United Republic of
TANZANIA

The National Costed Plan of Action for Most Vulnerable Children

2007 – 2010
Department of Social Welfare
Ministry of Health and Social Welfare





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TANZANIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ARV	Antiretroviral drugs
ASRH	Adolescent Sexual Reproductive Health
AYA	Awareness Youth Alliance
BCG	Baccille Calmette Guerin
CDC	US Centers for Disease Control and Prevention
CHF	Community Health Fund
C-IMCI	Community IMCI
CMAC	Council Multisectoral AIDS Committee
COC	Continuum of Care
CORPS	Community-owned Resource Persons
CSO	Civil Society Organization
DSW	Department of Social Welfare
EGPAF	Elizabeth Glazer Pediatric AIDS Foundation
ELISA	Enzyme Linked Immunosorbent Assay
FBO	Faith-based Organization
GTZ	German Tanzania
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
IDC	Infectious Disease Clinic
IEC	Information Education and Communication
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illnesses
IPG	Implementing Partners Group
ITNs	Insecticide Treated Nets
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MSF	Medicines Sans Frontiers
MoLYDS	Ministry of Labour, Youth Development and Sports
MTER	Medium Term Expenditure Review
MVC	Most Vulnerable Children including orphans
MVCC	Most Vulnerable Children Committee
NCPA	National Costed Plan of Action
NGO	Non Governmental Organization
NSC	National Steering Committee
OVC	Orphans and Vulnerable Children
PACT	Private Agencies Collaborating Together
PEPFAR	US President's Emergency Plan Fund for AIDS Relief
PHAST	Participatory Hygiene and Sanitation Transformation
PLWHA	People Living with HIV/AIDS
PMORLAG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Prevention of Mother-to-Child Transmission
RAAAP	Rapid Appraisal, Analysis, and Action Planning
RCH	Reproductive and Child Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania AIDS Commission
TAHEA	Tanzania Home Economics Association
TEHIP	Tanzania Health Intervention Project
TFNC	Tanzania Food and Nutrition Center
U5MR	Under-five Mortality Rate
UNF	United Nations Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
VMAC	Village Multisectoral AIDS Committee
WFP	World Food Programme
WHO	World Health Organization
WMAC	Ward Multisectoral AIDS Committee
YFS	Youth Friendly Services

Foreword

Chronic poverty, social disintegration, and the HIV/AIDS pandemic have increased the vulnerability of Tanzania's children. Their basic need for care, support, and protection is not being met. Traditional safety nets provided by extended families and the community are also weak.

The Government of Tanzania recognizes their difficult circumstances, and has begun taking steps to respond to their plight. Through the National Costed Plan of Action for Most Vulnerable Children (NCPA), the government has identified intervention strategies that will have a direct impact on the lives and welfare of the country's most vulnerable children.

The NCPA includes recommendations for the smooth scale up of service delivery; guidelines for improved standards of care, support, and protection; and advice on how to harness essential resources. It provides an implementation strategy and a clearly defined monitoring and evaluation component. It also includes an estimated cost package.

The NCPA is a tool that will help produce results through clearly defined activities and targets, careful costing, and identification of actors responsible for implementation. The NCPA is relevant to the overall national response to most vulnerable children within the local Tanzanian context. It offers a multisectoral and standardized approach that can be applied at all levels. Its goals are attainable in a specific timeframe. All will work together to provide a better future for our nation's children.

Hon. Professor David H. Mwakyusa (MP)
Minister of Health and Social Welfare

January 2008

Acknowledgments

The National Costed Plan of Action for Most Vulnerable Children (NCPA) is a significant achievement that underlines the Government of Tanzania's commitment to helping the most vulnerable children (MVC) in our society.

The plan was developed through hours of consultative meetings with a committed group of local, national, and international stakeholders. Many have worked tirelessly to make this document a reality. Sincere appreciation to representatives from government ministerial departments and agencies, local government authorities, the Tanzania Commission for AIDS (TACAIDS), bilateral organizations, development partners, United Nations agencies, and international and local nongovernmental, faith- and community-based organizations.

Special thanks to members of the Task Forces on the Rapid Assessment, Analysis and Action Planning Process (RAAP) for Orphans and Vulnerable Children, who worked intensively and constructively on the process in 2004. The RAAP Report provided essential inputs for developing the NCPA.

Thank you, as well, to the United States government and the American people for the funding and technical support provided through Family Health International to produce this document.

Having developed the NCPA, the Government of Tanzania is strongly committed to its successful implementation. Children are the nation's future. All stakeholders have an obligation to participate in creating a better environment for their growth and development, and especially for their care, support, and protection. Again, we thank all stakeholders for working to achieve implementation of this plan.

Mr. Wilson Mukama
Permanent Secretary
Ministry of Health and Social Welfare

January 2008

Preamble

HIV/AIDS and severe poverty continue to threaten the well-being of Tanzania's children. Those children whose parents are infected often serve as caregivers for their parents and siblings. An increasing number of children are forced to drop out of school or go without essential services, while others are forced to engage in economic activities to contribute to the family's survival.

The eventual death of parents often subjects children to emotional distress and physical neglect. They may feel they lack love, care, and protection. Many are denied access to health, education, food, legal, financial and psychosocial services. They face stigmatization, social exclusion, deprivation, and discrimination. All sectors of society—including NGOs, community-based organizations, families, local governments, and international organizations—must combine efforts to mitigate the impact of HIV/AIDS on children.

The National Costed Plan of Action for Most Vulnerable Children (NCPA) is a four-year action plan (2007–2010). Through an analysis of the situation of orphans and most vulnerable children, the NCPA presents a framework of goals, strategies, and actions that will promote the survival, growth, well-being, development, and protection of most vulnerable children in Tanzania. The plan spells out the responsibilities of different stakeholders in achieving objectives within the required timeframe. It also recognizes and seeks to harmonize existing policies, strategies, and programs that in some way address MVC, including Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGPR), and the National Policy on HIV/AIDS.

Implementation of this plan requires that strategies and actions be integrated into the Medium Term Expenditure Reviews of government ministries and into the budgets of local government authorities. Households, communities, and civil society organizations must also continue to play a role. All stakeholders must recognize that an investment in orphans and most vulnerable children is an investment in Tanzania's future.

Executive Summary

Identifying the Most Vulnerable Children

Using data from the population census, a standard classification of most vulnerable children has been developed that incorporates demographic characteristics and indicators of poor living conditions. It includes the following children

- those living in child-headed households
- those living in elderly-headed households with no adult from 20–59 years-old present
- those with one or both parents deceased
- those with disabilities
- those in rural areas: children with one surviving parent living in a house with poor quality roofing (grass and/or mud) and those with a disability living in similar poor conditions
- those in urban areas: children with one surviving parent living in a house with poor quality roofing (grass and/or mud) or with poor wall materials or without toilet facilities and those with a disability living in similar poor conditions

The number of most vulnerable children in Tanzania Mainland was estimated to be close to 930,000 in 2006—5 percent of the child population.

This classification recognizes that not all orphaned children are most vulnerable, and it equally recognizes that children living with a parent can be most vulnerable. The number of children in Tanzania Mainland with such characteristics was estimated to be close to 930,000 in 2006—5 percent of the child population.

Census data can be analyzed to derive estimates of most vulnerable children. The district analysis shows that of the 20 districts where the percentage of such children exceeds seven percent of all children in the district, four districts are in Dodoma, four are in Singida, two are in Iringa, and two are in Mbeya. Districts where more than 10 percent of children are most vulnerable include Dodoma Rural (13.3 percent), Singida Rural (10.8 percent) and Manyoni (10.1 percent). Other districts with high numbers of MVC are Iramba (9.7), Bukoba Rural (9.2), and Kondoa (8.1). A combination of factors—including orphanhood and very poor living conditions—causes children in these districts to be the most adversely affected.

Estimating a Level of Support for MVC

The level of support that might be provided to MVC has been estimated under different scenarios. In the base analysis, the direct support costs per child are estimated to be the amount of money that would be needed to raise the average per child expenditure for the poorest children (those living in households with expenditures more than 30 percent below the very poor living conditions line) to the average level

of expenditures for children living at around the national poverty level. Costs have been calculated separately for children at different ages: pre-primary, primary school age, and 15 to 17 years-olds, and separately for rural and urban children. Since about 40 percent of the child population lives at or below the national poverty level, it is unlikely that the national program will be able to finance support for vulnerable children above this level. To do so would imply support for the most vulnerable at levels above the norm for most children in their communities.

Summary of NCPA by Strategic Priorities

STRATEGIC PRIORITY	TOTAL COSTS (US$)			
	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Policy and Service Delivery Environment	2,760,100	135,600	135,600	135,600
HOUSEHOLD AND CHILD-LEVEL CARE				
Providing food support (cash or in-kind)	10,973,685	11,223,210	11,691,734	12,143,552
Providing support for non-food goods and services (cash or in-kind)	3,648,461	3,738,906	3,903,326	4,060,249
Providing training to care givers on caretaking skills	480,000			
Subtotal Household and Child-level Care	15,102,146	14,962,116	15,595,060	16,203,801
Child Security and Protection	45,300	2,490,000	699,000	690,000
Psychosocial Support	4,483,200			
Plan Implementation Monitoring and Evaluation	935,000	161,000	61,000	161,000
Resource Mobilization	935,000	161,000	61,000	161,000
GRAND TOTAL	**39,362,892**	**32,871,832**	**32,146,720**	**33,555,202**

Introduction

TANZANIA, like other sub-Saharan countries, continues to be deeply affected by HIV and AIDS. The epidemic poses a threat to the country's economic and social development and has exacerbated the vulnerability of most children, their households, and communities. A rapid increase in the number of MVC in the country has necessitated development of workable interventions for scaling up protection, care, and support—that is, the NCPA.

The NCPA will serve as a reference tool for government and stakeholders in their efforts to improve the lives of MVC and promote the rights of children.

The NCPA will serve as a reference tool for government and stakeholders in their efforts to improve the lives of MVC and promote the rights of children. The thrust of the plan is to develop and implement safety net systems that will deliver multifaceted care and support at the household level. It puts forward a concrete work schedule, specifying stakeholder's responsibilities and providing a clear framework for the continuation, improvement, and scaling up of OVC interventions. Periodic monitoring and evaluation exercises will guide the quality and effectiveness of the response.

The plan is also indicative of Tanzania's determination to meet UNGASS goals on HIV/AIDS for OVC, specifically targeting articles 65, 66, and 67 (see key instruments outlining UNGASS goals); governments' added motivation to realize millennium development goals by 2015; and the AU agreement to ensure OVC universal access to essential services by 2010.

The NCPA is linked to the national multisectoral HIV and AIDS strategic plan and the national AIDS policy. It expands on the country's MVC responses with support from the government, UN agencies, bilateral organizations, international nongovernmental organizations, and civil societies. To date some noteworthy international and national initiatives include

- ratification of the International Convention on Rights of the Child of 1989 (CRC) and the African Charter on the Rights and Welfare of the Child and the ILO Convention no. 182 on the Worst Form of Child Labour of 1999
- review of Child Development Policy of 1996 to incorporate MVC issues
- amendment, review, and enactment of legislation that safeguards the welfare, care, support and protection of children; the Child Bill is in the drafting process
- review, amendment, and renaming of the *National Guidelines and Strategies for Care of Orphans* (1994) to *National Strategies for Community Based Care, Support and protection of Orphans and Vulnerable Children*

- conducting in 1999 of a situational analysis of orphaned children in six districts (Bagamoyo, Makete, Magu, Karagwe, Musoma rural and Kisarawe)
- development of the *Early Childhood Development Program* for children 0–8 years with an emphasis on vulnerable children
- development of national guidelines for institutional care and support of MVC/OVC, aimed at providing standards for care and support of MVC/OVC living in institutions
- development of training manuals on parenting and community justice facilitation
- formulation of *National Policy on HIV/AIDS*
- development of the *National Plan of Action for Children for Tanzania* as an outcome of the "World Fit for Children" agenda agreed to at the 2002 UN-General Assembly Special Session for Children

The NCPA draws on the experience and outcomes of all significant responses to MVC in Tanzania. It was developed following the Rapid Assessment, Analysis and Action Planning Process (RAAAP), an exercise that contributed to identifying MVC interventions and formulating a framework for development of the plan. The Department of Social Welfare lead development of the NCPA in partnership with other stakeholders such as TACAIDS, UNICEF, WFO, UNAIDS, civil society organizations, and other government agencies. Resources were provided by the US government with additional leadership from Family Health International. Consultation with community, district, national and cross-sectional stakeholders has taken place to ensure maximum participation.

The NCPA will be implemented over a four-year period (2007–2010) following the development of concrete annual plans determining priority areas for MVC interventions in the districts.

Vision, Mission, Goals, and Objectives of the NCPA

Vision

To see Most Vulnerable Children (MVC) grow and develop to their full potential.

Mission

The NCPA will guide the implementation and expansion of interventions designed to enhance protection, care, and development of children, within the framework of a well-coordinated national response program. The program will be community-based, led by the central government, and supported by local government councils.

Goal

The goal of the NCPA is to scale up the national response to MVC, building on previous and existing experiences in reaching more MVC, with more services over a longer period of time by 2011.

Objectives

To ensure that MVC in Tanzania are protected from harm and receive access to essential services

To realize these objectives, the NCPA focuses on the following six thematic areas:

i. **Policy and Service Delivery Environment**

   Partners should carefully coordinate activities with one another, linking programs and mobilizing resources in a way that is most effective. Communities should be mobilized and their capacity built so MVCs can be identified early. Local authorities and communities should participate in the care, support, and protection of MVC, developing coordination mechanisms for MVC programs at the district level. This would include development of policies and guidelines focusing on MVC issue.

ii. **Household and Child-level Care**

   The basic or "core" needs of children and youth must be met to ensure their current and future wellbeing. Their basic needs include food and nutrition and non-food needs such as shelter and care, protection, health care, psychosocial support, education, and economic strengthening.

iii. **Protection and Security**

   Stigma and social neglect faced by MVC must be addressed, as well as all forms of child abuse and exploitation, including child trafficking, child labor, and commercial sex. It also aims to ensure succession of property to MVC.

The goal of the NCPA is to scale up the national response to MVC, building on previous and existing experiences in reaching more MVC, with more services over a longer period of time by 2011.

iv. Psychosocial Support

Fear, grief, trauma, and stigma faced by children must be addressed. The continuity of social relationships of MVC and their caregivers should be ensured. Children should receive love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination.

v. Measuring the Process

The progress of NCPA implementation should be monitored and evaluated. The quality of MVC responses should be evaluated and intervention effectiveness should be assessed. Outcomes should be evaluated (i.e. Have NCPA activities achieved their intended outcomes for MVC and the community?)

vi. Resource Mobilization

Adequate resources must be available to ensure effective and sustainable implementation of the NCPA.

Institutional Arrangements at the National Level

The Ministry of Health and Social Welfare

At the national level the Ministry of Health and Social Welfare (MOHSW) has overall responsibility in coordinating issues related to the welfare of MVC, undertaken by different stakeholders from the national to the community level. At the national level, the MOHSW will coordinate activities relating to the welfare of MVC supported by other central government ministries to ensure harmonization. They will need to develop mechanisms to promote transparency between key government ministries dealing with children's welfare—especially in regard to their current plans, budgets, achievements, and constraints.

At the national level the Ministry of Health and Social Welfare has overall responsibility in coordinating issues related to the welfare of MVC.

National Steering Committee for MVC

At the national level the coordination structure and management consists of a steering committee and a national technical committee. The aim of the steering committee is to ensure transparency, efficiency, and partnership in efforts to respond to the needs of MVC. The main functions of the steering committee include the following

- to ensure that government policies and plans conform with the International Convention on the Rights of the Child (1989), the African Charter Protocol on the Rights and Welfare of the Child (1990), the ILO Convention No. 182 (2001) on the Worst Forms of Child Labour
- to ensure there is mainstreaming of support for MVC in relevant government policies, development strategies, and programs in all government ministries, departments, and agencies at all levels
- to ensure adequate resources are allocated for MVC activities in all government ministries, departments, and agencies that support MVC
- to review and approve plans of action prepared or proposed by the Technical Committee for MVC
- to ensure effective coordination of all activities undertaken by stakeholders dealing with MVC

The National Steering Committee for MVC is permanent and led by the government. It has representatives from key government ministries and agencies. Local and international nongovernmental organizations and representatives from the donor community are invitees to attend committees meetings. The steering committee is chaired by the Permanent Secretary of the Prime Ministers office and meets twice each year.

National Technical Committee for MVC

The National Technical Committee for MVC is responsible for providing technical advice regarding care, support, and protection of MVC. The National Technical Committee helps and advises the National Steering Committee. It is composed of senior government officials from key sectoral and line ministries dealing directly or indirectly with MVC and includes representatives from both local and international NGOs. The National Technical Committee is also responsible for ensuring implementation of instructions from the National Steering Committee.

Figure 1. Coordination and Management of the MVC Response

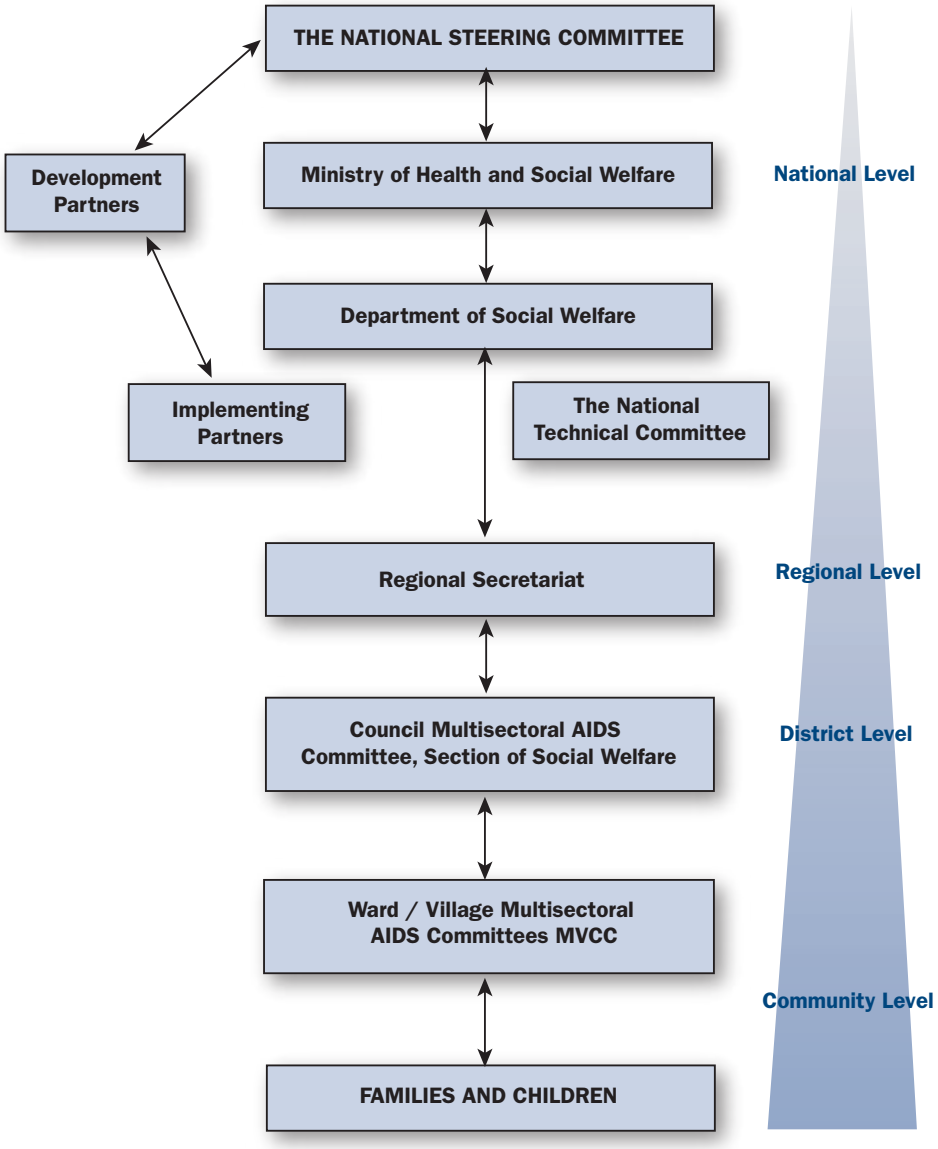
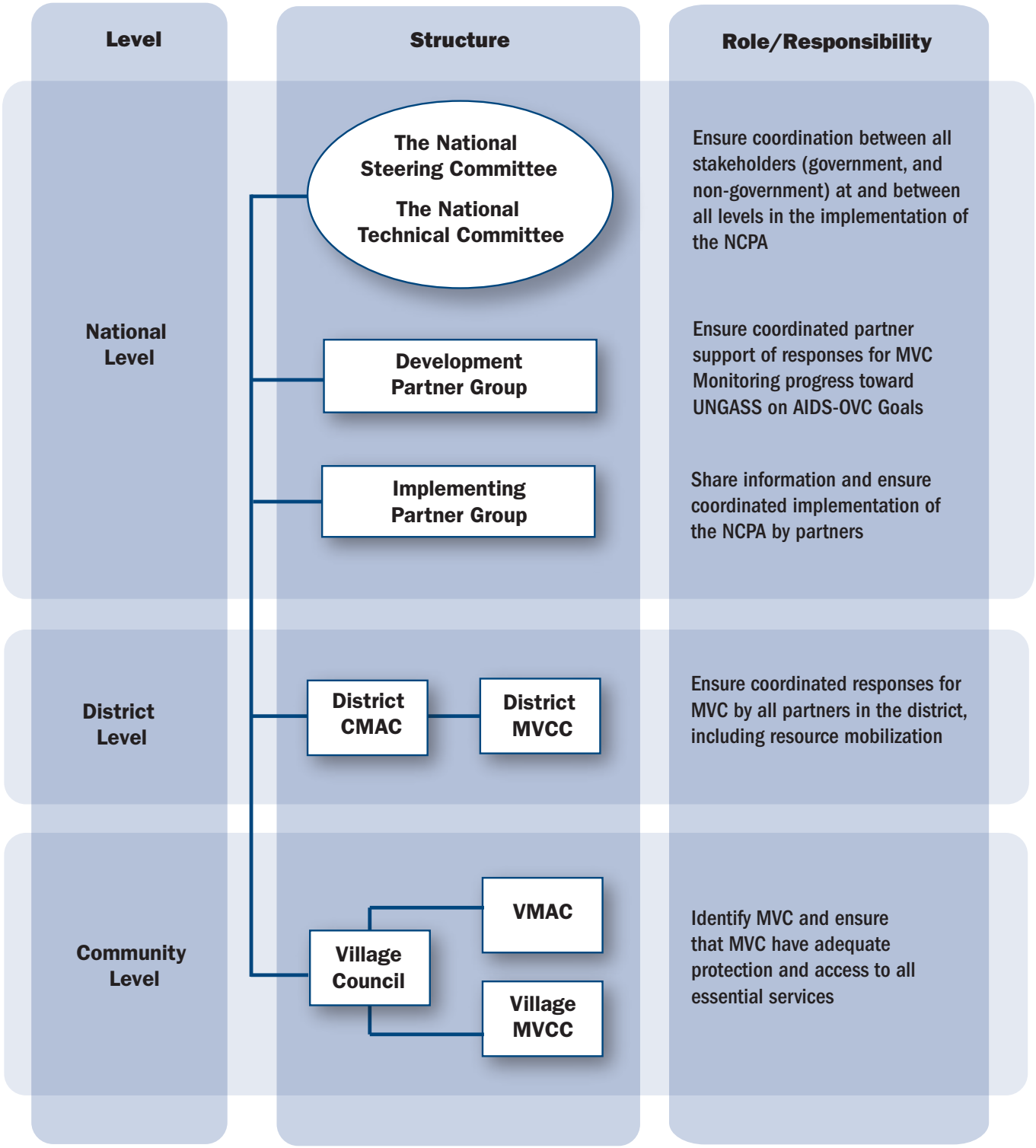


Figure 2. Institutional Arrangements



Coordination at District and Lower Levels

No new independent structure is proposed at the district and lower levels. MVC issues will be coordinated by existing structures.

- At the Council level, the Council Multisectoral AIDS Committee (CMAC) will be expanded to function as the District MVC Coordinating Committee by incorporating the social welfare officers responsible for the care, support, and protection of MVC.
- At the Ward level, the Ward Multisectoral AIDS Committees (WMAC) shall be expanded to function as the Ward MVC Coordination Committee by incorporating the Chairpersons and Secretaries of the Village MVC Committees.
- At the Village level, the Village AIDS Committee (VMAC) shall be strengthened to function as the Village MVC Coordination Committee by incorporating the Village MVC Chairperson and Secretary.

Coordination and Management of Non-State Actors

The Ministry of Health and Social Welfare will be responsible for coordinating non-state stakeholders involved in issues relating to the provision of care, support, and protection of MVC in the country. These stakeholders undertake their objectives and activities in various programs with support from a wide range of development partners and NGOs, both local and international. It is the ministry's responsibility to ensure that programs undertaken by other stakeholders conform to the guidelines outlined in the NCPA.

The Process

The NCPA has been developed in response to the need to scale-up responses for the most vulnerable children in the country. The process started with the Rapid Assessment Analysis and Action Planning (RAAAP) in 2004. It was followed by the design and development of the NCPA in 2005–2006. Both RAAAP and NCPA were developed in partnership with stakeholders who were involved through a consultative process and through a series of stakeholders' workshops in July 2006. The document was submitted to the technical team. It was updated by the technical team and stakeholders from 2006 to July 2007.

Identifying the Most Vulnerable Children

Conceptually, a vulnerable child is one who is living in high-risk circumstances whose prospects for continued growth and development are seriously impaired. In the international community, the term "Orphans and Other Vulnerable Children," or "OVC" sometimes refers only to children with increased vulnerabilities because of HIV/AIDS. At other times it refers to all vulnerable children, regardless of the cause of their vulnerability (e.g. chronic poverty, armed conflict, famine).[1] This definition falls short of capturing the children who are most at risk and in critical need of support.

1. PEPFAR, *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners: The President's Emergency Plan for AIDS Relief Office of the US Global AIDS Coordinator,* July 2006.

The government of Tanzania, together with development partners involved in MVC issues, has coined an operational definition for programming responses for the most vulnerable children (MVC)—that is, those most in need of services in the following way:

A ***child*** is any person below the age of 18.

An ***orphan*** is a child who has lost one or both parents.

A ***most vulnerable child*** is a child who experiences any of the following conditions:

- lives in extreme poverty
- is affected by a chronic illness and lacks adequate care and support
- lives without adequate adult support (e.g., in a household with chronically ill parents; a household that has experienced a recent death; a household headed by a grandparent; and/or a household headed by a child)
- lives outside of family care (e.g., in institutional care or on the streets)
- is marginalized, stigmatized, or discriminated against
- has disabilities and lacks adequate support

Using data from the *National Population Census and Household Survey of 2002*, a standard classification of most vulnerable children has been developed. It incorporates demographic characteristics and indicators of poor living conditions. It includes the following

- children living in child headed households
- children living in elderly households with only adults above 59 years
- children with one or both parents deceased
- in rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar poor conditions
- in urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without a toilet and children with a disability living in similar poor conditions

The most reliable criteria for the identifying MVC is derived from the community based participatory definition process. This classification recognizes that not all orphaned children are most vulnerable. It equally recognizes that children living with a parent can be most vulnerable. The number of children in Tanzania Mainland with such characteristics was estimated to be close to 930,000 in 2006—about 5 percent of the child population.

Estimating Level of Support for Most Vulnerable Children

As stated previously, the level of support that might be provided to MVC has been estimated under different scenarios depending on the level of expenditure desired. In the base analysis, the direct support costs per child are estimated to be the amount of money that would be needed to raise the average per child expenditure for MVC (those living in households with expenditures more than 30 percent below the poverty line) to the average level of expenditures on children living at about the national poverty level. Costs have been calculated separately for MVC at different ages (0–6 years, 7–14 years, 15–18 years), and separately for rural and urban MVC. Since about 40 percent of the child populations live at or below this level, a national program could finance support for MVC above this level, and to do so would imply support for the most vulnerable at levels above the norm for most vulnerable children in their communities.

Key Thematic Areas and Plan of Action for MVC

Policy and Service Delivery Environment

An effective policy and service delivery environment is a critical element in addressing comprehensively the complex needs of MVC. MVC issues are wide ranging. Addressing them requires joint multisectoral approaches and policy interventions. Coordination between partners (i.e. central government ministries, departments and agencies; local governments; civil society organizations; faith based organizations; and bilateral, multilateral, and UN agencies) will enable effective and coordinated resource mobilization and program linkages in the process of scaling-up of responses for MVC. Effective policies and programming for MVC are necessary for coordination between government ministries, departments, and agencies in clarifying and harmonizing their roles.

Delivering comprehensive support to MVC requires the strengthening of response systems at the community and local government level and/or establishment where they do not yet exist.

Effective scale up of responses requires building up and/or strengthening the capacities of the existing structures and networks that support healthy child development to gather, share, and use information, and to develop policy and program responses that lead to comprehensive and effective care for MVC. More important, delivering comprehensive support to MVC requires the strengthening of response systems at the community and local government level and/or establishment where they do not yet exist.

In addition, integration and linkage of services is important for enabling provision of a comprehensive package of services to MVC that meet several needs simultaneously. Fostering linkages of MVC responses by various government ministries, departments, and agencies is a crucial aspect of scaling-up MVC responses. It ensures adequate protection and universal access to essential services. Integrated or linked MVC responses have better chances for realizing greater response outcomes than the outcomes of individual responses or services.

Steps in this direction are already gaining momentum. Tanzania is currently implementing the National Strategy for Growth and Reduction of Poverty (NSGRP), which provides for a multisectoral approach to addressing vulnerability to poverty and other risks, including HIV/AIDS. Sectoral ministries have reviewed their policies and developed strategic plans to align their activities toward the realization of the NSGRP and Millennium Development Goal (MDG) targets. Ensuring children's access to essential services is essential to all policy documents and government directives. Coordination is being strengthened to enhance integration, linkages, and synergies in the implementation of various policies and government directives with respect to MVC.

Coordination mechanisms have been established to help implementing partners work together effectively and realize integration and linkages of MVC responses. At the national level, coordination space has been created through establishment of the National Steering and Technical Committees. The steering and technical committees

meet bi-annually and quarterly respectively. A system of MVC committees has been established at the local government and community levels. These committees bring together various stakeholders involved in MVC responses. Effectiveness of these committees depends on their ability to hold meetings and represent all stakeholders in the committee meetings.

Active involvement of people at the community level is important for the success of efforts to scale-up MVC responses. Social mobilization, advocacy, and enhancement of community participation are important elements of MVC responses programming. Implementing partners realize the importance of increasing the involvement and participation of communities in action surrounding issues that affect MVC, their households, and communities.

Policy and Service Delivery Environment

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE 1: To ensure coordination between all stakeholders at all levels in responding for MVC, including central and local governments, development partners, civil society, and the private sector				
Holding biannual Steering Committee Meetings	National Steering Committee	National level	Biannually 2007 to 2011	Number of meetings held and members attended
Holding quarterly Technical Committee Meetings	National Technical Committee	National level	Every quarter 2007 to 2011	Number of meetings held and members attended
OBJECTIVE 2: To share information with regard to issues and responses for MVC implemented by government ministries, departments, agencies, and other implementing partners				
Producing monthly implementing partner updates for MVC	Implementing partners and MDAs	National level	Every month 2007 to 2011	Number of updates for MVC in place and number of meetings held
Producing, printing, and distributing a quarterly MVC newsletter to stakeholders, including members of parliament	Implementing partners	National level	Quarterly 2008 to 2010	Number of newsletters distributed to stakeholders quarterly
OBJECTIVE 3: To strengthen existing MVC response systems (MVC Committees) and establish the systems where they do not yet exist				
Providing technical support to councils CMACs (Most Vulnerable Children Committee) to improve coordination of MVC issues	Councils	Council level	2007 to 2011	Number of councils supported with technical capacity-building
Scaling up MVC response systems in the councils where they don't exist	Ministry/councils	Ministry/ council level	2007 to 2011	Number of MVC identified Number of councils with MVC response systems established

Initial MVC responses laid the foundation for effective social mobilization. These included establishment of a response system that links councils with their communities. The response system has fostered working arrangements between key community agencies, including civil society organizations, nongovernmental organizations, community-based organizations, and faith-based organizations. The system has also facilitated establishment of partnerships with the private sector to fund community-based initiatives to respond to MVC, although coverage is still limited to a few districts. The aim is to cover the entire country with response systems.

Advocacy has been used successfully to mobilize responses for MVC at national and local levels. Advocacy has helped raise awareness among policy makers on the need to scale-up responses for MVC. It has influenced attitudes and increased community

Policy and Service Delivery Environment *continued*

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
Developing councils' strategic plans to implement the councils' MVC Plan of Action	Councils	Council level	2007 to 2011	Number of councils with strategic plans for implementation of the councils' MVC plan of action
OBJECTIVE 4: To advocate and ensure that actions are taken to guarantee MVC protection and access to essential services				
Conducting sensitization session for key government leaders at regional and district levels	MoHSW, regional and district	Regional and district levels	2007 to 2011	• Number of sensitization session held • Number of regions/ districts sensitized • Number of leaders sensitized
Organizing awareness fora at the community level by councils on protection and services to MVC	Councils	Councils level	2007 to 2011	Number of awareness fora held
OBJECTIVE 5: Quality assurance of responses to MVC				
Developing and reviewing existing policies; amending and enacting laws to ensure the rights of MVC are protected	MoHSW and line ministries in collaboration with stakeholders	National level	2007 to 2011	Policies developed and reviewed; laws amended and enacted
Developing and reviewing existing technical guidelines, training manual, and job aides	MoHSW and line ministries in collaboration with stakeholders	National level	2007 to 2011	Technical guidelines, training manual, and job aides reviewed and developed

support. Advocacy has been especially instrumental in encouraging provision of food and non-food materials to MVC and in ensuring that MVC have access to essential services. Advocacy will continue to facilitate the involvement of non-state actors—especially nonprofit organizations. It will make it possible to reach more councils that are inadequately covered by existing MVC programs.

Furthermore, community participation is crucial to the success of MVC responses programming. Ongoing responses for MVC are a testimony to best practices for effective community involvement and participation that have been realized by supporting interventions that build the capacities of families and communities in making informed decisions on who needs, what type of care, and how best to provide it. The established MVC committees at the community level have facilitated involvement of community members in designing, implementing, monitoring, and evaluating activities for MVC responses. This has enhanced ownership of the program and the likelihood that responses systems will be sustainable over time. The involvement of members of the community has allowed use of local resources (i.e., skills, knowledge and experience) to design and develop local strategies to respond to MVC issues. This approach has helped provide more relevant and effective responses for MVC and their caregivers.

Policy and Service Delivery Environment Activity Costs

ACTIVITIES	INPUT DESCRIPTION	MEASUREMENT UNIT	QTY/ UNITS	FRQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE 1: To ensure coordination between all stakeholders at all levels—central and local governments, development partners, civil society, and the private sector in responding for MVC									
Holding biannual Steering Committee Meetings	Meeting package per committee member covering costs	Number of committee members	20	Biannually	50	2,000	2,000	2,000	400
Holding quarterly Technical Committee Meetings	Meeting package per committee member covering costs	Number of committee members	30	Quarterly	50	6,000	6,000	6,000	600
			30	Monthly	20	600	600	600	600
OBJECTIVE 2: To share information with regard to issues and responses for MVC implemented by government ministries and departments, and other implementing partners									
Producing monthly implementing partner updates for MVC	Meeting package per implementing partner covering costs	Implementing partner updates	1	12 (Annually)	100	1,200	1,200	1,200	1,200

* IN US$

Policy and Service Delivery Environment Activity Costs *continued*

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FRQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
Producing, printing, and distributing a quarterly MVC newsletter to stakeholders, including members of parliament	Overhead costs (content collection, layout, design, printing, and distribution)	MVC newsletter	400	2	10	8,000	8,000	8,000	8,000
OBJECTIVE 3: To strengthen the existing MVC response systems (MVC Committees) and establishing the systems where they are not yet existing									
Providing technical support to councils CMACs (MVCC) to strengthen coordination of MVC issues in the Council	Travel costs for Department of Social Welfare (DSW) technical staff	Councils	132	1	400	52,800	52,800	52,800	52,800
Scaling up MVC response systems in the councils where they don't exist	Lump sum cost for introducing or implementing systems in the DSW/councils	Local governments/ councils	71	1	40,000	2,440,000 (61 districts councils)	440,000 (11 districts)		
Developing councils' strategic plans to implement the councils' MVC Plan of Action	Meeting Package per councils covering costs	Number of council staff/ consultants		1	250	2,500			
Providing technical support to councils CMACs (MVCC) to strengthen coordination of MVC issues in the Council	Travel costs for Department of Social Welfare (DSW) technical staff	Councils	132	1	400	52,800	52,800	52,800	52,800
Scaling up MVC response systems in the councils where they don't exist	Lump sum cost for introducing or implementing systems in the DSW/councils	Local governments/ councils	71	1	40,000	2,440,000 (61 districts councils)	440,000 (11 districts)		

* IN US$

Policy and Service Delivery Environment Activity Costs *continued*

ACTIVITIES	INPUT DESCRIPTION	MEASUREMENT UNIT	QTY/ UNITS	FRQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
Developing councils' strategic plans to implement the councils' MVC Plan of Action	Meeting Package per councils covering costs	Number of council staff/ consultants		1	250	2,500			
OBJECTIVE 4: To advocate for and ensure that actions are taken to guarantee MVC protection and access to essential services									
Conducting sensitization session for key government leaders at regional and district levels	Meeting costs per regionand district	Number of participants per regional and/or district	50	83 districts	15	18,675	18,675	18,675	18,675
Organizing awareness fora at the community level by councils on protection and services to MVC	Travel cost for council staff	Number of staff responsible/ council	83 districts	20 wards	200	332,000	332,000	332,000	332,000
OBJECTIVE 5: Quality Assurance of Responses									
Developing and reviewing existing policies; amending and enacting laws to ensure the rights of MVC are protected	DSW/key ministry staff/ consultancy	Work days	40	1	300	12,000			
Developing and reviewing existing technical guidelines, training manual, and job aides	DSW staff/key ministry staff/ consultancy	Work days	60	1	300	18,000			
Overhead cost and workshop package for participants to review materials and guidelines	Workshop participants	Work days	60	4	300	72,000			

* IN US$

Policy and Service Delivery Environment Activity Costs *continued*

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FRQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
Printing and distribution, and training of implementers	A package of implementation guidelines, training curricula, and job aides for implementing partners	Work days	2,000	1	40	80,000			
TOTAL COSTS						2,760,100	135,600	135,600	135,600

* IN US$

Objectives of the Policy and Service Delivery Environment

The objectives of a multisectoral policy intervention and collective and effectively coordinated service delivery environment are

- to ensure coordination between all stakeholders at all levels (central and local governments, development partners, civil society, and the private sector in responding for MVC)
- to share information with regard to issues and programs for MVC
- to strengthen existing MVC response systems (MVC committees) and establish systems where they do not yet exist
- to advocate for and ensure that actions are taken to guarantee MVC protection and access to essential services
- to mobilize and disburse resources for the implementation of the MVC National Plan of Action

Household and Child-level Care

The majority of MVC in Tanzania are cared for by relatives. In most cases the caregivers are poor. Consequently, meeting the core needs of MVC at the household level remains a challenge. MVC face two broad categories of needs that call for intervention. First, MVC have inadequate access to basic "core" livelihood needs. These include food and nutrition, shelter and care, protection, health care, psychosocial support, education, and economic support. Second, MVC face difficulties related to child rearing and individual child security and protection. Comprehensive interventions are required to address these core needs and ensure that all MVC have access to comprehensive and quality support packages regardless of the funding source or implementing partner.

Household level care is crucial in scaling up the response for MVC because wellbeing and optimum development of children can only take place if their core livelihood needs are supported. The NCPA suggests two specific areas that must be supported if the wellbeing and livelihood of MVC are to be improved: (i) food and nutrition and (ii) non-food support, which includes shelter; clothing, bedding and other household equipment and necessities, health care, educational and vocational training, and economic capacity strengthening.

Food and Nutrition

Access to adequate food and nutrition is crucial for children's physiological and emotional development. Guaranteeing household-level food security is important for ensuring healthy growth of MVC. According to the MVC response review carried out by TACAIDS in February 2004, after education, caregivers and community leaders mentioned food as the second major problem they face. Children often mention their need for food before they mention education. Insufficient food remains a significant issue in rural areas, although it may be even more difficult to meet the nutritional needs of those in the urban areas who are less likely to have land to cultivate. Food and nutrition are fundamentally intertwined with HIV transmission and the impacts of HIV/AIDS. In communities, food insecurity and malnutrition may increase vulnerability to the impact of HIV/AIDS. In child-headed households, where there are no adults with intimate knowledge of local farming systems, the food situation is believed to be much worse.

Nutrition in families is linked to food insecurity. Most respondents identified food as a basic requirement for the children in households, and indicated food shortages in households and communities affected. One can infer that MVC are likely to be affected by malnutrition much more than non-MVC. Many NGOs and CBOs help with intermittent distribution of food relief to families in areas where they operate. The *2000/2001 Household Budget Survey* established that over 35 percent of households were at risk of not meeting their basic needs. Nearly 20 percent of the households were below the food poverty line.

Shelter

Shelter is one of the most important and urgent needs of MVC. The magnitude of MVC needs for shelter varies from household to household and from place to place depending on the economic status of the household and location (i.e. rural versus urban). Shelter needs of MVC households can be categorized into the following groups:

- those who do not have shelter at all and are not capable of constructing any due to their age, physical disability, and/or economic status
- MVC who have shelter but of poor quality, requiring replacement and/or major upgrading
- MVC who have shelter that needs repairs and maintenance to improve its habitability
- MVC who live in rented shelter in urban areas and are not able to meet the cost of monthly rent

Required responses include

- strengthening community-based support for shelter (e.g., strengthening family-based care provided by extended family members; repairing and maintaining houses with MVC; building low-cost shelter)
- promoting innovative community responses to provide care in personalized settings when family options are not available, especially in urban areas (e.g. live-in schools, drop-in centers)

Clothing, Bedding Materials, and Other Household Equipment and Necessities

Sustainable access to basic household materials and facilities is important for the wellbeing of MVC. MVC need descent clothing and shoes, bedding materials, cooking facilities and utensils, water storage buckets, and other household items like soap; energy for cooking; and lighting, including firewood, charcoal, kerosene; and/or electricity for MVC in urban areas. Unfortunately, most MVC experience dire shortages of these essential items and often have to make do with very little.

Health Care

Through the Ministry of Health and Social Welfare, the government provides for preventive and primary health care needs of children. The government provides free access to health care services for those under five, free immunization for all children, and subsidized malaria prevention (bed-nets). Prevention and ART treatment for HIV infection is also important for MVC. The government in partnership with others provides access to free Prevention of Mother-to-Child Transmission (PMTCT), and offers other measures for preventing HIV/AIDS and STD transmission among adolescents.

However, it is difficult for MVC to access even the freely provided health care because they lack money to meet the associated extra expenses. This includes an inability to meet transport costs to the nearest health care provider. Besides difficulties buying prescribed medicines from pharmaceutical shops, a lack of funds often prevents MVC and their caregivers from joining the Community Health Fund in communities where it has been introduced.

Active measures are needed to ensure that MVC have access to essential health services provided by the government, nonprofit organizations, and the private sector. This includes supporting and ensuring that caretakers bring MVC to a clinic for health care and providing financial support to MVC to enable them to access services.

Education and Vocational Training

Securing MVC access to primary and secondary education as well as livelihood training for children affected by poverty and HIV/AIDS is important for building their capabilities and resilience. Through the Ministry of Education, the government has recognized the importance of education in fighting poverty and vulnerability. Measures taken to secure MVC access to school include abolition of primary school fees and provision of scholarships for secondary and tertiary education.

However, MVC face additional constraints that prohibit them from attending school regularly and remaining in the formal education system. This includes care-taking responsibilities—especially those in child-headed households and or those in households with elderly and critically ill parents or caregivers. MVC also often have difficulties affording required educational materials and school uniforms. The former could be addressed through community-mobilization efforts to keep MVC in school and/or to provide them with educational alternatives through the established MVC response systems. The latter could be addressed through provision of financial educational support, in-kind or financial, to the MVC to meet additional educational costs.

Capacity Development for MVC, Their Households, and Communities

Capacity development for MVC refers to the enhancement of the ability of concerned individuals, households, and communities to respond to their plight and continue with minimum disruption. It also refers to the enhancement of the capacity of MVC and households caring for MVC to access and use the various forms of care and support that may be provided. Families are the best hope for the care of vulnerable children, but they require additional support to meet children's immediate survival and longer-term development needs. Members of the community and families need a combination of economic, material, and psychosocial support measures to help those affected by HIV/AIDS to live longer, better, and higher quality lives. Building the psychosocial and economic capacity of MVC households and communities is an essential component of any strategy to scale up the national MVC response.

Socio-Economic Capacity Building

Socio-economic capacity development constitutes interventions at three levels: child-level, household-level, and community-level.

Child-level Interventions

A child is enabled, through his or her own capacities, to act on his or her own behalf to learn, integrate socially, and adapt to local circumstances. Socio-economic strengthening interventions directed toward children should complement rather than replace other programs, such as those that provide education and psychosocial support. Economic strengthening interventions that serve children directly include vocational training, apprenticeships, formal education, income-generating activities, microfinance services, and legal support.

Household-level Interventions

Children's survival, development, safety, and well-being depend primarily on the household in which they live. The household/family safety net provides belonging and emotional support. Common economic interventions at the household level include creation of market-linkages, financial grants, and credit, labor-saving techniques, advocacy, and legal support.

Community-level Interventions

Communities can serve as watchdogs and counselors on children's behalf where urgent needs such as neglect, exploitation, or abuse are rampant. The community also provides direct support such as clothing, food, and health care to vulnerable children when households cannot, due to sickness or economic problems. Key interventions include community fundraising, income-generating activities, and promoting linkages with existing civil service and faith-based organizations in the district or at national level. They can help mobilize external support.

Maturing children and adolescents need to learn how to provide for themselves and establish sustainable livelihoods. Economic opportunity/strengthening for MVC, their caregivers, and communities will be realized by linking MVC and their families with programs providing economic opportunities. Implementing partners will help communities link and/or undertake joint efforts with organizations that have significant experience and a high level of expertise in programs that support economic-strengthening activities.

Objectives of Household and Child-level Care

- Ensuring MVC access to adequate and good-quality food and nutrition
- Ensuring MVC access to core non-food necessities
- Ensuring that caregivers—especially in child-headed households—have adequate care-taking skills by providing them with training
- Ensuring MVC and their households have access to economic opportunity/strengthening

Household and Child-Level Action Plan

STRATEGIC ACTIONS	ACTORS/RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE 1: Ensuring MVC access to adequate and good-quality food and nutrition				
Providing food support (cash or in-kind)	WFP, DSW, local government councils, MVC committees, CSOs and FBOs	District and community levels	2007 to 2010	Number of MVC provided with food support by districts
OBJECTIVE 2: Ensuring MVC access to core non-food necessities				
Providing support for non-food goods and services (cash or in-kind)	DSW, local government councils, MVC committees, CSOs and FBOs	District and community levels	2007 to 2010	Number of MVC provided with support for non-food goods and services by districts
OBJECTIVE 3: Ensuring caregivers—especially in child-headed households—have adequate care-taking skills				
Providing training to caregivers on care-taking skills	DSW, local government councils, MVC committees, CSOs and FBOs	District and c ommunity levels	2007 to 2010	Number of trained TOT and caretakers provided with training in care-taking
OBJECTIVE 4: Ensuring MVC and their households access to economic opportunity/strengthening				
Linking MVC, their caregivers, and communities to programs/ partners offering economic opportunity/strengthening support	DSW, local government councils, MVC committees, CSOs and FBOs	District and community levels	2007 to 2010	Number of MVC provided with economic opportunity/strengthening support by districts

Household and Child-Level Action Plan Activity Costs

ACTIVITIES	INPUT DESCRIP-TION	MEASURE-MENT UNIT	QTY/ UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE 1: Ensuring MVC access to adequate and good-quality food and nutrition									
Providing food support (cash or in-kind)						10,973,685	11,223,210	11,691,734	12,143,552
OBJECTIVE 2: Ensuring MVC access to core non-food necessities									
Providing support for non-food goods and services (cash or in-kind)						3,648,461	3,738,906	3,903,326	4,060,249
OBJECTIVE 3: Ensuring that caregivers, especially in child-headed households. have adequate care-taking skills									
Providing training to care givers on care-taking skills	Training package for trainers and care givers per district	Regions	24	1	20,000	320,000	160,000		
OBJECTIVE 4: Ensuring MVC and their households access to economic opportunity/strengthening									
Linking MVC, their care-givers, and communities to programs/ partners offering economic opportunity/ strengthening support	Overhead costs	Districts	132	Qtrly					
TOTAL						**15,102,146**	**14,962,116**	**15,595,060**	**16,203,801**

* IN US$

Social Protection and Security for MVC

The realization and enjoyment of children's rights entail fulfillment of four fundamental basic rights:

1) access to basic needs and health services

2) right to develop to their fullest potential

3) right to protection

and

4) right to participation

The Context of Social Protection and Child Security

The realization and enjoyment of children's rights entail fulfillment of four fundamental basic rights, which are also provided for in the CRC and the African Charter on the Rights and Welfare of the Child. These include the following:

i. **All MVC, without discrimination of any kind, (physical disability, HIV/AIDS, gender, or age) have a right to access basic needs and health services, including**

- adequate and nutritious food
- shelter, clothing, and a reasonable standard of living
- safe and protective environment
- clean and safe water
- immunization
- treatment and medical care
- prevention of mother-to-child transmission of HIV (PMTCT)
- integrated management of child illnesses (IMCI)
- reproductive health services

ii. **Children's Right to Development**

All children, without discrimination, are entitled to the right to development, which also includes the right to develop to their fullest potential in every respect, including their personalities, talents, and abilities. Children's early development is a combination of physical, mental, and social growth. Therefore, the following developmental needs of all OVC must be met

- education and skills training
- practicing cultural and religious beliefs of their own
- stimulation and recreation

iii. **Children's Right to Protection**

All children have the right to be protected from violence, abuse, neglect, and exploitation. However, throughout their lives children, particularly the most vulnerable among them, are exposed to these negative factors due to their age and vulnerability. When violence against children occurs within families and in schools, communities, and institutions, abused and exploited children suffer out of sight. MVC are entitled to special protection against

- neglect
- abuse
- violence, both physical and psychological
- exploitation and discrimination

iv. Children's Right of Participation

The right to participation requires that children should be listened to on any matters or decisions that concern or affect them, and that their views should be given due consideration according to their evolving capacities. The best interest of the child should be a paramount consideration in all decisions and actions concerning children.

Another important aspect for consideration is ensuring the welfare of the children cared for in institutions.[1] Institutional care should be the last resort after all other means have failed to provide care. Support and protection of MVC in a family environment should be the best means for a child's optimum development. For children living in institutions, it is important to ensure the following important considerations are met:

- Mechanisms for reunification of children in institutional or residential care with their families and communities should be in place. Children should not be placed in institutional care just because they are disabled, but should be protected and raised in a family environment that ensures their care and psychosocial support.
- Existing mechanisms should ensure the power to interfere with and take necessary and prompt actions where it appears that children's institutions are abusing the rights of the children living there.
- When it comes to foster care and adoption, existing mechanisms should be strengthened to ensure that foster care is guided by the Children's Home Act. No. 4 of 1968 and adoption ordinance cap. 335 of 1955.

Resource availability (material and financial) is always among the major constraints for scaling up MVC responses. One of the measures proposed to resolve this constraint is the establishment of the MVC Fund at the local government and community levels. The main functions of the MVC fund will be as follows:

i. Support local NGOs, CBOs, and local support groups involved in the care and protection of OVC, and vulnerable households taking care of OVC.

ii. Support education, scholarship, and medical treatment of OVC and development of their vocational training skills; and provide working tools to OVC on a soft credit basis as a mean to reduce poverty among them.

iii. Strengthen community capacity and local government authorities in order to reach more OVC and provide high-quality care and strengthen the capacity of the Department of Social Welfare to provide technical support.

iv. Support coordination at all levels; monitoring and evaluation; data collection, analysis, interpretation, and its use; and research activities related to OVC.

v. Provide direct support to MVC and care-givers in terms of livelihood for survival as a short-term strategy and Income Generating Activities (IGA) as a long-term strategy.

The *Guidelines for Community-based Care, Support, and Protection of MVC* provide measures and responsibilities to ensure that MVC enjoy basic rights and health services.

These measures and responsibilities are considered in the relevant chapters of this action plan.

The need to enhance and provide social protection and security to children—especially MVC—is necessitated to a great extent by the weakening and even breaking down in some communities of the traditional systems that had safety nets offering protection and security to children. Since there has been an unprecedented increase in the number of MVC in Tanzania and AIDS has stood out as a major factor for orphanhood, traditional safety nets are overburdened and overstretched. Furthermore, safety nets have always been invoked to prevent children from falling below a given standard and are normally a short-term emergency measure.

Once the providers of those safety nets become overburdened, the safety nets gradually stop working, as for MVC in Tanzania. Parallel with this, the existing policy and legal framework does not sufficiently provide for the protection and security of children—especially those who have already been categorized as MVC.

Research and various studies have come up with findings that cases of child abuse and neglect are on the rise. Corporal punishment, which by global consensus is an inhuman treatment, is legalized in primary schools and tolerated in secondary schools and homes. Cases of sexual violence against children in their communities and by close relatives or dependants within their family; female genital mutilation; and other social vices like children being used for drug peddling or sex work are common.

Increased poverty—especially at the household level—is complicated further by other factors. Many children are subjected to child labor in order to support their families.

Current Responses in Social Security and Child Protection

As already indicated in the NCPA, current systems that exist in Tanzania for caring for MVC are still fragmented. At the core is the Department of Social Welfare (DSW), which develops guidelines and mechanisms for services. The DSW has inadequate resources and, until recently, has had a relatively low profile. Government-run social welfare schemes, large international initiatives, and an array of faith-based organizations (FBOs) and community-based organizations (CBOs) provide services but typically do not work together as a cohesive group. Though MVC support is the mandate of the DSW, the department has had inadequate human and financial resources to respond on a large scale. Moreover, responses to MVC in Tanzania have traditionally relied on extended family networks. With increasing numbers of orphans and MVC due to the HIV/AIDS pandemic, the traditional social safety net is now overextended and disintegrating.

Though DSW has made significant progress in developing a nationally applicable support mechanism, its scale is still far too small to address the majority of MVC and achieve the necessary coordination. Besides, the DSW's presence and its role within each district are not well understood. Many communities confuse the role and functions of the DSW with those of the Community Development Department. The Community Development Department mobilizes communities to help plan and implement social economic activities on a larger scale. The DSW is supposed to work with individuals and groups to ensure that they gain access to basic social services—a

daunting challenge for the DSW because it must work within a centralized government system while trying to address complex problems at the community level. Moreover, the DSW has extremely limited staffing.

To date, the DSW has only been able to place a social welfare officer in about 30 percent of the 119 districts in Tanzania. The remaining districts rely on regional coverage by just a few officers. In many districts, there is no coverage at all. Indeed, social welfare officers are assigned a range of responsibilities that can include everything from ensuring social welfare administration at hospitals and clinics to defending the rights of disabled individuals. Social welfare officers are often expected to pull together non-state resources within their community to ensure that people's needs are met.

In responding to these challenges, the DSW, through the Ministry of Labour, Youth Development and Sports, has recruited an additional 17 social welfare officers, and is in the process of recruiting additional officers in all districts. Furthermore, the DSW is in the process of decentralizing social welfare services to local government authorities, which will have a mandate to employ such services and pay salaries as any other local authority cadre. The process will enable mainstreaming of social welfare services, plans, activities, and budgets in the local authorities' plans, and their representation in the district management team.

Since there has been an unprecedented increase in the number of MVC in Tanzania and AIDS has stood out as a major factor for orphanhood, traditional safety nets are overburdened and overstretched.

In protecting children from falling into the worst forms of labor and withdrawing and rehabilitating those who are already in such employment, the government in implementing its international commitments—ratified ILO Conventions 138 regarding the minimum age of employment and 182 relating to the worst forms of labor—and has locally committed itself to develop and implement a time bound program aimed at achieving a sustainable elimination of the worst forms of child labor by the year 2010. The government will also create a social foundation to address all forms of child labor. Before this program, the government had already registered significant achievements in addressing the problem of child labor by participating in the IPEC program since 1995. The government, with the support of ILO/IPEC, convened a national roundtable in 2001 to set priorities and targets for the implementation of the time bound program. This roundtable provided stakeholders with a conceptual understanding of the worst forms of labor. It also served as a forum for defining target groups, identifying sectors and locations associated with the worst forms of child labor, and reaching a consensus on modalities for implementation. The program has two major components: (i) creation of an enabling environment that is conducive to eliminating the worst forms of child labor; and (ii) provision of direct support to the priority-targeted groups in selected districts. In order to achieve the two components, three inputs were designed:

i. A series of social protection measures aimed at providing viable alternatives to children at risk of being subjected to child labor, and those who are withdrawn from work as well as their families. The measures include economic empowerment to the target children's families; awareness-raising on child labor problems and its negative consequences on the welfare of children;

and educational and vocational training programs for children and counseling for families.

ii. A community monitoring system to complement the existing enforcement mechanism—especially regarding the status of children withdrawn from work and the supported families.

iii. An advocacy campaign geared toward changing attitudes and perceptions about child labor given that a number of people still accept child labor and regard it as beneficial to children, alleging that it builds character and develops skills for future survival.

The program's priority target groups are categorized as direct beneficiaries, indirect beneficiaries, and direct recipients. Under this program, about 30,000 children under the age of 18 will be prevented or withdrawn from the worst forms of child labor by the year 2010. To achieve this, four priority areas were selected and a number of children who would benefit were earmarked. The areas of priority are children in commercial sex work, Five thousand children were targeted for prevention withdrawal and rehabilitation in the districts of Ilala, Kinondoni, Temeke, Iringa Rural, Kondoa, Iramba and Arusha Municipal. An estimated 7,500 children were earmarked for being protection from the worst forms of domestic labor, withdrawn, and rehabilitated in the districts of Ilala, Kinondoni, Temeke, Iringa Rural, Kondoa, and Arusha. In the mining sector, 2,500 children were to be prevented from working and withdrawn in Mererani Simanjiro district. The target for commercial agriculture was 15,000 children to be prevented from working, withdrawn, and rehabilitated in Iringa Rural, Arumeru, Arusha, Urambo, and Mufindi. Children that are withdrawn from the worst forms of labor are subsequently rehabilitated through counseling, given psychosocial support, and ultimately reintegrated into society with concrete measures of ensuring that they are protected and will not return to the worst forms of child labor.

Cost per Child for Prevention and Withdrawal

	PREVENTION (in US$)	WITHDRAWAL (in US$)
Commercial sexual exploitation	22.00	65.00
Domestic child labor	22.00	38.00
Mining	15.00	75.00
Others	5.00	
Average cost per child	**21.33**	**59.33**

ILO Regional Offices, Dar es Salaam, Tanzania

Number of Children Withdrawn and Prevented in 11 districts: Jan. 2002–March 2005

SECTORS	TOTAL PREVENTED	TOTAL WITHDRAWN	TOTAL IN EACH SECTOR	COMMENTS
C-SEC	**2,992** (2,891 girls, 101 boys)	**4,045** (3,646 girls, 399 boys)	**7,037** (6,537 girls, 500 boys)	The target number of 5,000 has been surpassed by 2,037 children.
CDW	**3,292** (1,532 girls, 1,760 boys)	**2,701** (1,628 girls, 1,064 boys)	**5,993** (3,160 girls, 2,824 boys)	
Mining	**2,081** (727 girls, 1,354 boys)	**1,466** (430 girls, 1,036 boys)	**3,547** (1,157 girls, 2,390 boys)	The target number of 2,500 has been surpassed by 1,047 children
Commercial agriculture	**2,813** (1,105 girls, 1,708 boys)	**1,408** (551 girls, 857 boys)	**4,221** (1,656 girls, 2,565 boys)	
GRAND TOTAL	**11,178** (6,255 girls, 4,923 boys)	**9,620** (6,255 girls, 3,365 boys)	**20,798** (12,510 girls, 8,288 boys)	

Source: ILO Regional Offices, Dar es Salaam, Tanzania

The aforementioned statistics show that the program has already registered a lot of success in the prevention and withdrawal of MVC from the worst forms of child labor. After withdrawal and rehabilitation, the program has provided complementary, transitional, basic education to 16,000 children withdrawn from or at-risk of getting involved in the worst forms of child labor in all 11 districts. Furthermore, 7,500 children and 3,000 families have been provided with vocational education and skills training, respectively, in all 11 districts. However, in spite of remarkable success that have been registered under this program, the districts covered and the number targeted are very small compared to the number of MVC.

Other important responses include:

i. At the community level, provision of foster care and adoption of the orphans and other children who missed life in a family setting is one of the important safety nets to protect children. In response to this, the government has developed two guidelines that focus on MVC; namely, National Guidelines for Provision and Management of Foster Care and Adoption Services and National Guidelines for the Establishment and Management of Children's Homes. These guidelines will soon be operational.

ii. Twenty local government authorities have implemented the community-based identification of MVC, which is focusing on identifying and targeting MVC to help the community own the process and ultimately develop action plans on how to deal with MVC issues.

iii. A program to develop the capacity of communities to deal with MVC has been established. Under it, national and district facilitators are trained. This is in recognition of the fact that effective responses to MVC support, care, and protection require a decentralized strategy focused on empowerment of local communities in decision making, resource mobilization, and monitoring and evaluation of the program implementation process and outcome.

iv. Through community-based care, MVC committees are formed at the community level, community MVC welfare funds are established, and community justice facilitators/paralegals are trained. These paralegals will handle simple legal and non-legal issues that affect MVC at the local level.

On the part of non-state actors, several forms of MVC support have been achieved. These non state actors include UN and international NGOs and faith-based organizations that supported various initiatives through funding and initiation and implementation of various programs. Some of the initiatives are as follows:

i. Provision of legal aid services to the poor. Some organizations offer these services to children in the areas of inheritance, custody, maintenance, and sexual abuse. The services include conducting administrative follow ups and litigation in courts of law.

ii. Mass awareness-raising through media programs and simple publications, although the latter has limited circulation but does contribute. Some print media have specific programs targeting MVC.

iii. Training paralegals in the communities who handle matters that do not involve many legal technicalities or those of a non-legal nature. Under this approach, UNICEF and the government have been training people in 17 districts for the similar purpose of protecting and upholding the rights of children in relation to law. These are called community justice facilitators.

iv. Other initiatives to ensure social protection to children are in the form of specific campaigns, such as those against corporal punishment of children in all spheres, those in favor of abolishing female genital mutilation, prohibiting child labor, providing institutional care in the form of shelter and advocacy for the enactment of a progressive child and inheritance law, and the amendment of laws that fail to support the rights of the child—in particular MVC.

v. In ensuring that MVC—especially those orphaned by HIV/AIDS—continue enjoying family life and are not left to be predisposed to child labor, prostitution, or street life, a pilot initiative of "*Mama Mkubwa*" has been tried in Makete district, which has been hard hit with AIDS. Under this initiative, which has been pioneered by UNICEF, TAHEA, and other actors who intend to replicate it elsewhere, a respectable mature lady from the clan who commands some affection from the orphans is given the guardianship of them and lives among them to provide care, support, and protection. This guardian is supported economically in order to manage this task. This approach ensures that such children continue living in the same society and enjoying the same social bonds.

Challenges That Hamper Provision of Social Protection and Security to MVC

i. Legal provisions on children's rights are scattered in different statutes. Many laws are old and do not reflect existing children's rights. Some have provisions that oppress or expose children to vulnerability. Many are not accessible and user friendly, especially to the children themselves and their caregivers.

ii. The process of developing a new Children's Act has not been participatory enough for people with different ideas and perspectives. This may mean that a number of important issues are left out.

iii. Various services that are rendered to the MVC like legal aid, paralegal services, institutional care, and various advocacy campaigns in favor of MVC are uncoordinated. Because of this, it has been difficult to determine areas covered, beneficiaries who receive the services, and the impact of the services and that of the campaigns. There have been gaps or occasionally a duplication of efforts.

iv. Care, support, and protection of children and in particular MVC is a province of knowledge and expertise that many policy makers, legislators, and key implementers lack. Limited understanding or lack of knowledge has a bearing on the process, content, efficiency, and style of policies and laws implemented that relate to children—especially MVC.

v. Many policies do not adequately address MVC who are experience unique problems, such as children with disabilities. Furthermore, even those few that do exist are not adequately disseminated to the public.

vi. There is no comprehensive and coherent MVC situational analysis in the country that could give a clear picture of children's situation. Small studies based on the operationalization of specific projects have been done, most of them being geographically focused.

vii. The number of MVC is increasing quickly, and their predisposition to vulnerability is equally increasing. This does not correspond with the available resources.

viii. There is inadequate and outdate information on care, support, and protection of MVC provided to community members and other stakeholders, such as the mass media.

ix. The Department of Social Welfare of the Ministry of Labor, Youth Development, and Sports has not yet decentralized its structure to the community level. Because of this, social welfare issues—especially those concerning children—are not addressed properly.

x. There is a lack of comprehensive and well-coordinated programs on lifeskills for MVC within family and community settings. In addition, many guardians and child caregivers do not have adequate parenting skills.

xi. Discrimination and stigma facing MVC—especially those living with HIV/AIDS— are still prevalent in society. This sometimes prevents children from accessing antiretrovirals, health care, inheritance of the estates of their deceased parents, and other protections they deserve.

Strategies to Enhance Social Protection and Security of MVC

Poverty, especially at the household level, leads to the weakening of the traditional safety nets. It has been singled out as a major reason for children's vulnerability and ultimate lack of protection and security. In order to ameliorate this situation, emphasis should be placed on strengthening and supporting the capacity of families to protect and provide appropriate care for children. This can be achieved by mobilizing, enhancing, and strengthening community-based interventions, which are relevant and appropriate in ensuring the protection and security of children. Under this strategy, the focus should be to ensure that

i. Economic coping capabilities of families and communities to mitigate income poverty should be appreciated and strengthened.

ii. The existing values and norms of society that are protective to the children should be enhanced and institutionalized. With equal strength, norms and values that are overtly or covertly hampering the protection and security of children should vigorously be discouraged.

iii. Family and community-based initiatives to ensure social protection and security should not be undermined by external support. Instead, any external support should augment and compliment what already exists. Existing safety nets that have been in use should be supplemented and, where relevant and appropriate, improved.

iv. The government should encourage members of the public to provide foster care and/or adopt MVC who are missing a family life. Foster parents and those who adopt children will be motivated through cash transfers to them. Children will receive free or subsidized health and education services. In addition, foster parents, caregivers, and parents who have adopted children and have no previous child-rearing experience will be trained in parenting skills.

v. Civil society organizations that provide care, support, and protection to children should be financially supported by the government through a special fund established for that purpose.

vi. The time bound program on elimination of worst forms of child labor should be scaled up to cover more districts and target a greater number of children who may fall into the worst forms of labor, those who already perform worst forms of labor, or those who are members of families who have such children.

Given the fact that the knowledge of laws and policies that touch on children's issues is not sufficient among a good number of legislators and policy makers, there should be a specific program offering tailor-made courses and in-house training to improve their knowledge of issues surrounding MVC.

Some MVC are in conflict with the law. It is clearly known that a special procedure needs to be adopted in dispensing justice to children during their trial in courts of law. The special handling of the children requires knowledge and skills on the part of magistrates and prosecutors on the issues of children's rights. The prevailing situation in the judiciary shows that there is a dire need for magistrates and prosecutors to be exposed to children's rights, with an emphasis on MVC issues. This can be achieved in two ways:

i. Conduct training on children's rights for magistrates and prosecutors.

ii. Include a children's rights component in the syllabus of law school and prosecutor's courses.

The ongoing process is enacting a new child law before it comes to an end: there should be a comprehensive analysis and review of existing legislation and policies that focus on children in order to ensure that the new law clearly provides for the protection and security of the children pursuant to the principles and provisions

of the Convention on the Rights of the Child and other international human rights instruments. The new law should provide systems and mechanisms that are effective and child friendly so that it can, among other things, protect children from abuse and exploitation. MVCs' rights must be protected, especially in terms of inheritance and in providing a functional system for them to redress abuses and grievances, whether collective or individual. To achieve this, the following should take place:

i. An advocacy program should be designed that ensures the laws and policies that focus on children are known by all stakeholders and progressive provisions and perspectives—particularly on child care, protection, and security that will be drawn from the analysis—are advocated for in the new law. The responsible coordinators and actors are the two ministries that have a mandate to provide for children's social welfare and community development on behalf of the government, United Nations agencies, and local civil society organizations focusing on children's welfare.

ii. The ongoing process of enacting a new child law should be open so that everyone with a stake in children's issues can effectively participate and ensure that MVC issues are well captured in the law. Various studies and research findings on how MVC issues and social protection should be used in developing a new law should be consulted. These include findings by UNICEF, other international organizations, the Law Reform Commission, and civil society organizations.

iii. The new law, once ratified, should be simplified into a user-friendly form and disseminated widely to all stakeholders.

Nationally, the Department of Social Welfare is responsible for planning, providing, and coordinating the provision of social services. It is housed in the Ministry of Labour, Youth Development and Sports. Apart from the Department of Social Welfare, there are several other providers of social welfare services all over the country. These include but are not limited to community-based organizations, nongovernmental organizations, and religious organizations, to name a few. Despite their good efforts, social welfare provision in Tanzania is inadequately provided and weakly coordinated.

The government is implementing decentralization by devolution, which intends to grant local government authorities (LGAs) more autonomy and enhance their effectiveness in delivering high quality and responsive services. Unfortunately, provision of social welfare has not been considered in this endeavor. It is still highly centralized in the Department of Social Welfare. As a result, most LGAs tend to avoid taking responsibility for directly providing social services on the pretext that the responsibility lies with the Department of Social Welfare under the Ministry of Labour, Youth Development and Sports. This view is widely held, even though existing local government laws require them to provide welfare services.[2,3]

2. Department of Social Welfare, 2003, *Guidelines for Community Based Care, Support and Protection of the MVC.*
3. Sola, N. (2005). "*Report of the Study on the Need to Mainstream Social Welfare Services into the Local Government Structure.*" Report Submitted to the Ministry of Labour, Youth Development and Sports.

Currently, there is a huge lack of social welfare officers at the district level. At the regional level, there is an average of 2.47 staff per region, while at the district level there are 1.3 staff per district in the 35 districts said to have social welfare officers (see Sola, 2005). The number of social welfare officers operating at the district level is small (48) when compared with the number of districts and the increasing demand for social welfare services. Only 35 out of 119 districts have social welfare officers, meaning that the remaining 84 districts do not have public social welfare services. In order to enhance delivery of social welfare services at the district level, it is critically important to deploy employees in this field to the district level. For awareness on children's rights and MVC to be enhanced, it is important to form and strengthen committees on this subject from the national to the village level. Committee members will be trained in a descending order, whereby trained national facilitators will train district facilitators who will be members of district committees who will train members at lower levels. These committees will serve as referral points for the immediate problems that have occurred at that level for intervention. Existence of these committees at the community level will help track what may be happening at the household level, such as child abuse in the family that are not reported anywhere. Children who are abused may be able to report abuses to committee members who are known to them.

Objectives of Social Protection and Security of the MVC

Adequate protection and security for all MVC can be ensured through the following activities:

- Scaling up community justice facilitation by training more community justice facilitators
- Strengthening local community structures so they can carry out responsibilities for monitoring and protecting MVC
- Providing training and support to frontline workers, including local CSOs and FBOs, field staff, local volunteers, police, emergency hospital workers, school teachers, nurses, and staff of child residential care facilities
- Assisting police in constructively dealing with MVC who are in violation of the law
- Scaling up efforts to eliminate worst forms of child labor
- Improving mechanisms/systems to increase birth registration, improve access to basic social services, and facilitate inheritance claims
- Offering technical assistance to local authorities and communities to improve investigation, reporting, and follow-up on cases of rape, abuse, and neglect
- Reviewing and assisting in the development and strengthening of child law and protection services and policies, including adoption
- Embarking on communication or multimedia campaigns to support social norms that protect children and prevent child abuse and exploitation (information communication materials) as well as materials that reinforce or change social norms to encourage the practice of will writing, succession planning, and the enforcement of inheritance laws.

Social Protection and Security of MVC Action Plan

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE: Ensuring adequate protection and security for all MVC				
Scaling up community justice facilitation by training more community justice facilitators	UNICEF, USAID, PACT, DSW, FHI	District, ward, and community level	2008	# of community justice facilitators trained in each of the remaining districts
Strengthening local community structures in carrying out responsibilities for monitoring and protecting MVC	UNICEF, USAID, PACT, DSW, FHI	District, ward, and community level	2008	# of district councils provided with capacity-strengthening support
Providing training and support to frontline workers in how to constructively deal with MVC who are in violation of the law	UNICEF, USAID, PACT, DSW, FHI, Ministry of Home Affairs	District, ward, and community level	2008	# of district councils provided with capacity-strengthening support
Scaling up efforts to eliminate worst forms of child labor	UNICEF, ILO, USAID, PACT, DSW, FHI, Ministry of Home Affairs	District, ward, and community level	2008 to 2010	# of districts covered
Improving mechanisms/systems to increase birth registration, improve access to basic social services, and facilitate inheritance claims	UNICEF, USAID, PACT, Ministry of Health, DSW, FHI	District, ward, and community level	2008	# of districts covered
Reviewing and assisting in the development and strengthening of child law and protection services and policies, including adoption	UNICEF, ILO, USAID, PACT, DSW, FHI, Legal Sector Reform Programme, Ministry of Home Affairs	District, ward, and community level	2008 to 2010	# of districts covered
Communication or multimedia campaigns to support social norms that protect children and prevent child abuse and exploitation	UNICEF, ILO, USAID, PACT, DSW, FHI, the mass media	National and district level	2008 to 2010	# of informational communication materials produced and provided to the public through the media per year

Social Protection and Security of MVC Action Plan Activity Costs

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE: Ensuring adequate protection and security for all MVC									
Scaling up community justice facilitation by training more facilitators	CJF training package per district	Districts	61	1	30,000	1,830,000	-	-	-
Strengthening local community structures in carrying out responsibilities for monitoring and protecting MVC	To be trained together with the CJF facilitators	Districts	61	1	-	-	-	-	-
Providing training and support to frontline workers in how to constructively deal with MVC who are in violation of the law	To be trained together with the CJF facilitators	Districts	61	1	-	-	-	-	-
Scaling up efforts to eliminate worst forms of child labor (implementation of the ILO Time Bound Programme in the remaining districts	Overhead costs for withdrawing children from the worst forms of labor per district	Districts	132	1	5,000	660,000	660,000	660,000	660,000
Improving mechanisms/systems to increase birth registration, improve access to basic social services, and facilitate inheritance claims	Enforcement of accountability in the responsible government ministries, departments and agencies	Districts	-	-	-	-	-	-	-
Reviewing and assisting in the development and strengthening of child law and protection services and policies, including adoption	Consultancy	Work days	30	1	300		9,000		
Communication or multimedia campaigns to support social norms that protect children and prevent child abuse and exploitation	Package for development and communication of information education communication (IEC) materials	Package of IEC materials for newspapers, radio, and television	3 packages (1 for newspapers; 1 for radio; and 1 for TV	1	10,000		30,000	30,000	30,000
TOTAL						**45,300**	**2,490,000**	**699,000**	**690,000**

* IN US$

Psychosocial Support

Psychosocial support helps children deal with grief and bereavement and with the stigma, discrimination, and maltreatment they may experience at the hands of foster caregivers and/or members of the community. Providing psychosocial support stems from the recognition that children have feelings about their parents becoming ill and dying, including fear as well as grief, and that these feelings may be compounded by siblings becoming ill and dying. Children will continue to have distressing feelings about these deaths long into their adulthood unless supported at the time of illness and death to express themselves and have their feelings acknowledged as legitimate.

The psychological needs of these children include love, recognition and acceptance, protection, being valued, encouragement, comfort, and participation in important life events.

Children and youth need to be given sufficient time and support to come to terms with their loss. Otherwise, their feelings may be expressed at a later date in negative and destructive ways and may place these children at greater risk of contracting HIV themselves. The psychological needs of these children include love, recognition and acceptance, protection, being valued, encouragement, comfort, and participation in important life events. Caregivers need the knowledge and skills to care for psychologically affected children and provide for their daily basic needs. Children need to be educated, trained in moral values, played with, talked to, and listened to, and to be given the opportunity to participate in family and community activities, including sharing their opinions in matters that concern them. The national action plan proposes building the capacities of caregivers to address the psychological needs of children.

Existing Efforts to Provide Psychosocial Support for MVC

Currently, childcare institutions of various types provide care, support, and protection to MVC. Most of the caregivers in these institutions have not been properly trained in providing psychosocial support for children of different ages and family and cultural backgrounds. Most vulnerable children in childcare institutions have more growth and development challenges than MVC being cared for in family environments, despite the material inadequacies prevailing in these families. Consequently, children living in the street, children with disabilities, children in childcare institutions, and children with similar problems and living out of family environments are lacking psychosocial support to fill in for the missing family environment.

There are some good examples of psychosocial support initiatives currently operating in the country. PASADA and HUMULIZA have been singled out as being among the best projects. Below are the lessons from PASADA and HUMULIZA, which emphasize the need to integrate psychosocial support activities with programs that meet the other basic needs of children. Many other organizations provide psychosocial support to children, including Kiota Women's Health and Development (KIWOHEDE), which serves to protect the rights, health, and development of children in domestic service.

This organization includes trained personnel such as social workers, clinical officers, gender specialists, nurses, and teachers to

- help MVC overcome trauma
- help MVC regain self-esteem
- help MVC acquire knowledge and working skills
- provide counseling and income generation activities
- provide educational training

Others include Yatima Group Trust Fund, which provides basic needs parenting care to orphans; Kurasini National Children's Home; WAMATA, Upendo Counseling Centre, and Dogodogo Centre for MVC.

The Ministry of Education and Vocational Training

The Ministry of Education and Vocational Training serves the majority of school age children from pre-primary, primary, and secondary schools in the country (ages 5–6, 7–13, 14–17, 18–19, and 20–21). About 70 percent of the youth population is in either primary or secondary school. The ministry has engaged in intensive teacher and peer training in these schools. Teachers are being trained as both counselors and HIV/AIDS educators, and the ministry has plans to strengthen HIV/AIDS counseling services including promoting the following:

- life skills
- better learning
- communication among stakeholders in education
- learners' self-respect
- trust and confidence
- coping skills in response to traumatic events

The government is also implementing a friendly school environment program that will facilitate integration of all children, including MVC, into the school and teaching–learning environment.

Action Plan to Scale Up Psychosocial Support for MVC

Building Capacity in Psychosocial Support Through Training

It is important to address the quality of psychosocial support to most vulnerable children based on a clear understanding of the factors that affect them. Caregivers should be equipped with knowledge, skills, and appropriate attitudes to provide psychological support; these include skills to prepare children for the loss of a principal caregiver and skills for subsequent coping with future challenges. Caregivers should be educated in how to support MVC in dealing with the stress and anxiety of anticipated or past loss and in learning to manage their lives and those of others.

All people giving support to MVC should have a clear understanding of child development. Programs should train psychosocial support facilitators from the national level to the community level, as well as train the parents and other caregivers in families and in institutions. In addition, training materials need to be prepared and translated into Swahili so that the wider community can easily understand them. Specifically, capacity building is required in the following areas: Teaching Adults to Learn to Listen; Ensuring the Child's Rights; Acknowledging MVCs' Changing Roles; Creating an Enabling Environment in Communities and in Schools Through Training Members of the Wider Community; Allowing MVC to Be Children; Involving Youth in Solutions; Communicating with Children about HIV/AIDS; Talking about Death and Dying; Educating and Counseling MVC Individually, in Families, and in Groups; and Helping Children to Build Resilience.

Psychosocial Support Action Plan

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE: to improve the care, support, and protection of MVC through psychosocial support services in families and communities				
Reviewing existing psychosocial training programs and materials to determine strengths and weaknesses and make improvements	DSW and implementing partners	National level	2007 to 2011	Existing psychosocial training programs and materials reviewed
Printing and disseminating adequate psychosocial support materials for all districts and communities as well as implementing partners (CSOs and FBOs)	DSW and implementing partners	National level	2007 to 2011	Psychosocial support reading materials developed, printed, and distributed
Conducting stakeholder skills training sessions on psychosocial support for MVC using improved materials	DSW and implementing partners	National, district, and community levels	2007 to 2011	Staff and community volunteers trained
Establishing play centers, discussion groups, clubs, learning centers, and counseling centers in communities	DSW, local councils, and implementing partners	National, district, and community levels	2007 to 2011	Play centers, discussion groups, clubs, learning centers, and counseling centers in communities established

Psychosocial Support Action Plan Costs

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE: to improve the welfare/care of MVC through psychosocial support services in families and communities									
Reviewing the existing psychosocial training programs and materials to determine strengths and weaknesses and make improvements	Consultancy	Work days	30	1	300	9,000			
Printing and disseminating adequate psychosocial support reading materials for all districts and communities as well as implementing partners (CSOs and FBOs)	Outsourced activity to printing companies	Package of printed psychosocial support materials	132	1	30,000	3,960,000			
	Transport/ postage costs for dissemination of printed materials to implementing partners	Districts	132	1	300	39,600			
Conducting stakeholder skills training sessions on psychosocial support for MVC using the improved materials	Training workshop package within the districts	30 training workshop participants per district	132	1	60	237,600			
Establishing play centers, discussion groups, clubs, learning centers, and counseling centers in communities	Overhead costs	Districts	132	1	60	237,600			
TOTAL						**4,483,200**			

* IN US$

Plan Implementation Monitoring and Evaluation

Monitoring and Evaluation Framework and Indicators

Monitoring and evaluation is the systematic measurement and tracking of program activities and results. Monitoring refers to the ongoing assessment of the program's progress in implementation and in achieving its stated goals and objectives. It incrementally tracks program progress as the program is implemented. Evaluation refers to the use of social research methods to systematically investigate a program's effectiveness. Monitoring assesses what is being done, whereas evaluation assesses what has been achieved or what impact has been made.[4] M&E systems need to be as simple as possible while still able to answer the program's questions as well as respond to global requirements.

The MVC M&E framework for Tanzania is designed to monitor MVC programs, including inputs (resources), processes (activities), and outputs (results). The MVC monitoring data tool forms a basis for MVC program evaluation of the outcomes and impact of the program. The framework, which consists of core national and international level indicators (UNGASS indicators[5]) to allow the country or other MVC stakeholders to measure the impact of MVC interventions, identifies outcome and impact indicators.

Core National-Level Indicators

Domain	Indicator
Policies and strategies	Policy and strategy index reflecting the progress and quality of national policies and strategies for the support, protection, and care of orphans and vulnerable children
Education	School attendance ratio of MVC as compared with non-MVC
Health	Healthcare access ratio of MVC as compared with non-MVC
Nutrition	Malnutrition ratio of MVC as compared with non-MVC
Psychosocial support	Proportion of vulnerable children who receive appropriate psychosocial support
Family capacity	Proportion of children who have three locally defined basic needs met
	Proportion of MVC who live together with all of their siblings
Community capacity	Proportion of households with MVC that receive free basic external support in caring for the children
Resources	Government expenditure per child on MVC
Protection	Percent of MVC whose births are registered
	Percent of widows who have experienced property dispossession
Institutional care and shelter	Proportion of children who are living on the street or are in institutional care

Source: adopted and modified to fit MVC context from *Framework for the Protection of Children Living in a World Affected by HIV/AIDS*

4. The Global Fund 2003, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Guidelines for a Principal Recipient's Monitoring and Evaluation Plan.*
5. During April 2003, the UNAIDS Inter-Agency Task Team (IATT) on Orphans and other Vulnerable Children convened a broad coalition of stakeholders and reached consensus on a set of core indicators for the national-level measurement of the global goals for children orphaned and made vulnerable by HIV/AIDS.

Indicators are accompanied by detailed definitions and a mechanism for collecting the data. The full national MVC M&E plan outlines the steps for collecting the data centrally and in a standardized fashion.

Developing the MVC M&E Framework in Tanzania

A comprehensive and institutionalized MVC M&E system is lacking in Tanzania. The individual actors, mostly non-state actors, have been undertaking their own M&E initiatives mainly to monitor and evaluate their own programs. Most M&E efforts remain small in scale and have covered only the specific MVC support, care, and protection issues dealt with by the individual organizations.[6] These organizations often do not publicize or share their M&E results with other stakeholders. In addition, different indicators have been used by different organizations due to a lack of common MVC M&E protocols in the country. In addition to creating difficulty in ensuring reliability as well as internal and external validity of the M&E results, this approach does not comprehensively provide the necessary countrywide data required for maintaining, improving, or modifying the MVC interventions and reporting on national progress.

Over the past few years, one largely agreed upon M&E framework has emerged—i.e., the input-process-output-outcome-impact framework.[7] Within this framework, ***input*** refers to elements such as human and financial resources and time committed to the program or project. Examples of ***outputs*** are stocks of goods and delivery systems for care, support, and protection of MVC. These may include drugs and other essential commodities, new or improved services, trained staff, and information materials. Outputs are often the result of specific ***processes***, such as putting in place functioning MVC coordination mechanisms at all levels, preparing facilitators' training modules, training MVC and community justice facilitators and stakeholders, and encouraging community dialogues. ***Outcome*** refers to short-term or intermediate results of the program's activities (such as increased school attendance by MVC or reduced proportion of adolescent female OVC engaged in sex work), while impact refers to the long-term effects that can be attributed to the program (e.g., improved nutritional status of MVC or improved quality of life and life expectancy of MVC due to the MVC programs).

While the monitoring of inputs, processes, and outputs will be the responsibility of implementing agencies, monitoring of outcomes and impact will be a responsibility at the national level. This is because outcome and impact monitoring are often not linked to specific programs, but rather provide a general indication of change on key indices due to a variety of program efforts in the MVC area and other influences at national or subnational levels.

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6. These include the following: (i) Charwe Donald, Winifrida Koroso, Fredrick Kaijage, Jane Calder, Moses Dombo, and Jolly Nyeko, 2004, *A Review of the Tanzania National OVC Response under the "National Strategic Multi-Sectoral Framework 2000-2007: Conducted on Behalf of the Tanzania HIV/AIDS Commission (TACAIDS)*; (ii) Eastern and Southern African Universities Research Program (ESAURP), 2002, *Children Neglected: HIV/AIDS Orphans Study: Identification and Needs Assessment. A Report for NORAD*; (iii) Whitehouse, Anna, 2002, *A Situation Analysis of Orphans and Other Vulnerable Children in Mwanza Region, Tanzania: A collaboration between government and nongovernment, community, mission, and faith-based organizations working on behalf of these children.* Study supported by the Catholic Relief Services (CRS) Tanzania, in partnership with Kivulini Women's Rights Organization, Mwanza.

7. World Health Organization, The World Bank, UNAIDS, USAID, CDC, *The Global Fund (2004) Monitoring and Evaluation Toolkit, HIV/AIDS, Tuberculosis, and Malaria.*

In the table below (MVC Monitoring and Evaluation Pipeline for Tanzania) the pipeline represents the national MVC M&E framework, which provides a way to organize the data required to monitor MVC program progress and provides a logical order for collecting and analyzing information. The process starts with examining the required inputs (resources: financial, human, supplies, and facilities) for implementing activities, the activities themselves (including establishment of response system, training, and delivering of support packages to MVC), and then the resulting outputs (immediate effects, such as the number of districts covered and the number of MVC supported in each district by ward or community). Outputs may lead to outcomes (intermediate effects, including improvement in MVC access to essential services, such as education or health) that in turn may lead to impact (long-term effects, such as reduction in the relative number of MVC and improvement in the wellbeing of all children in the country).

To ensure that the MVC responses in the country are effectively and efficiently implemented to realize the intended outcome and impact, the following activities are to be undertaken:

- monitoring progress of the NCPA implementation process by implementing a management information system (MIS) to periodically capture information from implementing partners on what has been achieved in relation to planned activities and overall objectives (i.e., gathering basic information on project activities and services provided for routine monitoring purposes)
- evaluating the NCPA implementation process by assessing the quality of MVC responses (implementation quality assessment), achieved by undertaking both rapid assessment (annually) and detailed assessment and in-depth program analyses (after three years)
- assessing intervention effectiveness: outcome evaluation—i.e., determining whether and to what degree NCPA activities achieve their intended effects on individual MVC (individual outcome); program- and system-level outcomes; and community outcomes

MVC Monitoring and Evaluation Pipeline for Tanzania (with illustrative indicators)

MONITORING			EVALUATION (Effective Evaluation)	
INPUT	PROCESS	OUTPUT	OUTCOME (Short-term and intermediate effects)	IMPACT (Long-term effects)
• staff • funds • facilities • supplies	• training manuals/modules development • training of MVC facilitators and CJF • dialogue at national, district, ward, and community levels • coordination mechanisms for policy and program implementation: establishment of efficiently and effectively functioning committees responsible for MVC at national, district, ward, and community levels • putting in place a legal and program and policy implementation environment: review and implementation of laws that safeguard the welfare, care, support, and protection of children • resource mobilization from stakeholders and members of the communities in rural and urban areas	• trained staff (MVC and CJF facilitators) at all levels • effectively and efficiently functioning committees, which are responsible for MVC at all levels (national, district, ward, and village) • efficient and effective MVC care, support, and protection response systems at all levels (national, district, ward, and village) • availability of adequate resources (human and financial resources for responding to the needed care, support, and protection for MVC)	• increase in response by various actors to the care, support, and protection needs of MVC at all levels • increase in number or proportion of MVC and caregivers in communities who are effectively and efficiently provided with adequate care, support, and protection by the MVC program and other programs • increased school attendance of MVC • increased access to healthcare by MVC • increased proportion of children (0–4) whose births are registered	• coping capacity in communities to care for, support, and protect MVC • elimination of all forms of child abuse in rural and urban communities • changes in social norms related to MVC • improved socioeconomic status of families with MVC • improved nutritional status of MVC • improved quality of life of MVC • decreased percentage of children living on the streets

Monitoring and Evaluation Activities

The following are immediate actions that have been taken to ensure an effective and standardized national-level M&E plan for MVC efforts:

- national-level stakeholders meeting to discuss and refine the MVC M&E tool and framework
- revision and finalization of the M&E framework based on national stakeholders meeting and disseminate to stakeholders
- presentation of M&E framework to policymakers (e.g., senior representatives of ministries of various sectors; donors)
- translation of the MVC M&E tools and framework into Swahili for easy use at the community level
- mapping of existing M&E strategies and activities (e.g., what are the existing sources of data related to children that we can tap into for evaluation purposes?)

- development of procedural MVC national M&E plan to ensure standard practices
- MVC M&E capacity-building training sessions for all key stakeholders at all levels (national, district, ward, and community—village/street levels)
- printing of the MVC M&E plan, tools, and framework and distribution to all stakeholders at the national, district, ward, and village levels to ensure awareness and understanding at all levels and sectors

Data Collection and Management

Data will be collected and managed at different levels of implementation of the MVC costed plan of action. These levels are village through most vulnerable children committees (MVCC), ward (CMAC), CSO, CBO, district, regional, and at the national level, DSW. All levels must ensure that they collect high quality data using agreed upon national data collection tools. They also must use the data, and must report in a timely manner and according to agreed upon national channels to facilitate timely, evidence-based decisionmaking and planning.

M&E Coordinating Unit Responsibilities

The M&E coordination role is undertaken by the DSW-MOHSW at the national level and by the planning departments (social welfare section) at the local government levels. The general M&E coordination responsibilities at the national level are as follows:

- conducting national formative needs assessment (i.e., mapping to estimate size and locations of MVC; these will help determine which interventions are needed, who needs the interventions, and how the interventions should be carried out)
- aggregating results from collaborating partners (i.e., aggregating indicator data resulting from activities conducted by partners to assess progress of programs). There must be a well-defined system (i.e., reporting mechanisms and standardized reporting formats) for centralized reporting of key indicators. This system will require coordination among sectors and implementing partners.
- providing feedback to collaborating partners and implementing agencies on results of M&E activities undertaken by the government
- using M&E results to advocate for policy formulation and changes

National Capacity for Monitoring and Evaluating MVC Program

The development of a national MVC action plan must address national M&E resources and related systems needs for supporting MVC efforts. The collection of useful programmatic information requires resources and a skilled workforce at the national level and beyond. The government must commit to identifying sustainable resources if M&E is to be a routine part of program function. In creating the right environment, capacity development in M&E should aim to carry out the following activities:

- identify training needs
- identify and procure needed equipment and software

- organize formal training sessions and workshops at all levels, involving focal persons at the national, district, ward, and village levels
- facilitate informal learning by sharing experiences and skills in the field of monitoring and evaluation (e.g., organize informal discussion forums to discuss M&E best practices, share lessons learned, or teach M&E techniques)
- facilitate information sharing (such as meetings, training sessions, scholarships, grants, manuals, newsletters, and international electronic networks)
- maintain an M&E coordination unit at the national level, with financial and human resources, as well as logistical and infrastructure support (computers, IT support)
- provide technical assistance at the national level in policy development, advocacy, and how to apply M&E data in the design or improvement of programs. This is critical as it is often a weak component of M&E systems.

Data Quality and Data Flow Management

DSW will ensure that the standardized data collection process is in place and all actors adhere to it. In collaboration with partners, DSW will ensure that the relevant existing structures are provided with the necessary capacity building in addressing data quality.

The data collected and reported will be subjected to quality checks in the field (during supervisory visits) and at the program headquarters (central DSW M&E unit). The data will be checked for completeness (required fields on clients' characteristics and services provided are completed and information provided is disaggregated by age and sex when necessary); consistency and integrity (number reported on facility registers and activity report forms align); and reliability (definitions and measurements of MVCs' characteristics and services remain constant over time).

Paper-Based Data Management

Data will be collected routinely at the community level using designated standardized tools such as MVCC registers, which register all vulnerable children, and service monitoring registers, which will be used by volunteers, committees, CSOs, and CBOs during home visits and service delivery. On a quarterly basis MVCC will compile data to be submitted at the ward level. These reports will contain minimum information that will be transmitted to a higher level for decisionmaking and planning. Wards will compile the data from villages submitted and will submit this data to the district. The district will then compile district MVC data and send the data (minimum) to the DSW, with a copy to the regional secretariat. The department will analyze the information and submit to TACAIDS.

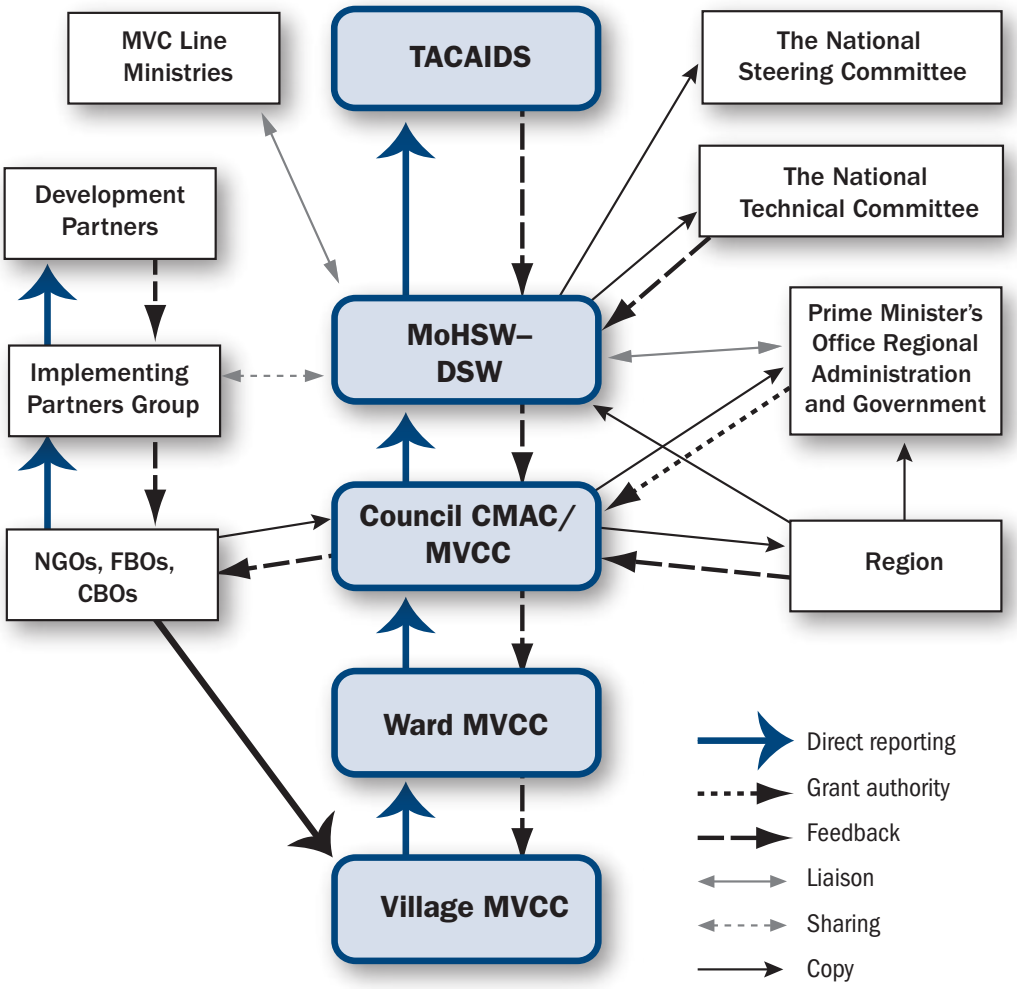
Data Management System

At the district, CBO, and NGO levels, a data management system will track all the information from communities. Once the MVCC have identified and enrolled MVC in their register, a copy of this register will be sent to the district for entry. Service providers will also get the names of the MVC from this register. Service providers (CBOs,

CSOs) will track all MVC they serve in a service providers register. On a quarterly basis they will send a copy/export electronic copy to the district for entry. In addition, service providers will be given service tracking forms that will be used by volunteers or other staff in their home visits. These forms will contribute to the service providers register. (See figure 3 below.)

At each level, data collectors will be trained on how to collect data and will be given continuous, supportive supervision to ensure data quality. Feedback on data quality will be given at each level. Data will be verified before it is sent upward. Efforts to avoid double counting within and among programs will be made.

Figure 3. Data Flow and Reporting



Data Use and Dissemination at the National Level

Timely, high quality data is needed for planning and decisionmaking. DSW will ensure the collection of this data by building capacities at all levels and ensuring adherence to the established standardized data collection for comparability of data. This process also will facilitate timely reporting at all levels.

At the national level, use of data is different from data use at the program level. At the national level, program managers need just enough information to determine whether the national effort is going in the right direction. This information is necessary for future planning and advocacy for necessary resources, legislative changes, refining national program priorities, and reallocating resources, among activities. Therefore, it is critical to identify formal mechanisms (i.e., technical workgroups) for regular review of data by program managers.

Data analysis will be conducted at the district and national level. On a quarterly basis districts will analyze the data and share it with stakeholders. The data will form a basis for lobbying for resources from business community people, individuals, NGOs, and other groups. This will also form part of monitoring at the district level, where coverage, quality, and type of services will be analyzed by service providers. At the national level, the data will be analyzed semiannually to gauge coverage and gaps for immediate and future planning. All the reports will be disseminated and shared across all stakeholders, such as parliamentarians and policymakers. The implementing partners will publish monthly and quarterly newsletters for advocacy purposes.

One of the biggest challenges of M&E is obtaining quality data in a timely manner. To facilitate the completion of reporting forms, it is essential that data submitted are compiled and fed back to users at the appropriate level, and that those actually providing data are kept informed of how the data are used. Most importantly, the communities should be the primary users of the information. Dissemination in very simple report formats will enable the communities to use the information.

Objective of Plan Implementation Monitoring and Evaluation

There is one main objective for the national plan of action implementation monitoring and evaluation: to ensure that the MVC responses in the country are effectively and efficiently implemented to realize the intended outcome and impact.

Measuring the Process Action Plan

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE: to ensure that the MVC responses in the country are effectively and efficiently implemented to realize the intended outcome and impact				
Implementing management information system (MIS) to periodically capture information from implementing partners on what has been achieved in relation to planned activities and overall objectives of the NCPA	DSW in partnership with the implementing partners	National and local government level	2008 to 2010	Quarterly reports on the status of the implementation process based on the information captured through the MIS
Evaluating the NCPA implementation process by assessing the quality of MVC responses (implementation quality assessment), achieved by undertaking both rapid assessment (annually) and detailed assessment and in-depth program analyses (after three years)	DSW in partnership with the implementing partners	National and local government level	2008 to 2010	Reports on the quality status of the implementation process and quality of support services
Assessing intervention effectiveness: outcome evaluation to determine whether and to what degree the NCPA activities achieve their intended effects on individual MVC (individual outcome); program- and system-level outcomes; and community outcomes	DSW in partnership with the implementing partners	National and local government level	2008 to 2010	Outcome/impact evaluation reports

Measuring the Process Action Plan Costing

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE: to ensure that the MVC responses in the country are effectively and efficiently implemented to realize the intended outcome and impact									
Implementing management information system (MIS) to periodically capture information from implementing partners on what has been achieved in relation to planned activities and overall objectives of the NCPA	MIS package (computers and accessories)	District councils	61	1	2,000	264,000	-	-	-
	Training package for M&E staff	District councils	61	1	20,000	610,000	-	-	-
	Overhead costs and data collection and processing		61	1	1,000	61,000	61,000	61,000	61,000
Evaluating the NCPA implementation process by assessing the quality of MVC responses (implementation quality assessment) by undertaking both rapid assessment (annually) and detailed assessment and in-depth program analyses (after three years)	Consultancy	Consultancy package (fees, transport, and other overheads)	1	1	50,000	-	50,000	-	50,000
Assessing intervention effectiveness: outcome evaluation to determine whether and to what degree the NCPA activities achieve their intended effects on individual MVC (individual outcome); program- and system-level outcomes; and community outcomes	Consultancy	Consultancy package (fees, transport, and other overheads)	1	1	50,000	-	50,000	-	50,000
TOTAL						**935,000**	**161,000**	**61,000**	**161,000**

* IN US$

Resource Mobilization Framework

Existing Resource Mobilization Framework

Initiatives in the country to mobilize resources for care and support to MVC include the following:

- the community-based care, support, and protection of the MVC program implemented by the Department of Social Welfare, Ministry of Labor, Youth Development, and Sports in collaboration with UNICEF and other partners such as AXIOS and Plan. Apart from mobilization of community resources and contributions (human, material, and financial) to support identified MVC in the community, the implementation of the MVC program also constitutes provision of matched funds by district councils and UNICEF. Communities or villages implementing the MVC program are required to sign a memorandum of understanding with UNICEF and open an account through which support from the district councils and UNICEF can be channeled.
- government of Tanzania budget allocations to support universal primary education, healthcare, social welfare, secondary school education, and ministry sustenance
- application for Global Fund–GF 4, done by the government in collaboration with stakeholders such as civil societies and the private sector.[8]
- Tanzania Multisectoral AIDS Programme/World Bank: mainstreaming OVC issues into the Child Development Statute
- USG (USAID/PEPFAR): data management system of service providers, development of the national action plan, facilitation of national and district level mainstreaming of MVC support, systems strengthening, and providing support to MVC through NGOs, FBOs, and other community initiatives
- support from other agencies and organizations, including UNICEF, NORAD, SIDA, ILO, USAID, local government circles, FBOs, and NGOs, to district, community, household, and individual child support initiatives.
- contributions from the communities through neighborhood associations and local support groups
- provision of care by households, communities, CBOs, and FBOs, which remain by far the main providers of care and support to MVC, though their quantifications remain a challenge

8. GF-4 is a five-year project with a budget of US$58 million and covering 24 districts. The project focuses on providing MVC with access to adequate, integrated community-based care; mitigating extreme poverty; and preparing MVC for the future through better access to education.

- funds raised by various actors for supporting MVC in an ad hoc manner. These fund mobilization efforts are not coordinated and do not complement each other, which makes it difficult to determine and obtain the required or appropriate funding level for supporting, caring for, and protecting MVC. This has been partly due to the lack of formalized and coordinated MVC fundraising frameworks and strategies in the country.

Developing the Resource Mobilization Framework

A sustained availability of adequate resources (human, financial, time, facilities, and equipment) is essential for achieving a successful and sustainable scaled-up MVC response. Consequently, seeking and securing additional support—both through funding and through "in-kind" donations of resources such as volunteer time—is inevitable. Apart from seeking additional resources from the central and local government to support MVC, potential sources of resources are the private sector, the donor community (development partners), and other local and international non-state organizations (NGOs, FBOs, and CBOs). A national framework, however, is required for a coordinated and effective resource mobilization strategy. The following table provides an overview of financial commitments by major MVC supporting agencies as of January 2005.

Financial Contributions to National MVC Response (in millions of US$)

	2005	2006	2007	2008	2009	2010
Domestic (A)****	46.0	50.7	55.7	61.3	67.4	74.1
Total external (B)	159.76	175.1	191.1	207.6	200.6	193.7
UNICEF	4.76	~4.7	~4.7	~4.7	~4.7	~$4.7
Global Fund Round 4	3.1	6.9	11.6	16.6	19.9	-
PEPFAR	4	~5	~5	~5	-	-
TMAP World Bank*	~$9.9M	~$17.5M	~$17.8M	~$18.3M	-	-
Community support**	138	141	152	163	176	189
Total resources available (A+B)	205.76	225.8	246.8	268.9	268	267.8
Total need (C) ***	345	352	379	408	440	472
Unmet need (C)-(A+B)	**139.24**	**126.2**	**132.2**	**139.1**	**172**	**204.2**

This table contains rough estimates of the total amount of funding needed to cover all of the services that should be provided to MVC.

Fundraising Framework and Strategy

The following are some of the suggested components of the national resource mobilization framework for a scaled-up response to MVC over the next six years.

National Level:

- government to dedicate and allocate adequate resources to the line ministries responsible for the care, support, and protection of MVC
- government to dedicate and allocate adequate resources to local governments for supporting MVC
- government to mobilize additional resources from the donor community
- government to mobilize additional resources from major investors in the country (e.g., banks, mining companies, industrialists, traders, and transporters)
- mobilization of resources from international and national NGOs and FBOs

District Level:

- local governments to dedicate and allocate adequate funds from their revenue to the support, care, and protection of MVC
- support from many organizations and individuals willing to donate time, resources, equipment, and staff. Local governments and district MVC facilitating teams to mobilize resources from local NGOs, business community, and prominent people in the district.

Community—Village/Street Level:

- village/street level governments to dedicate and allocate more funds from their revenue to village/street MVC fund/account
- village/street level governments to facilitate resources mobilization from prominent and wealthy people in the community
- village/street government to mobilize resources from members of the community

Resource Mobilization Action Plan

STRATEGIC ACTIONS	ACTORS/ RESPONSIBILITY	WHERE ACTION IS TO BE IMPLEMENTED	TIMELINE	OUTPUT INDICATORS
OBJECTIVE: to ensure availability of adequate resources to implement the action plan				
Government to dedicate and allocate adequate resources to the line ministries responsible for the care, support, and protection of MVC	Ministry of Finance, DSW MOHSW	National level	Every financial year	Mainstreaming of MVC issues in the medium-term expenditure framework (MTEF) and PER of the ministries responsible for care, support, and protection of MVC and increased proportion of funds allocated to supporting MVC
Government to dedicate and allocate adequate resources to the local governments for MVC support	Ministry of Finance and DSW MOHSW, Prime Minister's Regional Administration and Local Government (PORALG)	National level	Every financial year	Increased proportion of funds allocated from the central government to the district councils to support MVC
Government to mobilize additional resources from the donor community (holding a donor community round table and soliciting pledges)	Ministry of Finance and DSW MOHSW, PORALG	National level	First quarter 2008	Donor funds and pledges to support MVC
Government to mobilize additional resources from major investors in the country (e.g., banks, mining companies, industrialists, traders, and transporters) by holding roundtable meeting with national-level business community and soliciting pledges)	Ministry of Finance and DSW MOHSW, PORALG	National level	First quarter 2008	Business community pledges (funds) to support MVC
Government to mobilize resources from international and national NGOs and FBOs	Ministry of Finance and DSW MOHSW, PORALG	National level	First quarter 2008	NGO, FBO pledges to support MVC
Local governments to dedicate and allocate adequate funds from their revenue to the support, care, and protection of MVC	District council and district MVC facilitation team	District level	Every first quarter of each year	Increased proportion of funds allocated to MVC support activities in the district budget and adequate funds disbursed to village MVC accounts
Mobilization of resources from local NGOs, businesses, and prominent people in the district	District council and district MVC facilitation	District level	First quarter of each year	Pledges and contributions
Village/street-level governments to dedicate and allocate more funds from their revenue to village/street MVC fund/account	Village/street government	Village/street level	Annually	Adequate funds disbursed to village MVC accounts
Village/street-level governments to facilitate resources mobilization from prominent and wealthy people in the community	Village/street government	Village/street level	Twice annually	Increased proportion of resources mobilized from prominent and wealthy people in the community
Village/street government to mobilize resources from members of the community	Village/street government	Village/street level	Twice annually	Increased proportion of resources mobilized from members of the community

Resource Mobilization Action Plan Costing

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE: to ensure availability of adequate resources to implement the action plan									
Government to dedicate and allocate adequate resources to the line ministries responsible for the care, support, and protection of MVC	Medium-term expenditure reviews	Medium-term expenditure reviews	-	-	-	-	-	-	-
Government to dedicate and allocate adequate resources to the local governments for MVC support	Medium-term expenditure reviews	Medium-term expenditure reviews	-	-	-	-	-	-	-
Government to mobilize additional resources from the donor community (holding a donor community roundtable and soliciting pledges)	Roundtable meeting package (venue and refreshments)	Participants	30	1	50	1,500	1,500	1,500	1,500
Government to mobilize additional resources from major investors in the country (e.g., banks, mining companies, industrialists, traders, and transporters) by holding roundtable meeting with the national-level business community and soliciting pledges)	Roundtable meeting package (venue and refreshments)	Participants	50	1	50	2,500	2,500	2,500	2,500
Government to mobilize resources from international and national NGOs and FBOs	Roundtable meeting package (venue and refreshments)	Participants	30	1	50	1,500	1,500	1,500	1,500
Local governments to dedicate and allocate adequate funds from their revenue to the support, care, and protection of MVC	Roundtable meeting package (venue and refreshments)	Participants	30	132	20	79,000	79,000	79,000	79,000
Mobilization of resources from local NGOs, businesses, and prominent people in the district	Roundtable meeting package (venue and refreshments)	Participants	30	132	20	79,000	79,000	79,000	79,000

* IN US$

ACTIVITIES	INPUT DESCRIPTION	MEASURE-MENT UNIT	QTY/ UNITS	FQNCY	UNIT COSTS*	TOTAL COSTS PER YEAR*			
						YR 1	YR 2	YR 3	YR 4
OBJECTIVE: to ensure availability of adequate resources to implement the action plan									
Village/street-level governments to dedicate and allocate more funds from their revenue to the village/street MVC fund/account	-	-	-	-	-	-	-	-	-
Village/street-level governments to facilitate resource mobilization from prominent and wealthy people in the community	-	-	-	-	-	-	-	-	-
Village/street government to mobilize resources from members of the community	-	-	-	-	-	-	-	-	-
TOTAL						**163,000**	**163,000**	**163,000**	**163,000**

* IN US$

Appendices

Appendix I: Food Costs by Age Group

	0-6 years	7-14 years	15-18 years	Total
2007				
Total Number of MVC	**195,687**	**473,505**	**277,423**	**946,615**
Rural	157,917	384,610	206,675	749,202
Urban	37,770	88,894	70,747	197,411
Unit Cost per Child/Annum	6.39	11.26	15.83	
Rural Cost	1,009,090	4,330,709	3,271,665	8,611,463
Urban Cost	241,350	1,000,946	1,119,925	2,362,222
2007 TOTAL COST	**1,250,440**	**5,331,655**	**4,391,590**	**10,973,685**
2008				
Total Number of MVC				
Rural	168,224	381,945	216,316	766,485
Urban	40,235	88,278	74,047	202,560
Unit Cost per Child/Annum	6.39	11.26	15.83	
Rural Cost	1,074,951	4,300,701	3,424,282	8,799,934
Urban Cost	257,102	994,010	1,172,164	2,423,276
2008 TOTAL COST	**1,332,053**	**5,294,711**	**4,596,446**	**11,223,210**
2009				
Total Number of MVC				
Rural	172,809	396,052	227,453	591,314
Urban	41,331	91,539	77,860	802,044
Unit Cost per Child/Annum	6.39	11.26	15.83	
Rural Cost	1,104,250	4,459,546	3,600,581	9,164,376
Urban Cost	264,105	1,030,729	1,232,524	2,527,358
2009 TOTAL COST	**1,368,355**	**5,490,275**	**4,833,105**	**11,691,734**
2010				
Total Number of MVC				
Rural	177,501	410,242	237,710	825,453
Urban	42,454	94,819	81,371	218,644
Unit Cost per Child/Annum	6.39	11.26	15.83	
Rural Cost	1,134,231	4,619,325	3,762,949	9,516,506
Urban Cost	271,281	1,067,662	1,288,103	2,627,046
2010 TOTAL COST	**1,405,512**	**5,686,987**	**5,051,052**	**12,143,552**

Source: **Appendix IX**

Appendix II: Non-Food Costs by Age Group

	0-6 years	7-14 years	15-18 years	Total
2007				
Total Number of MVC	195,687	473,505	277,423	946,615
Rural	157,917	384,610	206,675	749,202
Urban	37,770	88,894	70,747	197,411
Unit Cost per Child/Annum	1.09	3.30	6.75	
Rural	172,130	1,269,213	1,395,056	2,836,399
Urban	41,169	293,350	477,542	812,062
Total	**213,299**	**1,562,563**	**1,872,599**	**3,648,461**
2008				
Total Number of MVC				
Rural	168,224	381,945	216,316	766,485
Urban	40,235	88,278	74,047	202,560
Unit Cost per Child/Annum	1.09	3.30	6.75	
Rural	183,364	1,260,419	1,460,133	2,903,916
Urban	43,856	291,317	499,817	834,991
Total	**227,220**	**1,551,736**	**1,959,950**	**3,738,906**
2009				
Total Number of MVC				
Rural	172,809	396,052	227,453	796,314
Urban	41,331	91,539	77,860	210,730
Unit Cost per Child/Annum	1.09	3.30	6.75	
Rural	188,362	1,306,972	1,535,308	3,030,641
Urban	45,051	302,079	525,555	872,684
Total	**233,413**	**1,609,050**	**2,060,863**	**3,903,326**
2010				
Total Number of MVC				
Rural	177,501	410,242	237,710	825,453
Urban	42,454	94,819	81,371	218,644
Unit Cost per Child/Annum	1.09	3.30	6.75	
Rural	193,476	1,353,799	1,604,543	3,151,817
Urban	46,275	312,903	549,254	908,432
Total	**239,751**	**1,666,701**	**2,153,797**	**4,060,249**

Source: Appendix IX

Appendix III: Projected Number of Children for 2007 by Vulnerability Criteria and Area of Residence

Vulnerability criteria

RURAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	2,968,920	2,264,982	740,653	5,974,555
Number of children in child-headed households	32,840	45,626	47,807	126,273
Number of children in elderly-headed households	67,449	144,695	55,604	267,748
Number of double-orphaned children	20,583	77,292	49,241	147,116
Number of maternal-orphaned children*	67,892	160,035	83,947	311,875
Number of paternal-orphaned children*	225,013	454,154	226,667	905,833
Total number of orphaned children	313,488	691,481	359,855	1,364,824
Number of disabled children	52,178	83,184	32,865	168,227
Most vulnerable**	**157,917**	**384,610**	**206,675**	**749,203**

URBAN	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	398,298	337,073	137,389	872,760
Number of children in child-headed households	10,145	15,630	27,346	53,121
Number of children in elderly-headed households	7,346	16,278	6,771	30,396
Number of double-orphaned children	6,149	30,979	24,421	61,549
Number of maternal-orphaned children*	17,973	53,369	36,513	107,855
Number of paternal-orphaned children*	52,626	127,653	78,001	258,279
Total number of orphaned children	76,748	212,001	138,935	427,683
Number of disabled children	9,188	14,457	6,511	30,156
Most vulnerable**	**37,770**	**88,894**	**70,747**	**197,411**

TOTAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,367,217	2,602,055	878,042	6,847,314
Number of children in child-headed households	42,985	61,256	75,153	179,393
Number of children in elderly-headed households	74,795	160,974	62,375	298,144
Number of double-orphaned children	26,732	108,271	73,661	208,664
Number of maternal-orphaned children*	85,865	213,404	120,460	419,729
Number of paternal-orphaned children*	277,638	581,807	304,667	1,164,112
Total number of orphaned children	390,235	903,482	498,788	1,792,505
Number of disabled children	61,366	97,640	39,376	198,383
Most vulnerable**	**195,687**	**473,505**	**277,423**	**946,614**

Source: Authors' calculations using Tanzania National Projections, 2006, and PHDR, 2006

* Children with at least one parent alive

** Composite of the following vulnerability criteria:

1. Children living in child-headed households
2. Children living in elderly-headed households
3. Children with both parents deceased
4. In rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar very poor conditions
5. In urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar very poor conditions

Appendix IV: Projected Number of Children for 2008 by Vulnerability Criteria and Area of Residence

Vulnerability criteria

RURAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,162,694	2,249,287	775,200	6,187,181
Number of children in child-headed households	34,983	45,310	50,037	130,330
Number of children in elderly-headed households	71,851	143,693	58,198	273,742
Number of double-orphaned children	21,927	76,756	51,537	150,220
Number of maternal-orphaned children*	72,323	158,926	87,863	319,113
Number of paternal-orphaned children*	239,699	451,007	237,239	927,945
Total number of orphaned children	333,949	686,689	376,639	1,397,278
Number of disabled children	55,584	82,607	34,398	172,589
Most vulnerable**	**168,224**	**381,945**	**216,316**	**766,485**

URBAN	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	424,293	334,737	143,798	902,828
Number of children in child-headed households	10,807	15,521	28,622	54,950
Number of children in elderly-headed households	7,826	16,165	7,087	31,078
Number of double-orphaned children	6,550	30,764	25,560	62,874
Number of maternal-orphaned children*	19,146	52,999	38,216	110,361
Number of paternal-orphaned children*	56,060	126,768	81,639	264,467
Total number of orphaned children	81,756	210,531	145,415	437,702
Number of disabled children	9,788	14,357	6,815	30,959
Most vulnerable**	**40,235**	**88,278**	**74,047**	**202,560**

TOTAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,586,987	2,584,024	918,998	7,090,009
Number of children in child-headed households	45,790	60,831	78,658	185,280
Number of children in elderly-headed households	79,677	159,858	65,284	304,820
Number of double-orphaned children	28,477	107,521	77,097	213,095
Number of maternal-orphaned children*	91,469	211,925	126,079	429,474
Number of paternal-orphaned children*	295,759	577,775	318,878	1,192,413
Total number of orphaned children	415,705	897,221	522,054	1,834,982
Number of disabled children	65,372	96,964	41,213	203,548
Most vulnerable**	**208,459**	**470,223**	**290,363**	**969,045**

Source: Calculated using Tanzania National Projections, 2006, and PHDR, 2006

* Children with at least one parent alive

** Composite of the following vulnerability criteria:

1. Children living in child-headed households
2. Children living in elderly-headed households
3. Children with both parents deceased
4. In rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar very poor conditions
5. In urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar very poor conditions

APPENDIX V: Projected Number of Children for 2009 by Vulnerability Criteria and Area of Residence

Vulnerability criteria

RURAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,248,891	2,332,364	815,113	6,396,368
Number of children in child-headed households	35,937	46,983	52,613	135,533
Number of children in elderly-headed households	73,810	149,000	61,194	284,004
Number of double-orphaned children	22,524	79,591	54,191	156,306
Number of maternal-orphaned children*	74,295	164,796	92,386	331,477
Number of paternal-orphaned children*	246,232	467,665	249,454	963,351
Total number of orphaned children	343,051	712,052	396,031	1,451,134
Number of disabled children	57,099	85,658	36,169	178,926
Most vulnerable**	**172,809**	**396,052**	**227,453**	**796,314**
URBAN	**0–6 YRS**	**7–14 YRS**	**15–17 YRS**	**TOTAL**
Number of poor children	435,857	347,100	151,202	934,159
Number of children in child-headed households	11,101	16,095	30,095	57,292
Number of children in elderly-headed households	8,039	16,763	7,452	32,253
Number of double-orphaned children	6,729	31,901	26,876	65,505
Number of maternal-orphaned children*	19,667	54,956	40,184	114,808
Number of paternal-orphaned children*	57,588	131,450	85,842	274,881
Total number of orphaned children	83,984	218,307	152,902	455,194
Number of disabled children	10,055	14,887	7,165	32,107
Most vulnerable**	**41,331**	**91,539**	**77,860**	**210,730**
TOTAL	**0–6 YRS**	**7–14 YRS**	**15–17 YRS**	**TOTAL**
Number of poor children	3,684,748	2,679,465	966,314	7,330,527
Number of children in child-headed households	47,038	63,078	82,708	192,824
Number of children in elderly-headed households	81,849	165,763	68,646	316,257
Number of double-orphaned children	29,253	111,492	81,067	221,812
Number of maternal-orphaned children*	93,962	219,753	132,571	446,285
Number of paternal-orphaned children*	303,820	599,115	335,296	1,238,232
Total number of orphaned children	427,035	930,360	548,934	1,906,329
Number of disabled children	67,153	100,545	43,335	211,033
Most vulnerable**	**214,1407**	**487,591**	**305,313**	**1,007,044**

Source: Calculated using Tanzania National Projections, 2006, and PHDR, 2006.

* Children with at least one parent alive

** Composite of the following vulnerability criteria:

1. Children living in child-headed households
2. Children living in elderly-headed households
3. Children with both parents deceased
4. In rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar very poor conditions
5. In urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar very poor conditions

APPENDIX VI: Projected Number of Children for 2010 by Vulnerability Criteria and Area of Residence

Vulnerability criteria

RURAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,337,111	2,415,928	851,871	6,604,911
Number of children in child-headed households	36,912	48,667	54,985	140,565
Number of children in elderly-headed households	75,814	154,338	63,954	294,106
Number of double-orphaned children	23,136	82,443	56,635	162,213
Number of maternal-orphaned children*	76,312	170,701	96,553	343,565
Number of paternal-orphaned children*	252,918	484,420	260,703	998,042
Total number of orphaned children	352,366	737,564	413,891	1,503,820
Number of disabled children	58,649	88,727	37,801	185,177
Most vulnerable**	**177,501**	**410,242**	**237,710**	**825,454**

URBAN	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	447,693	359,536	158,020	965,249
Number of children in child-headed households	11,403	16,671	31,453	59,527
Number of children in elderly-headed households	8,257	17,363	7,788	33,408
Number of double-orphaned children	6,911	33,044	28,088	68,043
Number of maternal-orphaned children*	20,201	56,925	41,996	119,123
Number of paternal-orphaned children*	59,152	136,160	89,713	285,025
Total number of orphaned children	86,264	226,129	159,797	472,191
Number of disabled children	10,328	15,420	7,489	33,237
Most vulnerable**	**42,454**	**94,819**	**81,371**	**218,643**

TOTAL	0–6 YRS	7–14 YRS	15–17 YRS	TOTAL
Number of poor children	3,784,804	2,775,465	1,009,891	7,570,160
Number of children in child-headed households	48,315	65,338	86,438	200,091
Number of children in elderly-headed households	84,071	171,702	71,741	327,514
Number of double-orphaned children	30,047	115,486	84,722	230,256
Number of maternal-orphaned children*	96,513	227,626	138,549	462,688
Number of paternal-orphaned children*	312,070	620,580	350,417	1,283,067
Total number of orphaned children	438,630	963,692	573,688	1,976,011
Number of disabled children	68,977	104,147	45,289	218,413
Most vulnerable**	**219,955**	**505,061**	**319,081**	**1,044,096**

Source: Calculated using Tanzania National Projections, 2006, and PHDR, 2006.

* Children with at least one parent alive

** Composite of the following vulnerability criteria:

1. Children living in child-headed households
2. Children living in elderly-headed households
3. Children with both parents deceased
4. In rural areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) and children with a disability living in similar very poor conditions
5. In urban areas: children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) or with very poor wall materials or without toilet facility and children with a disability living in similar very poor conditions

APPENDIX VII: Estimated Percentages of Children Who Are Most Vulnerable, by Age, Rural/Urban, and District, 2006

	RURAL				URBAN				TOTAL			
DISTRICT	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7 –14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN
DODOMA												
Kondoa	4.3	10.1	15.6	8.2	3.1	7.5	13.3	6.6	4.2	10.0	15.4	8.1
Mpwapwa	4.4	10.5	16.4	8.2	2.6	5.6	13.2	5.6	4.3	10.1	16.0	8.0
Kongwa	3.0	7.8	12.5	6.0	2.5	6.0	13.8	5.6	3.0	7.7	12.6	6.0
Dodoma rural	7.5	16.7	25.6	13.4	6.7	14.2	22.2	11.7	7.5	16.6	25.5	13.3
Dodoma urban	5.5	12.1	17.5	9.8	1.4	4.3	8.1	3.8	3.8	8.7	12.5	7.2
ARUSHA												
Monduli	4.1	7.9	12.4	6.4	1.6	4.8	9.6	4.0	3.9	7.5	12.0	6.1
Arumeru	2.0	5.1	7.1	3.9	1.5	4.4	9.6	3.9	1.9	5.0	7.6	3.9
Arusha	1.5	4.9	6.3	3.6	1.0	3.1	8.0	2.9	1.0	3.2	7.9	3.0
Karatu	1.8	3.9	6.9	3.3	1.2	3.9	10.3	3.3	1.7	3.9	7.1	3.3
Ngorongoro	4.7	8.0	14.9	6.9	2.8	6.9	7.2	5.2	4.6	8.0	14.5	6.9
KILIMANJARO												
Rombo	2.4	6.5	10.0	5.2	2.0	4.1	9.2	3.8	2.4	6.4	10.0	5.2
Mwanga	2.6	7.2	9.6	5.8	2.7	6.5	11.8	5.7	2.7	7.0	10.2	5.8
Same	3.0	7.4	9.1	5.9	2.9	6.5	11.8	5.7	3.0	7.1	9.9	5.8
Moshi rural	3.0	7.6	12.2	6.3	1.5	3.6	8.2	3.2	3.0	7.5	12.1	6.2
Hai	2.1	5.4	8.1	4.3	2.6	5.8	10.8	5.0	2.2	5.4	8.4	4.4
Moshi urban					1.4	3.0	8.2	3.1	1.4	3.0	8.2	3.1
TANGA												
Lushoto	2.8	6.7	9.6	5.3	3.1	7.3	9.2	6.1	2.8	6.7	9.6	5.3
Korogwe	2.0	5.4	8.7	4.3	2.1	6.4	11.7	5.5	2.0	5.5	9.3	4.5
Muheza	2.0	4.2	6.5	3.5	3.2	8.9	13.4	7.3	2.2	4.7	7.5	3.9
Tanga	1.9	4.7	8.3	3.9	2.2	6.9	10.4	5.6	2.1	6.3	9.9	5.1
Pangani	2.5	6.2	9.0	5.1	3.1	8.9	14.0	7.5	2.6	6.6	9.9	5.5
Handeni	2.0	4.8	9.1	3.9	1.7	5.0	10.5	4.5	2.0	4.8	9.2	4.0
Kilindi	2.6	5.6	10.3	4.6					2.6	5.6	10.3	4.6
MOROGORO												
Kilosa	1.9	4.3	8.1	3.6	3.3	7.7	16.0	6.9	2.2	5.0	9.9	4.4
Morogoro rural	2.6	6.3	11.9	5.4	3.3	9.9	18.8	8.5	2.7	6.4	12.1	5.5
Kilombero	1.9	4.3	8.0	3.7	2.0	6.1	12.1	5.3	2.0	4.8	9.2	4.1
Ulanga	1.7	4.2	7.7	3.5	4.0	10.0	16.8	8.5	2.0	4.9	9.0	4.1
Morogoro urban	1.1	4.6	10.6	3.6	1.3	4.0	9.8	3.8	1.3	4.0	9.9	3.7
Mvomero	2.2	5.7	10.7	4.7	2.7	7.8	13.8	6.5	2.2	5.9	11.1	4.9
PWANI												
Bagamoyo	2.0	5.1	9.4	4.3	3.7	9.0	17.3	8.4	2.3	5.8	11.0	4.9
Kibaha	2.9	7.7	13.7	6.5	2.6	5.0	11.9	5.1	2.7	6.5	12.8	5.9
Kisarawe	3.8	9.3	14.8	7.6	2.4	7.2	14.5	6.5	3.6	9.0	14.8	7.4
Mkuranga	2.4	7.0	10.9	5.3	3.2	10.3	17.1	8.3	2.4	7.3	11.8	5.6
Rufiji	3.3	6.3	10.9	5.4	4.4	11.1	19.8	9.3	3.5	7.2	12.9	6.2
Mafia	1.8	4.3	8.0	3.8	3.8	11.1	19.7	9.5	2.2	5.6	10.7	5.0

APPENDIX VII: Estimated Percentages of Children Who Are Most Vulnerable, by Age, Rural/Urban, and District, 2006 *continued*

	RURAL				URBAN				TOTAL			
DISTRICT	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7 –14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN
DSM												
Kinondoni	1.6	5.6	8.9	4.4	1.5	3.7	7.7	3.5	1.5	3.8	7.7	3.5
Ilala	2.6	5.6	8.7	4.6	1.2	3.9	7.7	3.5	1.4	4.0	7.8	3.5
Temeke	2.5	5.7	12.1	5.1	1.0	4.4	8.2	3.6	1.1	4.5	8.4	3.7
LINDI												
Kilwa	2.0	4.4	7.8	3.7	5.2	10.3	18.1	9.6	2.2	4.8	8.7	4.1
Lindi rural	2.3	6.6	11.1	5.2	5.2	14.6	21.8	11.8	2.6	7.7	12.8	6.1
Nachingwea	1.8	5.5	7.7	4.2	2.7	7.8	13.8	6.7	1.9	5.8	8.6	4.5
Liwale	1.7	3.3	4.7	2.7	1.6	5.4	9.1	4.5	1.7	3.7	5.9	3.0
Ruangwa	2.0	5.0	9.6	4.1	4.7	12.3	20.2	10.0	2.3	6.0	11.3	4.9
Lindi urban	3.0	5.9	13.0	5.5	3.7	8.1	15.6	8.0	3.5	7.4	15.0	7.2
MTWARA												
Mtwara rural	2.0	5.0	8.8	4.1	3.7	10.7	16.8	8.3	2.1	5.4	9.4	4.4
Newala	1.8	6.5	9.7	4.9	2.5	6.8	13.4	6.4	1.9	6.5	10.3	5.1
Masasi	2.5	6.9	9.7	5.3	5.0	11.7	17.0	9.8	2.9	7.7	11.2	6.0
Tandahimba	2.5	6.1	11.3	5.1	3.8	11.1	18.4	8.9	2.7	7.1	12.9	5.8
Mtwara urban	1.8	4.9	7.4	4.0	3.7	8.1	12.9	7.1	3.3	7.6	12.1	6.7
RUVUMA												
Tunduru	2.2	5.2	7.7	4.1	3.0	7.8	12.9	6.6	2.3	5.4	8.3	4.3
Songea rural	1.5	4.9	6.2	3.6	2.6	8.1	18.2	7.5	1.6	5.1	7.3	3.9
Mbinga	1.5	3.7	6.6	3.1	2.5	5.4	11.3	5.1	1.5	3.8	6.9	3.2
Songea urban	2.5	5.6	7.9	4.6	1.6	5.0	11.0	4.6	1.8	5.1	10.3	4.6
Namtumbo	1.4	2.9	5.9	2.6	4.2	8.6	14.2	7.5	1.5	3.3	6.5	2.9
IRINGA												
Iringa rural	3.0	10.8	17.9	8.4	5.9	15.2	24.5	12.2	3.1	11.0	18.1	8.5
Mufindi	2.8	7.8	14.3	6.3	5.0	12.5	19.1	10.8	3.0	8.3	15.1	6.8
Makete	4.2	11.7	17.7	9.4	6.1	15.8	29.0	14.5	4.3	12.0	18.8	9.8
Njombe	2.1	7.0	10.6	5.4	2.9	9.9	18.9	8.3	2.3	7.5	12.4	5.9
Ludewa	1.7	5.5	9.9	4.5	3.8	11.9	21.9	10.8	1.9	6.1	11.6	5.1
Iringa urban	2.4	8.4	11.8	6.3	2.3	7.8	13.9	6.8	2.3	7.9	13.8	6.8
Kilolo	2.8	7.4	9.8	5.7	2.8	10.3	21.0	8.8	2.8	7.6	11.0	6.0
MBEYA												
Chunya	1.6	5.2	10.0	4.0	3.2	9.5	18.6	7.9	1.7	5.6	10.8	4.4
Mbeya rural	2.3	7.1	11.6	5.5	2.3	8.2	14.3	6.3	2.3	7.3	12.0	5.7
Kyela	2.7	9.9	15.3	7.7	2.2	9.1	18.8	7.6	2.6	9.8	15.7	7.7
Rungwe	4.0	12.5	16.6	9.4	2.8	8.7	16.7	7.6	4.0	12.2	16.6	9.3
Ileje	2.2	7.4	12.0	5.8	1.7	6.6	19.2	7.0	2.2	7.4	12.2	5.8
Mbozi	2.0	5.5	9.3	4.3	2.9	7.1	15.9	6.4	2.1	5.6	10.0	4.5
Mbarali	2.6	7.4	11.9	5.7	4.5	11.6	19.7	9.7	2.9	8.0	13.2	6.3
Mbeya urban	2.4	7.6	11.9	6.0	1.8	5.9	13.4	5.4	1.9	6.1	13.3	5.5

APPENDIX VII: Estimated Percentages of Children Who Are Most Vulnerable, by Age, Rural/Urban, and District, 2006 *continued*

	RURAL				URBAN				TOTAL			
DISTRICT	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7 –14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN
SINGIDA												
Iramba	4.7	12.3	19.0	9.7	5.0	11.6	18.3	9.8	4.7	12.2	18.9	9.7
Singida rural	6.5	12.8	19.9	10.8	5.2	13.8	18.0	10.7	6.5	12.8	19.8	10.8
Manyoni	5.8	13.6	19.2	10.8	3.3	7.1	15.1	6.6	5.4	12.5	18.4	10.1
Singida urban	4.9	11.1	15.5	8.9	2.0	5.4	10.0	4.8	3.7	8.5	12.6	7.1
TABORA												
Nzega	2.2	4.8	7.2	3.8	2.7	7.3	12.5	6.1	2.2	4.9	7.6	4.0
Igunga	3.1	7.6	11.4	5.8	2.9	5.2	12.0	5.2	3.1	7.4	11.5	5.8
Uyui	2.1	3.7	6.3	3.2	4.6	10.0	19.3	8.4	2.1	3.8	6.4	3.3
Urambo	1.5	3.3	7.9	3.0	2.9	7.2	15.4	6.5	1.6	3.6	8.6	3.2
Sikonge	1.5	4.2	5.8	3.0	3.5	7.9	15.0	7.2	1.6	4.4	6.7	3.3
Tabora urban	1.8	4.7	6.9	3.7	2.1	5.4	9.8	4.7	2.0	5.2	8.9	4.3
RUKWA												
Mpanda	1.5	3.5	6.9	3.0	3.6	9.8	15.4	7.7	1.8	4.4	8.3	3.7
Sumbawanga rural	2.0	5.5	10.1	4.3	4.9	11.8	21.0	9.8	2.2	5.9	10.7	4.6
Nkansi	1.6	5.3	8.8	3.9	4.1	12.3	21.0	9.5	2.0	6.7	11.2	5.0
Sumbawanga urban	1.5	4.3	7.0	3.3	2.4	7.2	13.4	6.0	1.9	5.7	10.5	4.6
KIGOMA												
Kibondo	1.7	4.3	7.9	3.4	1.8	4.9	9.1	4.2	1.7	4.4	8.0	3.5
Kasulu	1.7	3.9	5.5	3.0	2.2	6.1	12.3	5.3	1.7	4.0	6.0	3.1
Kigoma rural	1.1	2.5	5.3	2.2	4.0	9.5	17.0	7.7	1.3	2.9	6.0	2.5
Kigoma urban	1.3	2.7	6.5	2.5	2.7	6.9	11.2	5.7	2.6	6.6	10.8	5.4
SHINYANGA												
Bariadi	1.6	3.7	6.6	2.9	2.2	5.6	12.4	4.9	1.6	3.7	6.9	3.0
Maswa	4.0	8.7	13.7	6.9	2.7	7.0	12.3	5.9	3.9	8.5	13.5	6.9
Shinyanga rural	2.3	5.6	7.7	4.3	3.6	10.8	17.9	8.5	2.3	5.6	7.8	4.3
Kahama	1.5	4.0	5.2	3.0	1.9	5.5	12.4	4.8	1.5	4.2	6.0	3.1
Bukombe	1.4	3.3	6.4	2.7	2.1	4.7	10.4	4.0	1.5	3.4	6.7	2.8
Meatu	4.2	9.7	14.8	7.5	1.7	6.7	12.1	5.0	4.2	9.6	14.7	7.4
Shinyanga urban	4.0	9.8	15.4	7.9	1.4	4.4	10.3	4.0	2.7	7.1	12.6	5.9
Kishapu	4.2	10.4	16.4	8.1	1.3	5.5	7.3	4.0	4.1	10.2	15.8	8.0
KAGERA												
Karagwe	1.3	5.0	10.5	3.9	0.8	6.3	14.9	5.3	1.2	5.0	10.6	4.0
Bukoba rural	3.6	11.4	19.8	9.1	3.4	13.0	24.2	9.9	3.6	11.4	19.8	9.2
Muleba	3.2	8.4	13.9	6.7	1.6	8.5	14.8	6.6	3.2	8.4	14.0	6.7
Biharamulo	1.6	3.6	7.2	2.9	2.5	6.4	13.9	5.4	1.7	3.8	7.9	3.2
Ngara	1.4	4.7	10.4	3.8	0.9	6.3	11.7	5.2	1.4	4.7	10.4	3.8
Bukoba urban	2.7	9.1	17.4	7.6	1.2	6.0	15.6	5.4	1.6	6.9	16.1	6.0

APPENDIX VII: Estimated Percentages of Children Who Are Most Vulnerable, by Age, Rural/Urban, and District, 2006 *continued*

	RURAL				URBAN				TOTAL			
DISTRICT	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7 –14 YEARS	15–17 YEARS	ALL CHILDREN	0–6 YEARS	7–14 YEARS	15–17 YEARS	ALL CHILDREN
MWANZA												
Ukerewe	2.0	4.7	6.7	3.6	3.7	7.8	13.3	6.4	2.2	5.1	7.5	3.9
Magu	1.9	5.2	8.4	4.0	2.6	6.4	12.3	5.3	2.0	5.3	8.7	4.1
Nyamagana					1.6	4.4	11.9	4.3	1.6	4.4	11.9	4.3
Kwimba	2.1	4.5	7.0	3.6	2.7	8.9	11.3	6.6	2.1	4.7	7.3	3.8
Sengerema	2.4	5.1	7.5	4.0	2.0	5.5	10.1	4.6	2.3	5.2	7.7	4.1
Geita	1.8	3.6	6.1	3.0	2.2	6.2	10.5	4.9	1.8	3.9	6.6	3.2
Misungwi	1.5	3.5	4.6	2.6	2.7	7.9	14.3	6.3	1.6	3.8	5.4	2.9
Ilemela	2.0	4.3	7.6	3.6	1.8	4.3	8.4	3.7	1.9	4.3	8.1	3.7
MARA												
Tarime	3.2	6.3	12.7	5.5	4.5	9.3	18.0	8.1	3.4	6.7	13.4	
Serengeti	2.7	6.3	11.5	5.2	3.3	7.7	17.4	7.1	2.7	6.4	12.0	
Musoma rural	2.2	5.3	7.8	4.2	3.8	7.8	15.0	7.2	2.3	5.4	8.0	
Bunda	1.8	4.5	7.9	3.7	3.4	7.4	14.0	6.4	2.1	5.1	9.1	
Musoma urban	2.2	2.9	4.8	2.8	2.2	5.8	11.4	4.9	2.2	5.7	11.2	
MANYARA												
Babati	1.2	4.0	6.5	3.0	2.5	6.6	10.5	5.4	1.4	4.4	7.1	3.3
Hanang	2.6	4.3	5.8	3.7	2.1	5.4	9.2	4.4	2.5	4.4	6.1	3.7
Mbulu	2.6	6.9	11.1	5.4	1.7	4.4	9.5	3.9	2.6	6.7	11.0	5.3
Simanjiro	3.2	5.4	13.6	5.0	1.9	5.0	14.4	4.6	2.9	5.3	13.8	4.9
Kiteto	4.8	9.7	17.0	7.9	2.0	4.8	10.3	4.1	4.5	9.0	16.0	7.5

APPENDIX VIII: Estimated Numbers of Vulnerable Children, by Type of Vulnerability and District, 2002

District	Single orphans*	Double orphans	Children with a disability*	Children from child- headed households	Children from elderly-headed households	Most vulnerable children	Percentage of all most vulnerable children
DODOMA							
Kondoa	6,562	1,895	965	1,933	8,048	18,317	2.19
Mpwapwa	4,928	713	934	1,563	3,067	10,468	1.25
Kongwa	2,892	912	535	1,255	2,582	7,687	0.92
Dodoma rural	17,289	1,492	2,962	3,429	6,553	29,241	3.50
Dodoma urban	4,439	1,895	485	1,742	2,831	10,680	1.28
ARUSHA							
Monduli	1,943	336	250	1,790	2,103	6,152	0.74
Arumeru	748	1,318	93	2,384	6,027	10,160	1.22
Arusha	23	1,153	1	1,665	758	3,502	0.42
Karatu	853	356	146	688	1,094	3,029	0.36
Ngorongoro	2,446	127	165	1,199	1,205	4,973	0.59
KILIMANJARO							
Rombo	24	1,142	0	1,325	4,662	6,806	0.81
Mwanga	291	596	48	651	1,872	3,330	0.40
Same	622	794	96	1,225	3,903	6,433	0.77
Moshi rural	123	2,161	10	1,936	8,162	11,924	1.43
Hai	438	1,174	18	849	3,029	5,278	0.63
Moshi urban	44	652	12	809	298	1,766	0.21
TANGA							
Lushoto	1,363	1,812	135	1,987	7,493	12,202	1.46
Korogwe	416	1,524	71	893	2,876	5,524	0.66
Muheza	422	1,102	83	1,325	2,527	5,319	0.64
Tanga	1,889	1,407	216	924	1,202	5,474	0.65
Pangani	110	259	15	238	504	1,077	0.13
Handeni	871	734	130	1,336	2,229	5,118	0.61
Kilindi	1,171	344	164	780	1,303	3,561	0.43
MOROGORO							
Kilosa	2,309	2,133	390	2,940	3,153	10,414	1.25
Morogoro rural	577	1,802	58	1,467	3,236	6,867	0.82
Kilombero	1,179	1,299	166	1,897	1,690	6,054	0.72
Ulanga	895	920	192	909	1,244	3,986	0.48
Morogoro urban	303	1,334	48	1,393	604	3,551	0.42
Mvomero	781	1,130	138	1,713	2,540	5,955	0.71
PWANI							
Bagamoyo	756	1,472	90	1,312	1,856	5,199	0.62
Kibaha	324	893	24	780	1,298	3,192	0.38
Kisarawe	208	628	16	656	1,627	2,972	0.36
Mkuranga	541	1,142	56	918	2,574	5,007	0.60
Rufiji	1,278	717	138	1,853	2,442	6,217	0.74
Mafia	221	181	16	167	364	921	0.11

APPENDIX VIII: Estimated Numbers of Vulnerable Children, by Type of Vulnerability and District, 2002 *continued*

District	Single orphans*	Double orphans	Children with a disability*	Children from child- headed households	Children from elderly-headed households	Most vulnerable children	Percentage of all most vulnerable children
DSM							
Kinondoni	1,458	6,839	145	5,128	1,045	14,305	1.71
Ilala	107	4,260	0	3,629	1,153	8,877	1.06
Temeke	895	5,363	104	4,408	1,177	11,618	1.39
LINDI							
Kilwa	311	738	14	1,065	1,612	3,598	0.43
Lindi rural	857	1,112	95	1,168	2,626	5,571	0.67
Nachingwea	313	580	49	530	1,890	3,270	0.39
Liwale	186	246	27	282	399	1,074	0.13
Ruangwa	388	359	25	630	1,201	2,511	0.30
Lindi urban	322	265	12	345	318	1,198	0.14
MTWARA							
Mtwara rural	336	699	52	983	1,920	3,860	0.46
Newala	375	585	51	827	2,084	3,737	0.45
Masasi	2,388	1,273	406	2,342	6,034	11,853	1.42
Tandahimba	750	608	90	1,211	2,371	4,871	0.58
Mtwara urban	901	425	91	824	386	2,477	0.30
RUVUMA							
Tunduru	617	783	103	985	2,748	5,054	0.60
Songea rural	240	865	36	516	1,477	2,966	0.35
Mbinga	494	1,537	63	1,528	3,190	6,672	0.80
Songea urban	350	988	80	747	703	2,762	0.33
Namtumbo	359	538	75	590	1,019	2,520	0.30
IRINGA							
Iringa rural	2,683	2,721	373	1,439	4,185	10,396	1.24
Mufindi	902	4,224	55	1,986	4,073	10,186	1.22
Makete	511	2,382	37	808	1,890	5,043	0.60
Njombe	1,607	5,008	193	2,117	4,310	12,358	1.48
Ludewa	384	1,414	39	843	1,181	3,534	0.42
Iringa urban	81	1,836	0	1,151	427	3,267	0.39
Kilolo	1,578	1,931	133	856	2,359	6,350	0.76
MBEYA							
Chunya	685	1,489	46	1,055	1,520	4,524	0.54
Mbeya rural	669	2,324	40	1,472	3,310	7,201	0.86
Kyela	151	2,730	3	1,047	2,920	6,429	0.77
Rungwe	481	4,702	5	1,537	8,203	13,592	1.63
Ileje	416	842	36	544	1,816	3,306	0.40
Mbozi	780	3,874	110	3,223	5,233	12,511	1.50
Mbarali	1,392	2,057	78	1,305	2,629	7,093	0.85
Mbeya urban	257	3,780	16	2,132	1,368	6,955	0.83

APPENDIX VIII: Estimated Numbers of Vulnerable Children, by Type of Vulnerability and District, 2002 *continued*

District	Single orphans*	Double orphans	Children with a disability*	Children from child- headed households	Children from elderly-headed households	Most vulnerable children	Percentage of all most vulnerable children
SINGIDA							
Iramba	10,291	1,458	1,649	1,724	4,922	18,785	2.25
Singida rural	14,730	1,342	1,873	1,213	5,504	23,280	2.78
Manyoni	6,086	825	693	1,134	2,169	10,301	1.23
Singida urban	2,266	529	177	479	805	4,059	0.49
TABORA							
Nzega	937	2,053	116	1,864	3,930	8,560	1.02
Igunga	5,262	1,051	924	850	2,216	9,965	1.19
Uyui	847	978	124	1,441	1,801	5,050	0.60
Urambo	1,313	1,299	96	1,766	2,393	6,656	0.80
Sikonge	375	523	59	772	702	2,340	0.28
Tabora urban	377	1,048	66	1,403	1,177	3,890	0.47
RUKWA							
Mpanda	1,597	2,422	209	2,156	2,331	8,237	0.99
Sumbawanga rural	890	1,805	126	2,848	4,189	9,449	1.13
Nkansi	1,491	1,196	183	1,151	1,986	5,692	0.68
Sumbawanga urban	631	1,166	40	863	1,192	3,698	0.44
Mpanda	1,597	2,422	209	2,156	2,331	8,237	0.99
Sumbawanga rural	890	1,805	126	2,848	4,189	9,449	1.13
Nkansi	1,491	1,196	183	1,151	1,986	5,692	0.68
Sumbawanga urban	631	1,166	40	863	1,192	3,698	0.44
KIGOMA							
Kibondo	684	884	220	1,382	2,368	5,260	0.63
Kasulu	1,562	1,292	326	1,953	3,588	8,420	1.01
Kigoma rural	1,199	1,342	152	1,696	1,386	5,604	0.67
Kigoma urban	1,769	825	187	836	501	3,975	0.48
SHINYANGA							
Bariadi	3,009	2,474	464	1,948	2,906	10,622	1.27
Maswa	6,522	1,532	1,113	825	1,787	11,313	1.35
Shinyanga rural	2,137	1,033	342	815	2,368	6,425	0.77
Kahama	1,519	2,481	201	2,351	3,742	9,943	1.19
Bukombe	1,863	1,175	181	1,518	1,756	6,255	0.75
Meatu	6,859	1,072	999	774	1,062	10,284	1.23
Shinyanga urban	1,588	830	192	630	714	3,787	0.45
Kishapu	6,577	1,008	1,081	570	1,298	10,046	1.20

APPENDIX VIII: Estimated Numbers of Vulnerable Children, by Type of Vulnerability and District, 2002 *continued*

District	Single orphans*	Double orphans	Children with a disability*	Children from child- headed households	Children from elderly-headed households	Most vulnerable children	Percentage of all most vulnerable children
KAGERA							
Karagwe	45	3,141	23	2,222	4,218	9,189	1.10
Bukoba rural	1,463	7,386	88	2,721	8,739	18,793	2.25
Muleba	639	4,613	27	2,208	7,219	13,335	1.60
Biharamulo	985	1,789	107	2,195	2,218	7,119	0.85
Ngara	160	1,745	9	948	2,252	4,755	0.57
Bukoba urban	54	1,263	2	525	412	2,114	0.25
MWANZA							
Ukerewe	894	1,103	154	1,318	1,893	5,203	0.62
Magu	1,326	2,559	170	2,411	2,876	9,017	1.08
Nyamagana	283	1,651	18	1,802	313	3,910	0.47
Kwimba	1,507	1,517	278	1,331	2,149	6,547	0.78
Sengerema	2,584	2,192	642	2,854	2,807	10,604	1.27
Geita	1,988	3,040	322	3,787	3,657	12,381	1.48
Misungwi	1,058	963	165	644	1,346	4,058	0.49
Ilemela	394	1,632	96	1,811	830	4,610	0.55
MARA							
Tarime	5,707	3,373	440	3,084	3,896	15,732	1.88
Serengeti	1,608	1,186	199	1,465	1,184	5,377	0.64
Musoma rural	1,514	1,822	45	1,911	2,760	7,792	0.93
Bunda	770	1,390	94	1,597	2,244	5,897	0.71
Musoma urban	488	839	29	752	559	2,553	0.31
MANYARA							
Babati	683	813	106	1,259	2,414	5,101	0.61
Hanang	1,970	346	339	488	1,126	4,175	0.50
Mbulu	4,250	396	569	835	1,127	6,961	0.83
Simanjiro	719	304	122	1,456	733	3,273	0.39
Kiteto	3,384	329	383	1,058	843	5,742	0.69
TOTAL	**200,354**	**185,962**	**27,769**	**172,828**	**292,341**	**836,032**	**100.00**

*Single orphans and children with a disability are included only if they are living in very poor conditions.

APPENDIX IX: Methodology for Costing MVC Support

The consumption categories and items presented in Table I were used to estimate the household expenditure on children for those living in the poorest households and those living at about the poverty line. The last column shows how expenditures were assigned to children.

Appendix IX—Table I: Itemized Expenditures and Expenditure Details

Expenditure item	Expenditure item details	Assumptions made
FOOD	All food expenditure, excluding expenditures on alcohol	Child share of household food consumption is equal to an adult equivalent share
CLOTHING	**For children under 2** - Baby clothing **For boys between 2 and 14:** - Shorts, trousers - Shirts, blouses - Underwear - Sweaters, vests - Socks - Repairs to clothes - Footwear **For girls between 2 and 14:** - Skirts - Shirts, blouses - Sweaters, vests - Underwear - Repairs to clothes - Footwear	
	For boys between 15 and 17: - Trousers - Shorts - Pullovers - Shirts - Vests - Underwear - Repairs to clothes - Socks - Leather shoes - Other men's footwear	Per adult equivalent share of the expenditure of clothing for adults, separately calculated for boys
	For girls between 15 and 17: - Khanga - Dresses, frocks - Skirts - Blouses - Underwear - Repairs to clothes - Stocking, socks - Leather shoes - Other footwear for women	Per adult equivalent share of the expenditure of clothing for adults, separately calculated for girls

Appendix IX—Table I: Itemized Expenditures and Expenditure Details *continued*

Expenditure item	Expenditure item details	Assumptions made
EDUCATION	SECONDARY EDUCATION - Educational materials - School uniform - Other education-related expenditure	Cost of primary education is based on household education expenditure for those households with children enrolled in primary education, excluding school fees.
	SECONDARY EDUCATION - School fees - School uniform - Educational materials - Other education-related expenditure	Costs related to secondary education are based on household education expenditure for those households that have children enrolled in secondary education.
BUS FARES		Expenditures on bus fares are assigned to children enrolled in primary and secondary education in urban areas only. Children ages 7 to 14 years are assigned a weight of 0.5, children ages 15 to 17 a weight of 1. Sum of weights includes household members ages 7 to 60.
MEDICAL TREATMENT	- Cost of use of dispensaries - Other health facilities - Prescribed medication - Household medication	Cost associated with medical treatment is based on age-specific probabilities of being ill and receiving treatment in case of costs associated with use of dispensaries, other health facilities, and prescribed medication. Cost associated with household medication is based on the age-specific probabilities of being ill.
PERSONAL AND HOUSEHOLD HYGIENE	- Toilet soap - Toothpaste - Toilet paper - Laundry soap	Child share of household expenditure on personal and household hygiene is equal to an adult equivalent share.
BASIC FURNITURE	- Beds - Chairs - Tables	Child share of household expenditure on personal and household hygiene is equal to an adult equivalent share.
BED TEXTILES	- Pillows - Bedsheets - Blankets - Mattresses	Child share of household expenditure on bed textiles is equal to an adult equivalent share.
BED NETS		Child share of household expenditure on bed nets is equal to an adult equivalent share.
KITCHEN UTENSILS	- Pots - Pans - Bowls - Plates - Cups - Glasses	Child share of household expenditure on kitchen utensils is equal to an adult equivalent share.
REPAIRS ON RESIDENTIAL UNIT		Child share of household expenditure on housing repairs is equal to an adult equivalent share.

Using the itemized consumption data from the *2000/01 Household Budget Survey* displayed in Table I, the following estimates were made:

1. Per-child household non-food expenditure in households living at about the basic needs poverty line
2. Per-child household food expenditure in households living at about the food poverty line
3. Per-child household non-food expenditure in the poorest households (with total expenditures below 30 percent of the basic needs poverty line)
4. Per-child household food expenditure in the poorest households
5. Difference between estimates 1 and 3, above, to estimate the average per-child gap in non-food expenditure
6. Difference between estimates 2 and 4 to estimate the average per-child gap in food expenditure
7. Calculation of total cost of direct support to children living in the poorest households, by applying estimates 5 and 6 to the total number of vulnerable children living in poor conditions

Appendix IX—Table II: Average per-child annual expenditure on food items in households living at about the food poverty line, expressed in TShs in 2006 prices

	AGE		
EXPENDITURE CATEGORY	0–6 YEARS	7–14 YEARS	15–17 YEARS
Food	47,400	83,553	119,938

Source: Calculated using HBS 2000/01 and Bank of Tanzania, 2006. Costs per child were calculated from HBS 2000/01 and adjusted for annual inflation as given by the Bank of Tanzania.

Appendix IX—Table III: Average per-child annual expenditure on non-food items in households living at about the basic needs poverty line, expressed in TShs in 2006 prices

	AGE		
EXPENDITURE CATEGORY	0–6 YEARS	7–14 YEARS	15–17 YEARS
Clothing	1,533	3,252	7,272
School		4,177	7,724
Medical	2,051	1,568	401
Hygiene	967	1,790	2,308
Furniture	253	533	929
Bus fares (for urban students)		1,184	1,650
Bed nets	72	93	98
Bed textiles	551	1,014	1,366
Repairs on housing	1	1	1
Kitchen	306	587	735
TOTAL	**5,734**	**14,200**	**22,484**

Source: Calculated using HBS 2000/01 and Bank of Tanzania, 2006. Costs per child were calculated from HBS 2000/01 and adjusted for annual inflation as given by BOT.

Appendix IX—Table IV: Levels of expenditure translated into monthly expenditures per child

	URBAN			RURAL		
AGE OF CHILD	0–6 YRS	7–14 YRS	15–17 YRS	0–6 YRS	7–14 YRS	15–17 YRS
Non-food items	475	1,183	1,874	475	1,084	1,736
Food	3,950	6,963	9,995	3,950	6,963	9,995

Source: Calculated using HBS 2000/01, NBS 2002, Bank of Tanzania, 2006.
Note: Urban non-food expenditures include provision for bus fares for students.

Appendix IX—Table V: Estimated gap in annual expenditure on non-food items and on food consumption of the poorest children compared with expenditures per child in households living at about the poverty line (in 2006 prices in TShs per child)

	URBAN			RURAL		
AGE OF CHILD	0–6 YRS	7–14 YRS	15–17 YRS	0–6 YRS	7–14 YRS	15–17 YRS
Gap in non-food consumption expenditure	2,381	7,651	13,415	2,381	6,800	12,360
Gap in food consumption expenditure	18,346	31,281	46,138	18,348	31,281	46,138

Source: Calculated using HBS 2000/01, NBS 2002, Bank of Tanzania, 2006.

Appendix IX—Table VI: These levels of expenditure translate into monthly expenditures per child as follows.

	URBAN			RURAL		
AGE OF CHILD	0–6 YRS	7–14 YRS	15–17 YRS	0–6 YRS	7–14 YRS	15–17 YRS
Non-food items	198	638	1,118	198	567	1,030
Food	1,529	2,607	3,845	1,529	2,607	3,845

Source: Calculated using HBS 2000/01, NBS 2002, Bank of Tanzania 2006.

The analysis shows clearly that the gap in expenditure for food is the largest element of cost, and that the poorest children are now living in conditions that do not meet their basic minimum nutritional requirements, with well-known consequences for their development.

The national costs of establishing systems of identifying and providing support for most vulnerable children through local authorities and partner organizations are estimated to be about TShs 50 million per district, a total for national coverage of about TShs 6 billion (US$4.7 million). Administrative/overhead costs are estimated at 15 percent to generate total costs as indicated below.

	TShs	US$
Start-Up Costs	6.0 billion	4.7 million
Administrative/overhead costs (@15%)	0.9	0.7
Annual Costs (in 2006)		
Direct support	37.8 billion	31.5 million
Administrative/overhead costs (@15%)	5.7	4.7
TOTAL ANNUAL COSTS (IN 2006)	43.5 billion	36.2 million

UNITED REPUBLIC OF TANZANIA

National Costed Plan of Action for Most Vulnerable Children

The National Costed Plan of Action for Most Vulnerable Children (NCPA) is a four-year action plan (2007–2010). Through an analysis of the situation of orphans and most vulnerable children, the NCPA presents a framework of goals, strategies, and actions that will promote the survival, growth, well-being, development, and protection of most vulnerable children in Tanzania. The plan spells out the responsibilities of different stakeholders in achieving objectives within the required timeframe. It also recognizes and seeks to harmonize existing policies, strategies, and programs that in some way address MVC, including Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGPR), and the National Policy on HIV/AIDS.

Having developed the NCPA, the Government of Tanzania is strongly committed to its successful implementation. Children are the nation's future. All stakeholders have an obligation to participate in creating a better environment for their growth and development, and especially for their care, support, and protection.

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