, disability and other forms of special needs and marginalisation. Social protection programs focus on redressing economic and social vulnerability and marginalisation. Such programs have a protective, preventative, promotive and transformative role in supporting rights for children and parents/caregivers. ECSP derivez from this larger social projection concept. Accordingly, ECSP is is mainly concerned with three main issues: availability of policies to protect the rights of children with special needs and promote their access to and participation in ECD services; availability of services for orphans and vulnerable children; and existence of financial transfer mechanisms or income supports to reach the most vulnerable families (which could include cash transfers, social welfare, etc). The policy environment and the section on integrating inclusion in ECE has addressed these issues. In the context of ECSP, this section concisely explores the state of vulnerable children in the locations in this study.

Child neglect is one of the most common forms of child vulnerability. The study inquired of the HoHs whether in their communities there are children who are not cared for properly. 38.2% of urban HoHs and 38% of rural HoHs indicate that such children do exist in their communities. Furthermore, 12.5% of HoHs from rural and urban settings respectively are aware of child head households in their communities. In addition, 51% of HoHs from both urban and rural settings are aware of children aged 0-8 years who can be considered to be particularly vulnerable. Finally, 4% of rural , and 40% of urban HoHs are aware of most vulnerable children who are not supported by TASAF.

Figure 5.13, shows that over 70% of HoHs from both urban and rural settings are of the view that there is no any effort by the mtaa/village leadership to help vulnerable children who are not supported by TASAF. This shows that MVCCs are not performing as expected despite most HoHs' perception that they are moderately effective.

Figure 5.13: Do Most Vulnerable Children Get and Support from the Mtaa/Village Leadership



5.3. Early Childhood Education (ECE)

ECE is primarily concerned with availability of high-quality childcare and/or preschool centres, availability of fee free pre-primary school, and parenting programs. 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 day-care 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. This indicate that there is a huge gap with regards to availability of ECE facilities in the country.

In the villages involved in the study, 6 have day-care centres, while 8 do not. In urban areas, nine have, while six do not. Daycare centres however, are not fee free because they are owned and operated privately. As far as community day-care centres are concerned, only one (1) was available in the study area. The rest of the villages and mitaa involved in the study did not have any community day-care centre. Community-based Day-care Centers (CDCs) are supposed to be established, run and owned by the respective community, with the respective mtaa/village government recognised as the official owner.

Mtaa/village executive officers involved in the study however were not able to confirm whether the day-care centres are officially registered with the social welfare department. Similarly, DSWOs and WSWOs could not with certainty confirm that all operating day-care centres in their districts/wards are officially registered. This underscores a flagged concern that some day-care centres are operating without registration. A concern was flagged that in some day-care centres children are taught by teachers with questionable credentials, particularly with regard to ECE. It was alleged that some teachers had only finished primary or ordinary secondary schools, and, without any further training were entrusted to teach children. Lack of appropriate teachers' training on how to facilitate ECE was deemed to be a risk, as it can have detrimental effects on children. It is recommended that DSWOs and WSWO should work particularly with the village/mtaa executive officers, to ensure that day-care centres are established and operated according to the regulations for day care centres.

The study investigated the awareness of the CDC Guidelines in FGDs with institutional actors at ward and village levels. Of 16 FGDs conducted in urban settings, participants in 7 agreed that they were familiar with the Guidelines while those in the other 9 said that they were not. Of 15 FGDs conducted with ward/ village institutional actors in the periphery, participants in 9 FGDs agreed that they were familiar with the Guidelines, while those in the other 6 had said that they were not. However, further probing among FGDs participants who indicated that they were familiar with the Guidelines, showed that some confused day-care centres and community day-care centres.

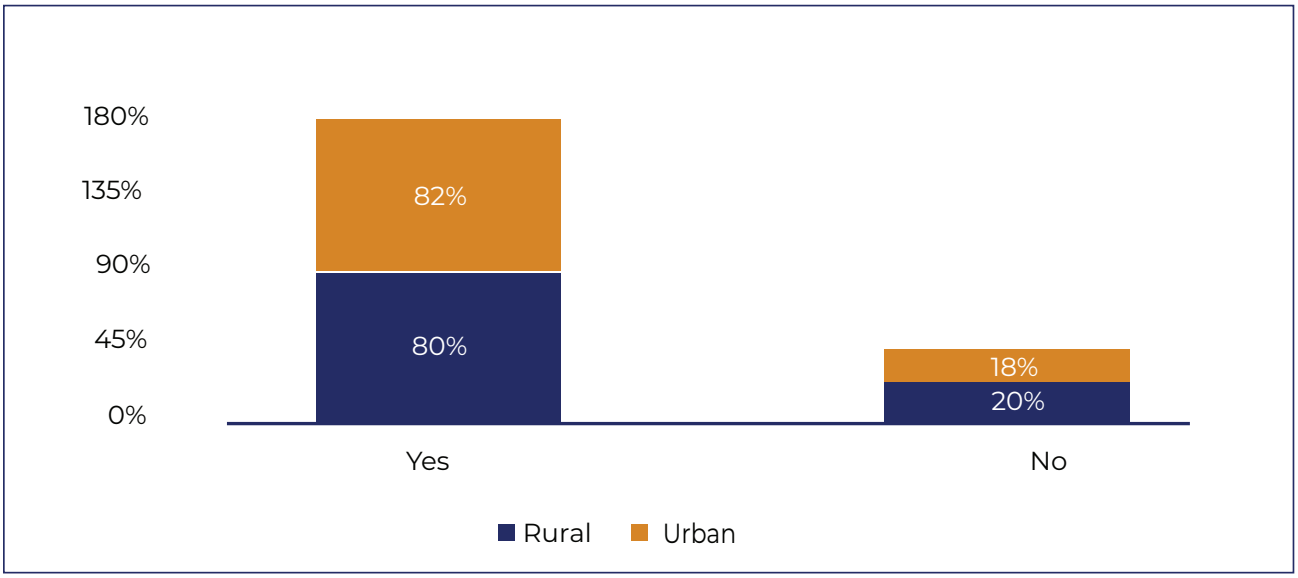
The study further learnt that DSWOs were more aware of the National Guidelines for Establishment of Day-care Centres than National Guidelines for Establishment and Management of Community-based Day-care Centres. Overall, 29 DSWOs stated that they were familiar with the Guidelines for Establishment of Day-care Centres and only 2 stated that they were not. With regard to the National Guidelines for Establishment and Management of Community-based Daycare Centres, 21 DSWOs stated that they were familiar with them while 10 stated that they were not.

These Community-based daycare centres are crucial particularly for low income households in urban areas and for the majority of rural residents. Lack of awareness regarding these Guidelines at DSWO level is very concerning considering the specific mandate of DSWOs specific mandate with regard to creches and day-care centres. This is because ward/village level actors, will inevitably need training, guidance and technical backstopping to be able to coordinate their communities to establish and operate CDCs.

Overall, the trend indicates clear inequity in the establishment and operation of CDCs, to the detriment of the majority of children. Considering the current trend whereby the majority of households rely on publicly available ECD services, CDCs have the potential to serve the majority of children in Tanzania. However, statistics on their establishment and availability are not very positive. The Guidelines on the establishment of CDCs are currently in their 4th year since their adoption in 2020. The study learnt that MoCDGWSG is in the process of developing a model CDC as established CDCs did not follow a specific model. Consultations with some of the partners/CSOs that pioneered the establishment of the existing CDCs suggest that although they are inspired by the CDC Guidelines, there were different models/ approaches in their establishment. An approved model would set basic CDC standards and ensure consistency in their establishment.

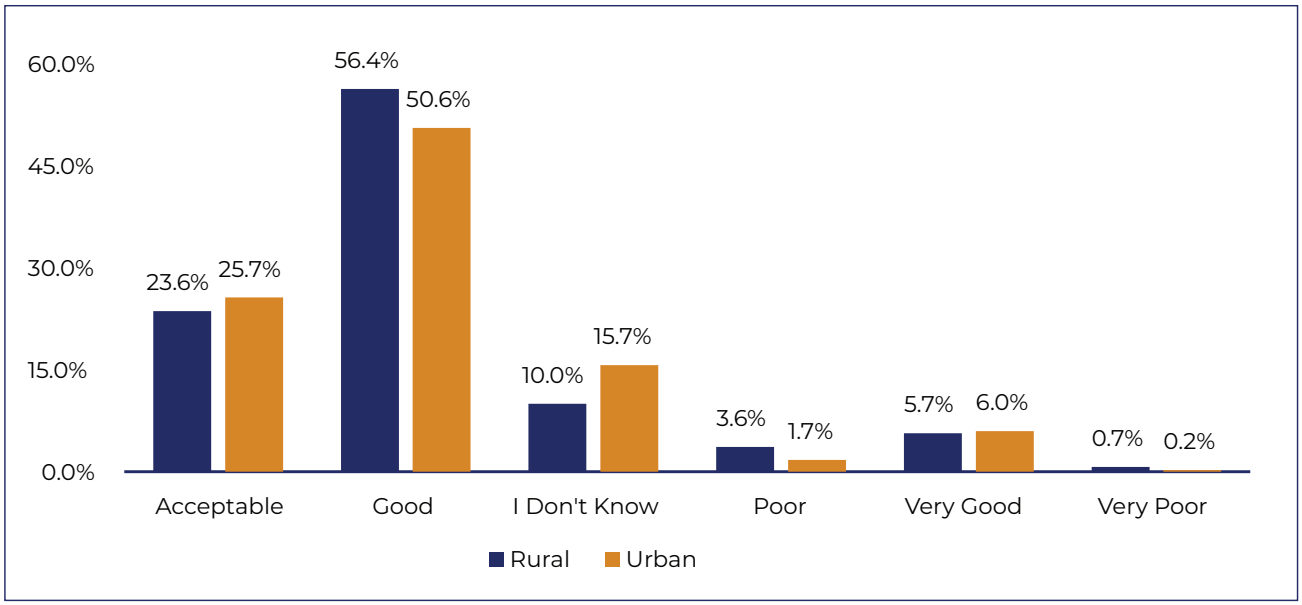
On the part of public primary schools, 13 villages had primary schools and only one did not have. In the urban areas, 12 mitaa had primary schools and only 3 did not. Similarly, that 78% of rural HoHs and 76% of urban HoHs said that there were primary schools in their localities. The study found that each public primary school has free pre-primary classes, and that this was a mandatory requirement. For most people these mandatory pre-primary classes are likened to crèches/day care centre. In that respect, as shown in Figure 5.14, 82% of urban based HoHs and 80% of rural based HoH stated that there are creches/day-care centres within their locality.

Figure 5.14: Availability of Day-care centres in the locality of the Study



Generally, HoH's in the locations of the study highlighted several challenges to ECE. Poor infrastructure, lack of learning materials and lack of qualified teachers were the main issues mentioned. However, when asked about their perception of the quality of education in the schools, as indicated in Figure 5.15, the majority i.e., 56.4% of HoHs from rural areas, and 50.6% from urban areas, stated that it was good, while 23.6% of rural HoHs and 25.7% of urban HoHs stated that it was acceptable.

Figure 5.15: Quality of education in public elementary /primary school in your locality



In terms of distance from home to school for children aged 3-5 years, 63.1% of urban based HoHs, and 59.3% of 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 although majority of children can walk comfortably two and from school, for a notable percentage distance between home and school is still a thorny issues for many children who are supposed to attend ECE facilities and might affect enrolment and attendance, or become too tasking for young children.

5.4. Early Childhood Health

The majority of the respondents, i.e, 62% of urban HoHs, and 52.7% of rural HoHs mentioned a government owned dispensary as the health facility nearest their home Furthermore, 61% of rural HoHs and 74% of urban HoHs said that, to get to the nearest health facility, they usually walk. 74.8% of rural HoHs and 80.3% of urban HoHs were also of the opinion that in case of a medical emergency at home, it is possible/convenient to quickly rush someone to the nearest health facility. It is clear that the national policy of cascading health services down to the community level has positive results for the population and should be sustained. Equipping primary health facilities to provide comprehensive basic healthcare including MCH services is most important for ECH. With regard to quality of maternal and paediatric care in public health facilities, more than 60 percent of HoHs from both urban and rural areas rated them as good. However, shortage of medicines was highlighted as the most pressing challenge in public paediatric services.

Regarding routine immunisation, more than 99% of both urban and rural HoHs stated that their young children were fully immunized according to the recommendations of the Ministry of Health. However, only 64.8% and 65.7% of HoHs from rural and urban areas respectively said they knew what constituted full routine immunisation before the age of 2. However, responses from DMOs indicate that there could be rural-urban discrepancies regarding adherence to basic childhood immunisation in the LGAs. 9 out 14 DMOs from urban LGAs stated that adherence was excellent while two stated that it was above average and 3 stated that it was average. On the other hand, out of 15 DMOs from periphery LGAs, 10 stated that adherence was above average while 2 stared that it was excellent and 3 stated that it was average.

On prevention of mother-to-child-transmission (PMTCT), out of 15 DMOs from periphery LGAs, 10 stated that the rate of pediatric HIV infection in their respective LGAs was low, and 4 stated that it was moderate. On the other hand, out of 14 DMOs from urban LGAs, 10 stated that it was low, 3 stated that it was moderate while 1 stated that it was high. Overall, it is clear that pediatric HIV infection is still a serious concern.

Furthermore, out of 14 DMOs from urban LGAs, 6 were of the view that women's acceptance of mandatory health screening particularly for syphilis and HIV during ANC visits was perfectly acceptable; while 7 stated that it was acceptable and 1 was neutral. Similarly, out of 15 DMOs from periphery LGAs, 10 were of the view that it was acceptable, while 5 were of the view that it was perfectly acceptable.

Moreover, the study explored whether mandatory health screening deters some women from attending ANC and/or delivering in health facilities. Out of 15 DMOs from periphery

LGAs 8 were of the view that it did, and 7 were of the view that it did not. Similarly, out of 14 DMOs from urban LGAs, 7 were of the opinion that it did, and 7 that it did not. Nevertheless, out 14 DMOs from urban LGAs, 6 stated that the rate of women delivering in health facilities was excellent, and 6 stated that it was above average and 2 stated that it was average. On the other hand, out of 15 DMOs from periphery LGAs, 4 stated the rate was excellent, 8 stated that it was above average, 2 stated that it was average and 1 stated that it was below average.

The study also explored whether community members were aware of early childhood stimulation, and what it constituted. Early childhood stimulation, in the context of responsive caregiving entail the caregiver's appropriate feedback interaction when the child sends out behavioral signals (Rasheed & Yousafzai, 2015; Landry, et al., 2012). Findings from the FGDs indicate that the majority of grassroots institutional actors were not aware, while a few had heard of the concept but did not know what it entailed. The majority of FGD respondents were also with the view that the majority of community members do not know anything about early childhood stimulation.

6. ECD Coordination and Accountability Mechanisms

Due to the complex and diverse nature of ECD, Tanzania uses a multi-sectoral approach (MSA) in delivering ECD services. This approach entails a deliberate, integrated, and collaborative process, bringing together various stakeholder groups and sectors to establish interrelated goals and jointly achieve a policy outcome (**Subhash & Kumar, 2017**). Consequently, MSA is described as an approach, "...which can span across various ministries, government agencies, nongovernmental organizations, relevant stakeholders and other groups, with a common goal in addressing a particular issue" (**Amri et al. 2022:2**). However, to optimally achieve the desired goals, ECD services need to be timely delivered as a package **Berry, at al., (2013)**. This fact underscores an important recognition that beyond the inevitable need for a multisectoral approach through a variety of service delivery channels, coordination is critical. In this context coordination entail the alignment of early childhood services, interventions, and community resources to support a collaborative, cross-disciplinary, and cross-agency service delivery process for children in the early childhood phase and their families. Coordination therefore constitutes a crucial link of policies to intended ECD outcomes. The multisectoral nature of ECD services needs strong coordination and accountability mechanisms to attain effective package-wise services at the point of delivery.

6.1. Why is a multi-sectoral approach essential?

MoHCDGEC (2021:25), identifies ineffective coordination among ECD stakeholders as derailing progress towards the attainment of national ECD goals. There is inadequate coordination modalities to guide multisectoral coordination of nurturing care services, while "...each ECD related sector has its own policy that specifically guides the implementation of programmes/activities within the respective sector" (bid.). However, whereas programs, activities and interventions are designed and delivered sector-wise, the lives of children who are in the early childhood phase and those of their parents and/or families are lived holistically, not sectorally.

Access to ECD services has to be balanced across the key sectors because attaining one without the other does not optimally achieve the desired outcomes. Ideally, engaging multiple sectors and partners is meant to achieve collective ownership of a policy goal. It is also meant to establish mechanisms for leveraging knowledge, expertise, reach, and resources, to enable parties to benefit from their combined and varied strengths as they work toward the shared goal of producing better policy outcomes (**USAID, 2014**). A fundamental and ideal achievement of 'a multi-sectoral approach' is therefore to synthesise collective and complementing efforts towards ensuring quality ECD services are 'integrated', and equitably available and accessible at the point of delivery.

According to **MoHCDGEC (op cit: 60)**, the Tanzania NM-ECDP was developed and is "... designed to ensure all ECD related sectors are engaged by interlinking and integrating relevant actions, forums and structures to maximise provision of services and increase

access to reach all children irrespective of their status." The two most relevant coordination objectives the NM-ECDP is expected to deliver, include: one, "...strengthening of inter-sectoral coordination and ensuring the institutional capacity to coordinate ECD and authority to meet its mandate;" and two, "...strengthen partnerships and inter-sectoral coordination at national and sub national levels (ibid.)" Coordination is therefore essential to minimise the practice of ECD stakeholders working discretely, by enabling them to collaborate effectively, smoothly, efficiently and complementarily towards the attainment of national ECD goals.

6.2. Tanzania ECD Leadership, Management and Coordination Structure

This section briefly comments on the ECD 'Leadership, Management, and Coordination Structure' set-forth by NM-ECDP, in pages 60-61.

The National Master Plan for Early Childhood Development (NM-ECDP) assigns leadership and coordination of the plan to the Prime Minister's Office (PMO). However, it is unclear which specific department within the PMO holds operational responsibility. In addition, the NM-ECDP suggests integrating nurturing care components into existing committees, but this approach seems to be less effective than the more comprehensive ECD committees established in 2006.

The NM-ECDP encourages ministries to incorporate ECD components into their plans and allocate resources. However, it leaves unanswered how to effectively monitor and coordinate activities across ministries with potentially different priorities. The plan assigns regional and local government coordination to the President's Office-Regional Administration and Local Government (PO-RALG). Notably, the NM-ECDP emphasizes the need for collaboration between PO-RALG and the Police Department, especially the Children and Gender Desk, as well as the court system.

Finally, the NM-ECDP overlooks several ministries crucial for ECD service delivery, such as the Ministry of Agriculture for food security and the Ministry of Constitutional and Legal Affairs for legal frameworks related to child protection. This omission could downplay their roles in implementing the plan.

6.3. Tanzania ECD Delivery Coordination Levels

This section provides a concise overview of the key coordination levels and actors in Tanzania's delivery of ECD.

6.3.1. National Level: International Involvement

At the national level there are stakeholders from outside the country. Tanzania is a member of the United Nations (UN), the African Union (AU) and regional bodies such as the Southern African Development Community (SADC), and the East African Community (EAC). Equally noteworthy at this level are bilateral funds and agencies; international organizations, philanthropic organisations and INGOs.

Thus, Tanzania is party to various international agreements on ECD as a member of the UN, AU, and regional bodies like SADC and EAC, and through bilateral funds and agencies, international organizations, and NGOs. These agreements present a challenge in coordinating them into a cohesive national ECD strategy. Additionally, aligning programs and resources from various sources to achieve these goals is difficult because programs are scattered and lack a central tracking system.

Furthermore, these programs are often implemented by multiple agencies in specific regions, and funders may support the same ECD issue through various programs and agencies. This makes it difficult to determine the total investment in ECD and identify funding gaps. Mapping these programs and resources is crucial to ensuring coordinated and equitable efforts towards achieving ECD goals. The Prime Minister's Office (PMO) is best suited for international ECD coordination due to its authority, and the National ECD Coordinator needs access to comprehensive data to be effective.

6.3.2. National Level: Internal Scene

The National Level Internal Scene entails all key (rather than lead) ministries responsible for the attainment of national ECD goals. In 2023 the Government developed a Guideline for the coordination of the 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 (PJT-MMMAM) 2021/22-25/26*." The Guidelines explain clearly the coordination structure and delivery responsibilities of each key ministry and cascades down to regional and village/mtaa levels. Thus, Tanzania has a well-defined structure for coordinating ECD efforts at the national level. The Prime Minister's Office (PMO) oversees coordination, with a directorate specifically for ECD and a National ECD Coordinator at the Ministry of Community Development. Each key ministry has its own ECD coordinator, and important structures like Cabinet meetings and the NM-ECDP Executive Committee facilitate communication. However, the plan overlooks some crucial ministries, such as those for Public Service Management, Agriculture, and Legal Affairs. These ministries play vital roles in areas like social protection, food security, and child justice.

To improve monitoring and data collection, Tanzania has developed a National ECD dashboard and is working on a scorecard. These tools aim to provide a comprehensive picture of ECD interventions across various sectors. The national coordination structure is less effective at regional and local levels (LGAs) where ECD services are delivered in a sector-specific way, with each ministry (e.g., education, health) having its own approach. This fragmented approach undermines the national goal of integrated ECD services.

The issue persists at the community level (villages/wards). Ward and village leaders are designated as ECD coordinators, but they often lack awareness and training for this role. Consequently, there's a lack of collaboration between families, service providers, and agencies. Community Health Workers (CHWs) often fill the gap by providing information and guidance, but a more coordinated system is needed. Generally, Tanzania has a promising national ECD coordination framework, but significant challenges exist at regional, local,

and community levels. Investment in capacity building and improved collaboration across sectors and agencies is crucial to ensure a more integrated approach to ECD service delivery.

6.3.3. Child Protection Coordination: The Case of Women and Children Protection Committees

National Plan of Action to End Violence Against Women and Children in Tanzania (NPA-VAWC) (2017/18–2021/22), put in place the coordination structure to operate from the national to the local level. These include the National Protection Steering Committee (NPSC), NPA-VAWC National Protection Technical Committee (NPTC) and Thematic Working Groups (TWGs). The Plan guided that pre-existing committees focusing on violence prevention and response at the regional, district and community levels be merged and renamed as Women and Child Protection Committees. Some of the pre-existing committees which were to be amalgamated into the new committees include Child Labour Committees, the Gender Based Violence (GBV) Committees, District Child Protection Teams (DCPTs) and Most Vulnerable Children Committees (MVCCs). This report uses WCPCs to demonstrate some of the inherent coordination issues in the ECD services delivery.

Child Protection Committees have been in existence for several decades in Tanzania although their effectiveness has often not lived up to their potential (Mnzava, 2017). MVCCs were introduced as part of most vulnerable children programmes to build the capacity of communities to provide care, support, and protection to their most vulnerable children (Kessy, 2014:13). An important attribute of the establishment of MVCCs was that they were established at ward and village levels (ibid.). They were mandated with community-based identification of MVCs, and mobilisation of resources (Mamdani et al. 2009: 24). Studies found that some of the challenges that confounded MVCCs include, "...lack of intervention coordination, inadequate human and financial capacity, poor community participation, lack of commitment by government leaders, lack of follow up, and poor MVC data management." (Mmasa & Mbaula, 2016:10).

According to the National Guideline for Identification of Most Vulnerable Children and Linkage to Care, Support and Protection of 2017, councils and communities are obligated to identify and support MVCs with MVCCs playing a central role at the community level. The Guideline recognises the existence of MVCCs and directs the formation and capacity building of MVCCs "...should build on existing committees at each level" (p. 6). The Guidelines also instruct that MVC should be integrated in Council Plans and Budget.

There are two coordination issues which needs to be noted in the outset: First, while these Guidelines were developed a year after NPA-VAWC, they did not adhere to the concept of 'Women and Children Protection Committees (WCPCs),' and instead retained MVCCs. This has brought confusion on the ground. Some people believes these WCPCs and MVCCs are different committees; again, some actors recognise WCPCs, although less so, while others continue to use MVCCs. Second, this flags the question regarding the role of TASAF and Councils as far MVC are concerned, and underscores the coordination challenge in the dominant parallel/sectoral interventions programming approach.

The Guidelines place the Department of Social Welfare in collaboration with PO-RALG as the Ministerial level structure. This level has the responsibility to constitute and build the capacity of Regional Level MVC Facilitators. The regional level Facilitators are responsible to oversee, supervise and facilitate MVC identification in their respective councils. Below Regional Facilitators are Council Facilitators Teams which are oriented by the Regional Facilitators. Again, the role of CFTs is to oversee, supervise and facilitate MVC identification in the Council and respective wards. Below the CFTs, are Ward Facilitators Teams (WFTs) who are to be oriented by CFTs. Below the WFTs are village/mtaa MVCCs. These are trained by WFTs. The role of village/mtaa MVCCs is to facilitate identification of MVC in the entire village/mtaa; link MVC to care, support and protection as and when needed; then monitor, evaluate, document and report.

There are also Guidelines for the Responsibilities of Community Development Experts in Regional Secretariats and Local Government Authorities, i.e., "*Mwongozo wa Majukumu ya Wataalam wa Maendeleo ya Jamii Katika Sekretarieti za Mikoa na Mamlaka za Serikali za Mitaa*" of 2019 issued by the Directorate of Community Development of the MoCDGWSG. According to these Guidelines, one of the overall duties of community development officers is to build the capacity of community to deliver child rights and parenting responsibilities. This responsibility is cascaded to Community Development Officers at the ward and village/mtaa levels. For example, it is the responsibility of the ward level CDOs to promote the establishment and administration of Children's Councils at the ward and village/mtaa levels. At this level, also the Guidelines directs on the establishment of 'Child Development Desk.' This desk is responsible for overseeing, managing, and coordinating the implementation of child rights, delivery of parenting education at the family level and general child development.

Currently, the responsibilities of MVCCs are similar to the responsibilities of the Social Welfare Department, as stipulated in the Guidelines for the Responsibilities of Social Welfare Officers i.e., '*Mwongozo wa Majukumu ya Maafisa Ustawi wa Jamii.*' This results in an overlap of responsibilities instead of MVCCs being a structure that support social welfare officers. Of particular relevance are the responsibilities of social workers at the LGAs, which are postulated in 'Services for Families, Children and Early Childhood Care,' particularly under the 'Child Welfare Services' section. While in theory and professionally, the portfolio differences between social workers and community development officers are well laid out, in practice their distinct roles are blurry and there is often an overlap of roles. It is very challenging for CDOs and Social Workers to do their work to ensure child development and aim at actualising child rights with community level interventions and activities without stepping on each others' toes, often working with the same or similar partners, i.e., INGOs, NGOs, and IOs.

The study also learnt that, on top of MVCCs, and Child Development Desks, there are also Community Justice Facilitators (CJFs), and Community Case Workers (CCWs). However, the establishment of MVCCs, which are currently mostly referred to as WCPCs, and availability of CJFs, and CCWs is uneven and inconsistent, signalling a palpable coordination challenge. For example when asked whether in their regions there are Regional Women and Children Protection Committees, among the urban DSWOs, 9 said yes, while 7 said no; and among

the periphery LGAs, 7 said yes, 6 said no and 2 did not know. When asked whether there are District/Council Women and Children Protection Teams (DWCPTs), among the urban based DSWOs, 3 said yes, while 13 said no; while among the periphery LGAs, 13 said Yes, and 2 said no. On the other hand, when Officers in Charge of Gender Desk at the District level were asked whether there were District Women, Children Protection Teams (DWCPTs), among those based in urban LGAs, 8 said yes and 4 said no; while among those based in periphery LGAs, 12 said yes and 1 said no. There is an alignment between the responses of DSWOs and Gender Desk Officers from periphery LGAs, while there is clear inconsistency between DSWOs and Gender Desk Officers from urban LGAs.

With regard to the existence of Ward WCPTs, among DSWOs of urban LGAs, 11 said yes, 5 said no; among periphery LGAs, 9 said yes, 5 said no, and 1 did not know. On whether each mtaa/village has a WCPT, among the urban LGAs DSWOs, 8 said yes and 8 said no; while those from periphery LGAs, 9 said yes and 6 said no. On the other hand, when the Officers in Charge of District Gender Desks were asked whether there were women and child protection committees/teams in each village/mtaa, among those who based in urban councils 3 said yes, and 9 said no; while for those who are based in periphery LGAs, 5 said yes, 6 said no and 2 said they did not know. On whether there is an active relationship between the police gender desk and village/mitaa gender and child protection committees/teams, of the Officers in Charge of District Gender Desks based in urban LGAs, 9 said yes, and 3 said no; while among those based in periphery LGAs, 9 said yes and 4 said no.

On whether each village/mtaa has recognised CJFs, overall 8 DSWOs said yes, while 22 said no, and 1 did not know. On whether each street/village has a recognised/registered Lead Community Case Worker (LCCW), overall 14 DSWOs said yes, while 17 said no. Again, whether each village/street in the councils have registered/recognised CCWs, 20 DSWOs said yes, while 13 said no. Furthermore, on whether each village/street in the councils have registered/recognised Community Health Workers (CHWs), overall 20 DSWOs said yes, while 11 said no. How do we explain the variation across the country? CHWs for example are volunteers, who are given incentives from LGAs and projects. How do we explain their prevalence in some localities/LGAs and their scarcity or absence in others? This comes down to coordination challenges.

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Among other things, NM-ECDP was developed to address ECD coordination challenges. However, the impact of the parcelization of ECD services into sectors continues

unabated. This is a challenge because clearly we are not able to achieve coherence and complementarity. Of particular note is that, currently, the general feeling is that if certain ECD components are achieved, then we have delivered on ECD. This thinking assumes the sum of ECD stakeholders' activities constitutes the whole. ECD needs to be approached from a systems point of view, coordination meaning it achieves a network of unique, interlocking relationships, with discernible structural and communication patterns. This is necessary because to achieve optimum ECD outcomes for each child, ECD sectors and services need to be delivered with a high degree of interdependence, coherence and complementarity.

Conclusion

It has been unequivocally established that the emotional, social and physical development of young children has a direct effect on their overall development and on the adult, they will become. In that respect, ECD is an indispensable foundation for children's entire wellbeing; and it is essential for them to develop the intellectual skills and creativity necessary for them to realise their full potential and become productive adults. Thus, equitable early childhood policies and programmes are crucial to ensure universal quality early childhood development. 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 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 level regarding young children with disabilities. Most ECE infrastructures are not inclusive, and there are insufficient teachers adequately trained to facilitate IECE. Furthermore, there are insufficient 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. The study also found that there are clear rural/urban disparities in terms of availability of ECE facilities and enrolment of children with disabilities. Overall, there is very limited understanding of what constitute early childhood education. Most household and LGAs actors, consider the currently mandatory pre-school class to entail the entirety of ECE. The difference with creches and daycare services are unclear.

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 the 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 for their children.

The study also learnt that while LGAs are mandated with the responsibility to deliver ECD services, there is limited capacity for ECD budgeting at LGA levels, and uncertain and even uneven allocation of resources across ECD sectors. There are geographical and sector variations in ECD investment e.g., there is an indication that ECE, ECH and ECN are prioritised in investment over Child Protection and Social Protection. Furthermore, some ECD components are prioritised while others receive little attention. For example there is large scale investment in 'immunisation, Vit A drops, early childhood while very little is invested in 'parenting' or biofortification. This deprives parents/guardians of the knowledge of what to do to ensure that their children have the best possible start to life.

The study underscores the point that, evidently, while there is significant investment in ECD, at the same time there are glaring gaps that call for more investment. However, determining whether there is adequate, under or over ECD investment is a challenge in Tanzania because of the lack of readily available data on the cost of specific ECD interventions or ECD budget gaps. In addition, there are complex multi-financiers, multiple pathways and multilayers of ECD investments, across diverse sectors. As a result, there is a lack of clear guidance on the national priorities for ECD investment leading to inconsistent prioritisation. Overall, Tanzania does not have a specific ECD package with specific budget line allocations as ECD is embedded in blanket budget lines. As a result it has been challenging to identify what exactly is the budgeting for ECD programs and services, what are the gaps and what exactly should be financed.

Further, the study learned that private sector engagement is mostly as providers of ECE, ECH services and ECN products such as fortification and bio-fortification. It is however clear that the role of the private sector in ECD is currently not adequately documented. It is evident that the local private sector has the potential to, and is already playing a substantial role in the provision of ECD services. However, there is limited concrete, systematic engagement with the public and non-state actors.

The study also learnt that Government efforts to cascade ECD services to the grassroots level is showing positive results. There is evidence that to some notable extent ECD services particularly relating to ECH, ECE, and ECN are available and accessible at grassroots levels, with negligible rural-urban bias. The majority of HoHs affirmed that they can access most ECD services, although the quality of services is still wanting. Services provided at the household level, such as nutrition have been seen to be the most challenging of the services. Overall however, ECD services however are still not universal with some localities accessing such services while others are not. Furthermore, there is a clear unevenness with regard to the distribution and access across ECD sectors. Optimum impact will not be attained when a child gets one or two of the services while missing out on several others. Delivery of each ECD domain needs to be equitable for 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 seems to persist. There is little complementarity between ECD sectors which leads to uneven delivery of and access to ECD services. The study also learnt that parents/guardians and grassroots communities are not adequately engaged as the epicentre of ECD services. The theory of change grounded in attaining sustainable transformation necessarily requires that people are part of the process and are pioneers of change, as they themselves change. Instead of superimposing ECD services, or delivering them in a paternalistic manner, both public and private interventions should strongly endeavour to involve community members to be part of the deliberation on ECD issues, and to be a critical part of the solution.

Recommendations

Policy Recommendations

A thorough analysis of ECD policies, legislations, regulations, and guidelines has revealed that Tanzania ECD policy environment is rich. However, there are two glaring thorny issues. First, early childhood has no separate identity but is encompassed within the broad concept of childhood as a whole, thereby rendering largely invisible some specific early childhood development issues. Second, the policy environment is disjointed and needs to be synthesized. Thus, it is recommended that:

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

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

c) Revision of the Food and Nutrition Policy for Tanzania, 1992 (NFPT) to recognise and provide for early childhood nutrition.

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

e) Development of specific regulations and guidelines 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.

f) Amendment of the TFNC Act to ensure it provides on specific issues of nutrition. Currently it does not ensure production and utilisation of food in a manner that achieves and maintains adequate national levels of nutrition.

g) There is need to develop a compendium of ECD policies, legislations and regulations in Tanzania. This should be one document that summarises all they key policy documents related to ECD.

h) There is a need for preparation of a specific essential ECD services package in Tanzania. It is recognized that Tanzania has adopted and localized the Care for Child Development (CCD) package. However, the package can be revisited and broadened to ensure that it constitutes the basic mandatory ECD services in Tanzania. The Table below indicate the preliminary recommendation for such a package:

Domain	Specific Early Childhood Development Services and Rights
Pregnancy Package (Conception to birth)	• Family Planning Services • Maternal education involving both parents • Parenting training involving both parents • Antenatal Care • Mandatory HIV Testing and PMTCT services • Provision of Free Insecticide-Treated Bed Nets (ITNs) • Iron and folic acid supplements for pregnancy women • Nutrition counselling for pregnant women • Prevention and treatment of maternal depression, pre-eclampsia and eclampsia; sepsis etc;
Birth Package (0-6 months)	• Primary healthcare (PHCs) facilities adequately equipped with all components of prenatal care, birthing care, postnatal care and basic emergency obstetric care services. • Skilled attendance at delivery • Essential care for newborn babies • Early initiation of breastfeeding, within one hour of birth. • Birth registration • Continued exclusive breastfeeding from 0-6 months • Maternity and paternity leave and adequate care • Parenting training involving both parents
Early Childhood Health	• Education about early stimulation, growth and development • Free health services for children who are 5 years and below • Mandatory health insurance coverage for children above 5 years old • Water, Sanitation and Hygiene (WASH) (Access to adequate clean and safe water; adequate sanitation; handwashing with soap) • Safe family and play spaces • Routine and mandatory immunisation • Early stimulation and responsive caregiving e.g., care for child development intervention • Therapeutic Zinc supplements for diarrhoea • ECD corners at health facilities • Early identification of children with development deletes and early intervention/referral • Integrated management of childhood illnesses • Prevention of mother-to-child transmissions of HIV • Prevention and treatment to of malaria
Early Childhood Nutrition	• Appropriate complimentary feeding (age/health appropriate) • Safe diet • Adequate food • Nutrition security • Age appropriate diet • Food fortification • Food biofortification • Deworming • Salt iodisation • Micronutrient supplementation • Prevention and treatment of moderate and severe malnutrition

Early Childhood Education	• Creches • Daycare services, particularly community childcare, early childhood care, early learning materials and related development programs • Home-based childcare • Pre-primary education • Early primary education • Inclusive early childhood education • Parenting programs related to children's early learning
Early Childhood Safety and Security	• Birth certificate • Mandatory social assistance/cash transfer programmes for vulnerable pregnant women and under 8 year children/ households • Family care, foster care and institutional care • Delineation of child protection services in early childhood • Description of the scope of obligations that must be met to maintain child safe environments in ECE facilities and care services, in schools, and in households. • Measures related to prevention of, and response to, early childhood exploitation, abuse, neglect, harmful practices and violence. • Case management • Child friendly spaces • Parenting programs related to prevention and response to violence against children and other early childhood protection issues

Coordination Recommendations

Alignment across all stakeholders will increasingly move the country towards amalgamation of ECD interventions at the services delivery level. To attain a holistic approach in ECD, there is need for more investment in national level coordination to deliver:

a) Early childhood development is a relatively new concept and most actors do not comprehend exactly what it means. The Swahili version 'Makuzi na Maendeleo ya Awali ya Mtoto' still lacks social-cultural connotations to enable actors to fully understand its meaning at once. Development and vigorous dissemination of simplified versions of the concept are essential to ensure it enters into everyday conversation in professional, social and household settings.

b) There needs to be adequate dissemination of priority ECD guidelines, plans and action points particularly to LGAs, and community levels. E.g., there is need for quick and effective dissemination of the National Guidelines for Establishment and Management of Day Care Centers; National Guidelines for the Screening, Identification, and Assessment of Children/Learners with Special Educational Needs; The National Guidelines for Identification of Most Vulnerable Children and Linkage to Care, Support and Protection; etc. We have many instruments which if implemented will make a serious difference despite any policy or legislative gaps that may still exist. However, their dissemination, particularly at LGA, ward and mtaa/village level is very limited.

c) There should be specific ECD coordination capacity building of ECD coordinators at all levels, particularly at regional, LGAs and community levels. ECD related knowledge, attitudes and practices seem to be high at the national level but continue to wane as we move down the hierarchy to the household level. It is recommended that there should be capacity building and cascading of the national level integrated approach to the regional and LGAs level. Dissemination of guidelines, action plans and programs should be associated with effective capacity building and monitoring and evaluation. Most of the Guidelines identify institutional actors and describe their responsibilities, but there is limited training on how to deliver on those roles.

d) All levels of coordination should ensure there is a consistent understanding of what constitute ECD, its importance and prevailing national, LGA and village/mtaa gaps.

e) Clarification of a programmatic approach towards ECD service delivery, through cross-sector aligned prioritisation, planning, budgeting and implementation.

f) Documentation of the role of the private sector in ECD should be carried out and there should be systematic, concrete engagement of the sector, in partnership with NSAs and the public sector, both at the national and local government level.

g) Effective engagement of Early Childhood Parliamentary Group should be enhanced as it has a critical influencing role in the Parliament and in the constituencies.

h) Effective engagement of Development Partners ECD related Working Groups should be enhanced.

i) 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 should be developed. While the need for effective early childhood interventions is particularly urgent, standardised and accurate cost data are critical for the provision of quality ECD services at scale, in order to make the case for more and better investments.

Programmatic Recommendations

a) Advocacy for ECE and ECN to be declared as child rights in the country;

b) A project should be designed to model effective provision of Inclusive Early Childhood Education is essential. Currently, we lack a clear case study of what it means and what it takes to have community based inclusive early childhood education.

c) Design an intervention to enhance ECD investment at home. The family is the primary and first ECD services provider. Currently there are very limited effective efforts targeting parenting and ECD provision at the household level.

d) A community day-care centre model should be developed and disseminated to ensure there is consistency in establishment of community daycare centres.

e) Coordinate a multi-stakeholder approach to upscale the establishment of community day-care centres across the country - the current pace is slow and many children continue to miss out on ECE

f) Undertake ECD awareness creation and capacity building at LGA, Ward and Village/Mtaa level - For example the study noted that there were no designated budget lines for ECD related services at the LGA level, which made it difficult to identify specific ECD budgets. There is also a challenge in specifying what exactly constitutes ECD services, and disaggregating ECD specific interventions (ie., those that directly influence ECD outcomes) and ECD-sensitive interventions (ie., those that indirectly influence ECD outcomes). Capacity building on ECD budgeting is therefore essential at the LGAs levels.

g) Undertake a thorough assessment of IECE: This is because implementation and scaling up of disability-inclusive early childhood education (IECE) to support children with disabilities requires understanding of how specific approaches work in various contexts. This will also help identify the suspected low enrolment of children with disabilities, as well as the attrition rate post-enrolment. Issues such as teachers training, assistive devices, capacity development of education officers, issues related to transport of learners with disabilities, issues related to personal assistants, family support, and psycho-social support needs to be examined thoroughly.

h) Advocacy for ECD to be in the MTR Framework. Currently Tanzania is moving towards monitoring specific ECD indicators. It is therefore essential to have identifiable ECD budget lines, and clarity from the MoFP on how ECD should be articulated.

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