Tanzania: Zanzibar

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2013

Policy Goals	Status
1. Establishing an Enabling Environment Zanzibar does not have a strong legal framework to promote access to health care services and appropriate dietary consumption for pregnant women and young children. The establishment of an institutional anchor will help coordinate ECD across sectors; regular meetings and strong communication will be critical to success. Establishing clearer financial allocations for ECD within sectors may allow more efficient spending and implementation.	Emerging ●●○○
2. Implementing Widely The scope of health and nutrition programs is adequate in Zanzibar; however, these programs do not cover all regions. Caregiver and parental education on child health development, domestic abuse prevention, and early stimulation could be promoted further and scaled up. Enrollment in preschool is higher in urban areas and among wealthier families.	Emerging ●●○○
3. Monitoring and Assuring Quality Administrative and survey data are not collected for all important ECD indicators in Zanzibar. Standards for early learning are lacking. No system is in place to monitor children's development and the quality of ECD service delivery.	Emerging ●●○○

Systems Approach for Better Education Results

WORLD BANK GROUP

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

Zanzibar and Early Childhood Development

Zanzibar is a semiautonomous part of the United Republic of Tanzania. It consists of two main islands: Unguja and Pemba. Zanzibar has the autonomy to administer and manage its own internal affairs including the provision and financing of social services, such as education and health.

Zanzibar has a population of 1.3 million inhabitants (2012) with a growth rate of 3.1 percent per year, and 49 percent of the population lives under the basic needs poverty line (less than one dollar per day). Forty-six percent of the population lives in Zanzibar City (including the extended Zanzibar Urban/West Region), while the remainder lives in rural areas. Agriculture contributes significantly to the island's economy (MSWYWCD Strategic Plan 2011–15). The population of Zanzibar is very young, with children under 15 years of age making up 45 percent of the population. ECD-aged children (83 months and less) make up 24.6 percent of the total population. Maternal and child mortality are high in Zanzibar, with an under-five mortality rate of 101 per 1,000 live births in 2010 (see Table 1).

Enrollment in early childhood education is low, with only 14 percent of children under the age of six attending preprimary school (see Table 1). The Ministry of Social Welfare, Youth, Women, and Children Development (MSWYWCD), established in 2010, was assigned to lead ECD efforts.

SABER–Early Childhood Development

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

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

Table 1: Snapshot of ECD Indicators in Zanzibar with Regional Comparison

	Zanzibar	Ethiopia	Kenya	Tanzania	Uganda
Infant mortality (deaths per 1,000 live births, 2010)	61	68	55	50	63
Below-five mortality (deaths per 1,000 live births, 2010)	101	106	85	76	99
Moderate and severe stunting (below-five, 2006–10)	24.4% (2014)	51%	35%	42%	38%
Net preprimary enrollment rate (three to six years of age, 2010)	13.8%	4%	29%	33%	14%
Birth registration 2000–2010	79%	7%	60%	16%	21%

Source: Road map to accelerate the reduction of maternal, newborn, and child mortality in Zanzibar (2008–2015), Education Policy (2006).

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: Establishing an Enabling Environment, Implementing Widely and Monitoring, and Assuring Quality. Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of policy levers are identified, through which decision makers can strengthen ECD. Strengthening ECD policies can be viewed as a continuum; as described in Table 2, countries can range from a latent to advanced level of development within the different policy levers and goals.

Figure 1: Three Core ECD Policy Goals

Table 2: ECD Policy Goals and Levels of Development

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

Policy and Practice: What Should be in place in an Effective ECD System?

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

Box 1: Checklist to Consider How Well ECD Is Promoted at the Country Level

What should be in place in an effective ECD system?		Zanzibar: In policy	Zanzibar: In practice
Health care	Standard health screenings for pregnant women	Guidelines guarantee free antenatal care visits	49% of pregnant women receive antenatal care at least four times
	Skilled attendants at delivery	**No policy**	54% of births are attended by skilled attendants Nurses are trained, and more than 90% of health centers have qualified nurses or midwives
	Childhood immunizations	Expanded Program of Immunization	95% of one-year-old children are immunized against DPT
	Required well-child visits	**No policy**	36% of children below five with diarrhea receive oral rehydration 66% with suspected pneumonia are taken to health care provider Monthly well-child visits are required
Nutrition	Breastfeeding promotion	**No policy**	19.7% of newborns are exclusively breastfed until six months of age
	Salt iodization	**No policy**	64% of households consume iodized salt
	Iron fortification	**No policy**	Specific data unknown
Early learning	Parenting programs (during pregnancy, after delivery, and throughout early childhood)	**No policy**	Madrasas have piloted this in some rural communities (Unguja and Pemba)
	Child care for working parents (of high quality)	**No policy**	Specific data unknown

	Free initial education (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)	Education Policy (2006)	14% enrollment rate in preprimary
Social protection	Services for orphans and vulnerable children	Child Act (2010)	There are 336 children sheltered in residential homes
	Policies to protect rights of children with special needs and promote their participation and access to ECD services	Inclusive education	In 2004, only 2,000 children with special needs were offered seats in five primary schools
	Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc.)	**No policy**	Specific data unknown
Child protection	Mandated birth registration	**Births and Deaths Registration Act (2006)**	79% birth registration rate
	Job protection and breastfeeding breaks for new mothers	**Labor Law**	New mothers are guaranteed breastfeeding breaks
	Specific provisions in judicial system for young children	**No policy**	Friendly Child Court established
	Guaranteed paid parental leave of at least six months	**No policy**	No paid paternal or maternal leave
	Domestic violence laws and enforcement	**No policy**	Specific data unknown
	Tracking of child abuse (especially for young children)	**No policy**	19% of girls and 11% of boys report child abuse

Note: Red: Requires urgent attention, no policy exists; *orange:* in place, but limitations in practice; *green:* adequately addressed.

Policy Goal 1: Establishing an Enabling Environment

➢Policy Levers: Legal Framework • Intersectoral Coordination • Finance

An enabling environment is the foundation for the design and implementation of effective ECD policies[2] and consists of the following: the existence of an adequate legal and regulatory framework to support ECD, coordination within sectors and across institutions to deliver services effectively, and sufficient fiscal resources with transparent and efficient allocation mechanisms.

Policy Lever 1.1: Legal Framework

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

National laws and regulations could be strengthened to better promote health care for pregnant women and young children. No policy guarantees free antenatal visits and skilled delivery; however, guidelines are in place that exempt women from paying for those services. Even though 90 percent of pregnant women make at least one antenatal care visit, only 12 percent of women start attending antenatal care visits in the first trimester of pregnancy as required by the national guidelines. The quality of antenatal care could be improved: Not all pregnant women receive all necessary laboratory tests and necessary medical examinations. Only 51 percent of deliveries are performed by skilled attendants. Standard health screening for sexually transmitted diseases and HIV are provided for pregnant women, and 71 percent are tested every year. Efforts are ongoing in Zanzibar for the prevention of mother-to-child transmission (PMTCT) of HIV through availability of PMTCT programs in various health facilities. Children are

[2] Britto, Yoshikawa, and Boller (2011); Vargas-Barón (2005).

required to receive all necessary immunizations free of charge. Almost all health care facilities (96 percent) offer immunization services. Among children under the age of five, 85 percent are fully immunized, and monthly well-child visits are required.

National laws and regulations do not promote appropriate dietary consumption for pregnant women and young children. Currently no national law promotes compliance with the International Code of Marketing of Breast Milk. At any given time, 98 percent of children are being breastfed, and 54 percent are breastfed within the first hour of life. Only 20 percent of babies in Zanzibar are exclusively breastfed until six months of age (National Nutrition Survey 2014). Guidelines on the importance of exclusive breastfeeding are not yet finalized. No national policy is in place that encourages salt iodization, and fortification of staples with iron is not mandatory. The National Nutrition Survey (2014) found that 64.4 percent of households consume iodized salt. One-quarter of school children suffer from goiter (TFNC 2001/02). Lack of iodide may lead to poor educational outcomes and productivity in children born from iodine-deficient mothers. Undernutrition is also a predominant problem in Zanzibar, with high levels of stunting, wasting, and most importantly, nutritional anemia (TDHS 2004/05).

National laws and regulations to some extent promote early childhood learning. According to the Education Policy (2006), the government of Zanzibar (GoZ) provides two years of early childhood education (baby class, kindergarten [KG] 1, KG2) free of charge. Parents are required to pay for uniforms and meals. There is a high concentration of preprimary schools in the less populated urban areas compared to rural areas, where 69 percent of the population resides. In the country are found 24 government schools, 157 privately owned schools, and 84 community-based madrasa schools initiated by the Aga Khan Foundation and supported by Madrasa Early Childhood Programme Zanzibar. Both the financial burden on parents and unequal distribution of preprimary schools in urban/rural areas cause enrollment to be very low (13.8 percent). Early childhood education in Zanzibar is part of basic education. Including preprimary education in the basic education system demonstrated a stronger commitment from the GoZ regarding ECD and led to increased enrollment.

National laws and regulations could be strengthened to better promote opportunities for parents and caregivers to provide care to newborn and infants during their first year of life. In Zanzibar following childbirth, mothers and fathers are entitled to maternity and paternity leave**.** Women are guaranteed breastfeeding breaks while at work; however, no assurance is given of breastfeeding facilities, laws to protect from employment discrimination, or maternity leave guarantees. The Ministry of Finance is still discussing the possibility of starting to pay maternity and paternity leaves. Table 3 compares parental leave policies in East Africa.

Table 3: Regional Comparison of Maternity and Paternity Leave Policies

Zanzibar	Kenya	Ethiopia	Uganda
There is 100% paid maternity for three months, and paternity leave is allowed in some institutions	90 days paid maternity leave at 100% salary for women; two weeks of paternity leave	Minimum of 90 days paid maternity leave at 100% salary; no paternity leave	60 days of maternity leave at 100% salary; four days of paternity leave at 100% salary

Source: ILO 2012.

National regulations promote child protection and care for all ECD-aged children. According to the Birth and Registry Act (2006), each newborn should be registered within 42 days of birth. Table 4 compares birth registration rates of several neighboring countries. With 79 percent rate of birth registration, Zanzibar has the highest rate in the region.

Table 4: Regional Comparison of Level of Access to Birth Registration

	Zanzibar	Tanzania	Ethiopia	Kenya	Uganda
Birth registration	79%	16%	7%	60%	30%

Source: UNICEF Country Statistics 2010.

Most vulnerable children and orphans are offered free temporary and long-term housing by the GoZ. The first children's homes were established in 1965, and today eight residential homes shelter roughly 336 children (88 girls and 248 boys). A better data management system could be initiated to keep track of all the children who go in and out of residential homes. According to the Child Bill Act (2010), residential homes should provide children with quality health care, nutrition, and education. The Zanzibar Guidelines for Residential Care developed by the Department of Social Welfare in collaboration with

Family Health International aim to guarantee quality ECD services, harmonization across all shelters, and development of strategies to move children from residential homes back into the community. Children do not receive adequate early childhood development services mainly because of the large number of children for the small number of social workers, limited communication with children from outside the orphanage, lack of age-appropriate tools in the classrooms, and a low budget, which limits availability of food containing nutrients for proper child growth.

According to the Education Policy (2006), children with special needs are assured access to inclusive education. There is no policy directed toward children with needs in regard to other ECD services. In 2004 the only five primary schools offering places for students with special needs could accommodate only 2,000 students. Inclusive education has not been fully implemented yet, but inclusive education curriculum in teacher training has been incorporated. A higher awareness by the community of the importance of specialized education for children with special needs could accelerate implementation of other services.

In 2009 a national survey on violence against children in Zanzibar was conducted. The results of the survey showed that violence against children is a notable problem in Zanzibar. From 2010 to 2012, 77 abused children reported at the Child Protection Unit for various physical abuses. More than one in 20 girls and roughly one in 10 boys reported experiencing sexual violence.[3] Only a small percentage of children who experienced sexual abuse would report it (19 percent of girls and 11 percent of boys). Only 10 percent of children who experience sexual abuse will receive service. The national judiciary system has made interventions to protect children through the introduction of the Friendly Children's Court put in place in 2013 at the High Court of Zanzibar. Law enforcement officers are trained on gender-based violence issues. Training for lawyers, judges, and law enforcement officials in dealing with children, as well as the creation of a child advocacy body, could further strengthen these interventions.

The GoZ somewhat promotes reduction of family violence by training health workers to identify child abuse and neglect, tracking child abuse, and reporting activities as well as providing a taskforce for domestic violence prevention. There is no training for Early Childhood Care and Education (ECCE) teachers on identification of abuse and neglect. Prevention of child abuse through home visits is also lacking.

Policy Lever 1.2: Intersectoral Coordination

Development in early childhood is a multidimensional process.[4] To meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, nonstate actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with nonstate actors are also essential.

Zanzibar has established an institutional anchor to lead ECD policy and coordinate across sectors. However, the country lacks a multisectoral ECD strategy. Various ministries in different sectors are responsible for the planning, implementation, and monitoring of ECD services. ECD education services are under the responsibility of the Ministry of Education and Vocational Training (MoEVT) at the central level and nongovernmental organizations (NGOs) at the local level. ECD health and nutrition services have an entity only at the central level, the Ministry of Health (MoH). Based on the current GoZ structure, local government does not have the mandate to implement ECD health services yet. ECD child protection falls under the responsibility of the MSWYWCD at the central level, which is responsible for the setting and delivery of ECD services, establishing standards for ECD providers, and monitoring access to ECD services and quality, as well as coordinating between different ECD-responsible agencies and entities. Figure 2 depicts the main departments within MSWYWCD along with its strategic functions, as well as the different target groups. The GoZ through the MSWYWCD is considering developing an integrated ECD policy to complement the new Children Policy (2012), which includes an ECD component.

[3] Ministry of Welfare, Youth, Women, and Children Department Strategic Plan 2011–15.

[4] Naudeau et al. (2011); Neuman (2007); UNESCO-OREALC (2004).

The Department of Social Welfare and Agency and the Zanzibar Madrasa Resource Center (ZMRC, 1988) within the MSWYWCD (established in 2011) is the institutional anchor for ECD. In the Department of Social Welfare two staff members are dedicated to ECD. ZMRC has several appointed staff members, including ECD practitioners and trainers, monitoring & evaluation officers, and finance officers. A national ECD working group within the MoEVT is made up of key members from ministries and NGOs.

ECD interventions are not coordinated at the point of delivery to ensure that children receive integrated services. In Zanzibar, ECD implementers do not meet regularly, and no progress reports are created, which hinders successful intersectoral coordination. No ECD goals are established for ECD service delivery in education, health, nutrition, and social protection sectors. The MSWYWCD through the Department of Social Welfare in collaboration with UNICEF is now in the process of conducting an ECD assessment on the status provision of ECD services in Zanzibar.

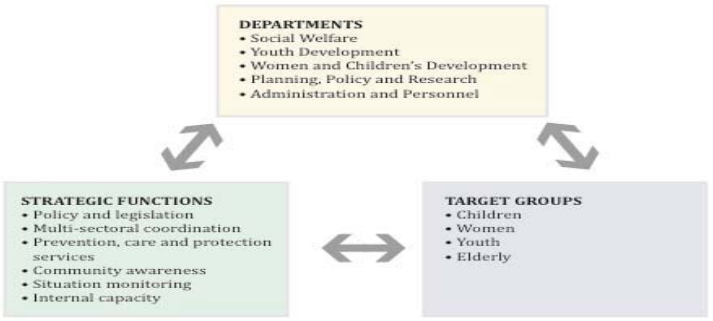
Policy Lever 1.3: Finance

Emerging

Although legal frameworks and intersectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensure that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits.[5] *Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.*

The budget process for ECD allocation is transparent in Zanzibar. The amount spent on ECD is based on different criteria within ministries. No national law or policy mandates a minimum level of funding for ECD across ministries. Explicit criteria such as number of children in subnational level and geographical location are being used for the allocation of early childhood health funding. ECD funding for social protection is based on the number of children and the characteristics of these children. No formulas are associated with these criteria in both sectors, and no criteria are being used for nutrition and child protection funding.

Figure 2: The Framework for the 2011–15 Strategic Plan



No process is in place to coordinate financial allocations for ECD across sectors. The government can accurately report public ECD expenditures in the education sector. A large proportion of the financing in health, education, and child protection is provided by external sources. Table 5 gives the available data regarding total GoZ budget expenditure and external donors in all ECD sectors. The GoZ contributed 42 percent in the Expanded Program on Immunization (EPI) program from 2008 to 2011 (EPI comprehensive multiyear plan). The government will continue to provide all traditional vaccines and injection materials for the next five years.

Table 5: Total Budget Distributed across Sectors in Zanzibar

	Government Total Expenditure	External Donors Contribution
Education (year 2011)	$257,791	$175,000 (UNICEF)
Health (year 2012)	Not available	$2.8 billion (GAVI, UNFPA, WHO)
Nutrition (year 2012)	$9,300	$66,910 (UNICEF)
Child Protection and Social Protection Services (year 2012)	$34,354	Not available

Sources: MTEF-Department of Social Welfare, Nutrition Unit, Ministry of Finance, EMIS Department, Budget Speech of MoEVT.

The burden of finance for ECD services is not distributed evenly across various segments of society, and the cost of services remains a barrier to access. Although

[5] Hanushek and Kimko (2000); Hanushek (2003); Valerio and Garcia (2012).

preprimary education is supposedly free, parents are still asked to pay for stationery, uniforms, transport, and the cost of minor repairs on school buildings when necessary (Education Policy 2006). Poverty is still a contributing factor for the low enrollment observed in preprimary schools. Official data on the cost of these fees or variations between schools are not available. In the period 1996–99, the government contributed 25.5 percent of the total education expenditure. Additional funding came from parents (3 percent) and from external donors (70 percent).

According to policy, pregnant women and young children should receive comprehensive free medical treatment. Because of budget constraints, many pay for consultation and treatment. The Household Budget Survey (HBS) 2009/2010 revealed that many patients complained about unavailability of drugs at the health centers (9 percent) in rural areas as well as long waiting times in the urban facilities.

Policy Options to Strengthen the Enabling Environment for ECD in Zanzibar

Legal Framework

➢ **Create a national ECD policy to strengthen already available guidelines to ensure adequate health care services for pregnant women and young children.** A large percentage of pregnant women do not receive quality antenatal care and assistance of delivery by a skilled attendant. Young children and pregnant women are constrained to pay for medical services that should normally be free according to national guidelines. Developing a national policy could put more pressure on health centers to both provide regular ECD training for health professionals and better quality of service. The GoZ could establish minimum standards for service delivery and penalties for health centers that do not meet the requirements.

➢ **Expand child protection interventions through training of lawyers, judges, law enforcement officers, and ECE teachers to recognize and deal with child abuse.** The proportion of children who report child abuse is much lower than that which experiences it. It is important for professionals dealing with children to be able to recognize signs of abuse. Many child-abuse cases are not prosecuted because children are afraid of testifying in court in front of their presumed perpetrator. Zanzibar launched its first Friendly Children's Court on February 5, 2013. The Friendly Children's Court allows children to testify via television link in a room where trained judges, social workers, and few family members can be present. Training of lawyers, judges, and law enforcement officers on recognizing child abuse could also be beneficial. Training of ECE teachers is necessary because children spend more hours in the day communicating with the teachers than they do with their parents. If teachers learn how to detect child abuse through identification of key behaviors, they can address abuse immediately.

Intersectoral Coordination

➢ **Mandate regular meetings of the national ECD working group and ECD practitioners.** Zanzibar has established an Institutional anchor to coordinate ECD across sectors. ECD implementers at the subnational level and the national ECD working group, which includes state and nonstate stakeholders, do not meet regularly. Organizing regular meetings could improve intersectoral coordination and help move the ECD agenda forward.

➢ **Establish ECD goals and a system to monitor quality at service delivery.** Zanzibar has ECD guidelines integrated in sector plans such as education and health. No ECD goals have been set within each ministry, and no coordinated system is in place at the point of delivery to ensure that children receive integrated services. Once implementers start meeting regularly, preset objectives and regular quality monitoring and impact evaluation could ensure broader delivery of ECD services to young children.

Finance

➢ **Clarify allocation of ECD within sectoral budgets and coordinate budget procedures.** Determining the ECD budget as a coordinated effort across ministries could provide increased and more efficient financing for ECD services. At present, only the Education Ministry can accurately report ECD expenditures. If other ministries also started tracking ECD spending, the government would be in a better position to make decisions on the types of programs to support in the short and long term.

➢ **Put in place a conditional cash transfer system to increase enrollment in preprimary school.** Children from poor families do not attend preprimary school because their parents cannot afford to pay for their uniforms and meals. Box 2 presents the Conditional Cash Transfer system put in place in Mauritius to promote ECE

enrollment. The government there gives financial support to families to incite parents to send their children to preschool. Mauritius was able to achieve an 85 percent enrollment rate with this program. This same type of system could be put in place in Zanzibar especially targeting children from the poorest families.

Box 2: Relevant Lessons Learned from International Experience on Financing ECD

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

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

Key considerations for Zanzibar:

- ✓ It will be important to determine the appropriate funding level to maximize effectiveness of policy.
- ✓ Incentivizing on-time enrollment for preprimary school could help address the significant problem of low preprimary enrollment rates (as discussed in Section 2.1)

Policy Goal 2: Implementing Widely

➢ Policy Levers: Scope of Programs • Coverage •Equity

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

Policy Lever 2.1: Scope of Programs

Emerging

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 3 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

ECD programs are established to target a large number of beneficiary groups in Zanzibar, but interventions to reach parents could be improved. Zanzibar has many established ECD programs in various sectors including education, health, nutrition, and child and social protection. These interventions are geared toward the following beneficiary groups: young children, pregnant women, and parents and caregivers. The GoZ has not put together a list of integrated ECD services that young children should receive. As presented in table 6, interventions targeting parents and caregivers are almost nonexistent. In the education sector, parent committees are established at ECD centers, but there is a piloted home visiting to provide parenting messages through Madrasa Early Childhood Programme, Zanzibar.

ECD programs are established in all essential areas of focus. A variety of interventions are established in all essential areas of ECD service provision including in health, education, nutrition, and social and child protection**.** Coverage is essentially limited to only five subnational divisions (Urban West, North and South Unguja, and North and South Pemba). A disparity is seen in ECD interventions across sectors, with more programs available in the health sector and the education sector being the least covered.

Figure 3: Essential Interventions during Different Periods of Young Children's Development

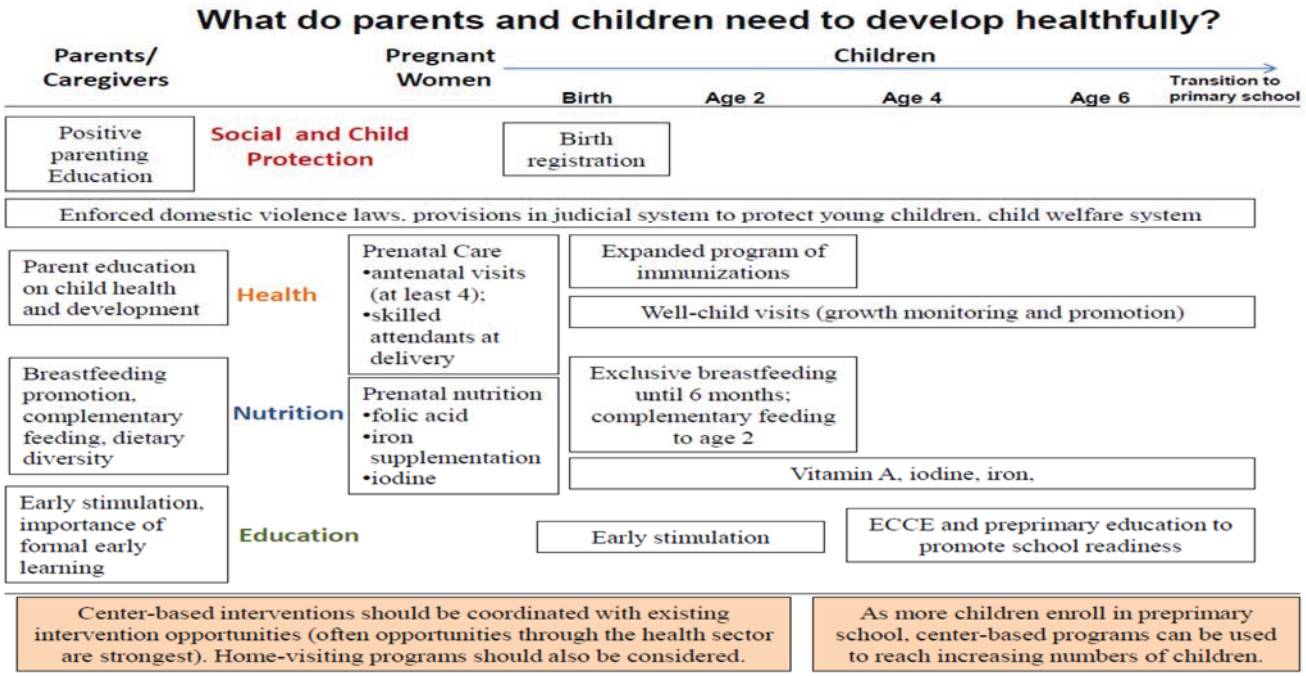


Table 6: ECD Program and Coverage in Zanzibar

ECD intervention	Scale		
	Pilot programs	Number of regions covered	Universal coverage
Education			
State-sponsored preprimary/kindergarten education	—	5	—
State-sponsored ECCE	More than 50 schools	5	—
Community-based ECCE	84	5	—
Health			
Antenatal and newborn care	—	5	—
Integrated management of childhood illnesses and care for development		10	—
Childhood wellness and growth monitoring	—	5	—
National immunization program	—	5	—
Nutrition			
Micronutrient support for pregnant women	—	5	—
Food supplements for pregnant women	—	—	—
Micronutrient support for young children	—	5	—
Food supplements for young children	—	—	—
Food fortification	—	—	—
Breastfeeding promotion programs	—	—	—
Anti-obesity programs encouraging healthy eating/exercise	—	—	—
Feeding programs in preprimary/kindergarten schools	—	—	—
Parenting			
Parenting integrated into health/community programs	2	2	—
Home visiting programs to provide parenting messages	—	5	—
Special needs			
Programs for OVCs (boarding schools and children's homes)	—	—	—
Interventions for children with special (emotional and physical) needs	—	—	—
Anti-poverty			
Cash transfers conditional on ECD services or enrollment	—	63 households	—
Comprehensive			
A comprehensive system that tracks individual children's needs	—	—	—

Policy Lever 2.2: Coverage

Emerging

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

Access to essential ECD health interventions for pregnant women and young children could be improved. According to the Demographic and Health Survey (DHS 2010), in Zanzibar, 99 percent of pregnant women receive antenatal care at least once, but only 49 percent attend more than four antenatal care visits. According to the Roll-Back Malaria survey of 2007, 74 percent of children slept under an insecticide-treated mosquito net (ITN). DHS 2010 showed that 55 percent of children under five years of age in Zanzibar in at-risk areas slept under an ITN. DHS 2004–5 revealed that only 36 percent of children below five years of age with diarrhea received oral rehydration and continued feeding. The EPI intervention in Zanzibar is commendable, resulting in 95 percent of one-year-old children immunized against diphtheria-pertussis-tetanus (DPT)—the highest rate compared to neighboring countries (Table 7).

Access to essential ECD nutrition interventions could be improved. Nutrition is an important component of child health, and undernutrition is a notable problem in Zanzibar. Nutrition interventions should begin at the prenatal stage because newborn health is directly linked to maternal health. In Zanzibar, 78.7 percent of children six to fifty nine months of age have access to vitamin A supplementation, according to the 2014 National Nutrition Survey. According to the same survey, 49.3 percent of households in Zanzibar consume iodized salt. Iodine deficiency has deleterious consequences on the child's mental and physical development. The consumption of iodized salt in homes could be better promoted in Zanzibar. Table 8 gives a regional comparison of access to essential nutrition services. Zanzibar has the lowest rates of both stunting and prevalence of anemia among children below the age of five (24 percent and 75 percent, respectively).

Access to preprimary education in Zanzibar is limited. According to the HBS 2009/2010, among the total population five to 14 years of age, only 14 percent have attended preschool, and 28 percent are not educated at all. The rate of illiteracy in that age group has seen a significant decline since HBS 2004/2005, but there is still room for improvement to allow children more access to early childhood care and education. Late access to preprimary education may lead to the high number of overaged children in primary schools. The rate of preprimary attendance is also correlated with the area in which the child lives, with a higher attendance rate in urban versus rural areas. No significant difference is seen in enrollment based on gender, which suggests equal access to basic education for both girls and boys. The GoZ has made significant progress in reducing the distance between households and schools; this change has had a positive impact on school attendance rates.

Table 6: Regional Comparison of Level of Access to Essential Health Services for Young Children and Pregnant Women

	Zanzibar	Tanzania	Ethiopia	Kenya	Uganda
One-year-old children immunized against DPT (corresponding vaccines: DPT3ß)	94.6%	91%	90%	93%	60%
Children below five with diarrhea receive oral rehydration/ continued feeding (2010)	36% (year 2005)	53%	15%	43%	39%
Children below five with suspected pneumonia taken to health care provider (2010)	66% (year 2005)	No data	5%	50%	47%
Pregnant women receiving antenatal care (at least four times)	49%	43%	19%	47%	48%

Source: UNICEF Country Statistics 2010.

Table 7: Regional Comparison of Level of Access to Essential Nutrition Services for Young Children and Pregnant Women

	Zanzibar	Tanzania	Ethiopia	Kenya	Uganda
Children below five with moderate/severe stunting (2006–10)	24.4% (2014)	42%	51%	35%	38%
Infants exclusively breastfed until six months of age (2010)	19.7% (2014)	50%	52%	32%	62%
Infants with low birth weight	6.9%	10%	20%	8%	14%
Prevalence of anemia in pregnant women (2010)	No data	58%	62.7%	55.1%	41.2%
Prevalence of anemia in preschool-aged children	24% (2014)	75% (2005)	70.6% (2005)	84.2% (1999)	70.5% (2001)

Source: UNICEF Country Statistics 2010; WHO Global Database on Anemia.

Policy Lever 2.3: Equity

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services.[6] One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

There is equity in access to ECCE based on gender. The gender parity index for both gross and net enrollment in preprimary education in Zanzibar was 1.0 in 2013 (EFA Assessment 2001–13). According to the Education Policy (2006), during the basic education stage, boys' and girls' dropout rates are essentially equal. A higher enrollment rate is seen in private schools compared to public schools for children ages four to six years old.

ECCE services could be better tailored to accommodate children with special needs. In Zanzibar the Inclusive Education policy (2006) gives special needs children access to ECE. Current preprimary schools do not have the means to meet the special needs of these children. The Inclusive Education unit is still collecting data that will reveal the number of children with special needs currently enrolled in ECD centers. The ECD curriculum and teaching materials are translated into the major language, Kiswahili. Mother tongue instruction is encouraged in ECD education, but it is not mandatory.

Policy Options to Implement ECD Widely in Zanzibar

Scope of Programs

➢ **Promote parent and caregiver education on ECD-related services and provide wider coverage of ECD programs.** Most essential health (childhood vaccinations, antenatal care visits for pregnant women), education (access to preprimary school), and social protection (child welfare system) ECD-related services are available to young children, but what seems to be lacking is the parents' and caregivers' education. Young children's development requires continued follow-up both at school and in the household. Better promotion of home visiting to provide parenting messages and parenting education on domestic abuse prevention could be beneficial. The child's caretaker will learn and understand how to provide an adequate healthy environment for proper early childhood development. This could be done by building up on the already existing parent committees at ECD centers.

All essential ECD programs are available only in certain regions of the country (see Table 6). Better coordination between sectors could allow sharing of ideas on how to expand the programs to achieve universal coverage.

Coverage

➢ **Monitor ECD services at the point of delivery.** Many pregnant women and young children still pay for medical services that should be free. This discourages some people from seeking medical care when they are sick, and consequently some pregnant women and young children do not receive the necessary ECD health services they need. Better monitoring at service delivery could help identify these gaps in services.

➢ **Scale up nutrition programs.** Undernutrition is still a major problem among children because of a lack of food supplementation programs or feeding programs in preprimary schools. Box 3 illustrates the Nutrition Enhancement Program (NEP) launched in Senegal, which managed to scale up nutrition interventions through utilization of resources provided by the health sector. This shows that coordination between sectors is crucial.

[6] Engle et al. (2011); Naudeau et al. (2011).

Box 3: Relevant Lessons Senegal: Improving Access to Nutrition Interventions in Hard-to-Reach Populations

Example from Senegal: Coordinatin Service Delivery across Sectors

In 2002 the Nutrition Enhancement Program (NEP) was launched by the government of Senegal to provide multisectoral support for nutrition and enhance nutritional conditions for children below five and pregnant and lactating women. It includes a community-based growth monitoring and promotion and community Integrated Management of Childhood Illness (IMCI) with maternal counseling, home visits, and cooking demonstrations. The project integrated nutrition interventions (e.g., growth monitoring and promotion) with existing health sector interventions (e.g., IMCI). The Ministry of Health and local development agencies already provided a relatively good scope of coverage of health interventions in local communities. Thus, the nutrition sector leveraged existing resources for delivering the NEP interventions. Because of the synergetic effect of bringing together the nutrition and health sectors, the NEP became a mechanism for delivering other essential health and nutrition services provided by existing programs (including ITNs and vitamin A supplements). By 2012 the government of Senegal expanded the community nutrition program to reach more than 60 percent of the target population.

Key Lessons for Zanzibar:

- ✓ Given that the MoH in Zanzibar already provides relatively good access to health services, including expanded coverage for childhood immunizations, these health sector programs could be expanded to include nutritional components.
- ✓ Promoting feeding practices combined with the delivery of essential health services can be an effective strategy to promote the holistic development of children.

Equity

➢ **Increase access to ECD for poor families, especially in rural areas.** In Zanzibar, the majority of ECD schools are concentrated in the urban area, creating an urban-rural disparity. Poor families still cannot afford ECD education for their children because of the fees levied on parents. The GoZ could put in place mechanisms to expand access to ECD to poor families. In addition to the already existing housing benefits given to some families with young children, there could be a CCT system put in place to relieve the financial burden on the poor families (see Box 2).

Policy Goal 3: Monitoring and Ensuring Quality

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

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

Policy Lever 3.1: Data Availability

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

Both survey data and administrative data are collected on access to ECD in Zanzibar, but only a few indicators are collected. The MoEVT along with the ZMRC collect enrollment data for ECD. Currently 37,792 children are attending ECD in Zanzibar. They are divided into public, private-for-profit, and private-not-for-profit institutions, with the private-for-profit institutions leading in the enrollment rate with 23,989 students. The child protection unit collects administrative data regarding the number of children registered in the child protection system. In 2012, there were 24 existing cases of young children in the system and 24 new cases entering. Survey data are collected for access to health ECD services for pregnant women and young children. According to DHS (2010), 68 percent of pregnant women attended more than four antenatal care visits. The EPI intervention showed good results with 87 percent of children being immunized for DPT by the age of one. Anemia is a major problem in Zanzibar, especially among children under the age of five: 69 percent of children under the age of five suffer from anemia (DHS 2010). This is an improvement compared with the rate of 75 percent observed in 2004–5 (DHS). Table 9 gives a summary of all the administrative and survey ECD data available in Zanzibar.

Data available on the differences in ECCE access and outcomes for special groups are limited to only two special groups, and tracking of child development is lacking. The EMIS unit in Zanzibar differentiates ECD enrollment only by subnational divisions and gender. Data are not collected based on mother tongue, socioeconomic status, and special needs. The EMIS department is still collecting data for the various indicators for young child development. This data collection system does not monitor level of service delivery and quality, as well as child development outcomes.

Table 8: Availability of Data to Monitor ECD in Zanzibar

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

Policy Lever 3.2: Quality Standards

Emerging

Ensuring quality ECD service provision is essential. A focus on access—without a commensurate focus on ensuring quality—jeopardizes the very benefits that policy makers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children.[7]

ECCE learning standards are somewhat clearly established in Zanzibar. The GoZ has two preprimary curricula that have been approved and are available for teachers to use: the madrasa preschool curriculum, issued in 2000, and the Zanzibar preschool curriculum, issued in 2012. Both curricula are endorsed by the Institute of Education. The MoEVT ensures that the primary curriculum is a continuation of the preprimary curriculum. It is still in the process of developing learning standards for ECCE centers.

Requirements for ECCE professionals have been established, but training for health workers regarding ECD services is lacking. ECE teachers for children up to 83 months of age are required to have completed upper secondary school, obtained a certificate in ECD or specialized course, and participated in specialized training for ECD. Private education institutions and government-sponsored institutions provide in-service training for ECCE service delivery to ECE professionals. This is required only when teaching children ages 60–83 months. ECE professionals are also required to complete a preservice fieldwork practicum in ECCE. The MoEVT regulates this training. In 2013 the Madrasa Early Childhood Teacher Training Centre (MECTTC) was officially registered by the Zanzibar Vocational Authority. Both short-term (six months) and long-term (two years) certificate courses are offered by MECTTC or the Ministry of Education's ICT department.

Health workers in Zanzibar are not required to receive training in ECD message delivery such as developmental milestones, childcare parenting, and early stimulation. With this training, health workers could be able to accurately assess how a child is developing and provide parents with other health-related ECD requirements to ensure proper child development.

Established infrastructures standards for ECCE facilities exist in Zanzibar. Service delivery standards could be improved. No policy states a specific child-to-teacher

[7] Bryce et al. (2003); Naudeau et al. (2011); Taylor and Bennett (2008); Victoria et al. (2008).

ratio required in ECCE centers. The madrasa preferred ratio is 1:15. The average child-to-teacher ratio for children ages four to six years is 20:1 in public schools and 12:1 in private schools. No minimum number of hours of preprimary education per week is required. Both public and private preprimary schools are open 25 hours per week.

Construction standards exist for ECCE facilities, and all institutions need to meet all the requirements to obtain their permit. No specific policy mandates access to potable water and hygienic facilities, but it is mentioned in the construction standards as well as in the Education Policy (2006). No policy or requirement specifies minimum physical space per child.

Specific registration and accreditation procedures are required for all ECCE facilities and some health facilities. Preprimary centers cannot be registered if they do not meet all the construction standards, and mechanisms are in place to identify quality improvement of the centers. ECCE facilities receive announced inspection visits at unspecific times from the registrar and the inspectorate office of the Department of Preprimary Education within the MoEVT.

Rigorous registration procedures exist only for hospitals and health centers. No construction standards are in place for health posts.

Policy Lever 3.3: Compliance with Standards

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

State and nonstate ECCE facilities are required to comply with established infrastructure standards, but no service delivery standards have been set for them to follow. All preprimary facilities respect all the infrastructure standards. There is no way to measure compliance with service delivery such as child-to-teacher ratio or number of opening hours because no standards are established for those indicators in Zanzibar.

ECCE professionals comply with established in-service training standards/professional qualifications, but no tracking is done of compliance with pre-service training. The EMIS department and the ZMRC office collect data for the number of ECD professionals who have completed their in-service training. Records show that 438 preprimary teachers for children ages 60 to 83 months as well as 360 paraprofessionals or community ECCE volunteers have received the training

Box 4: Relevant Lessons from International Experiences in Monitoring and Ensuring Quality

Example from Jamaica: Ensuring Quality in ECCE Provision

The **Early Childhood Commission** (ECC) was established by an act of parliament, the Early Childhood Commission Act, in 2003. The commission has the responsibility to ensure the integrated and coordinated delivery of early childhood programs and services. Through its varying activities, the ECC will guide the holistic development of children, including physical, cognitive, social and emotional development. The commission has a range of legislated functions, one of which indicates direct responsibility to supervise and regulate early childhood institutions (ECIs).

Standards for the operation, management, and administration of ECIs: Under Jamaican law, there are two types of standards: Those transmitted by an act or regulations and that therefore carry legal consequences, and those that serve to improve practice voluntarily and are not legally binding. For practical purposes, quality standards for ECIs include both sets of standards, with clear indications of those standards that are legally binding.

Standard statements for ECI: To improve the quality of services provided by ECIs, the ECC has developed a range of robust operational quality standards for ECIs. The act and regulations, which together comprise the legal requirements, specify the minimum levels of practice below which institutions will not be registered or allowed to operate. The standards that are not legally binding define best practices for early childhood institutions and serve to encourage institutions to raise their level of practice above minimum requirements. Although ECIs are encouraged to achieve the highest possible standards to ensure the best outcomes for children, the legally binding standards guarantee that minimum standards are met.

Inspection and registration: Inspection of ECIs is the procedure designated under the Early Childhood Act for ensuring that operators comply with the minimum acceptable standards of practice. The ECC is required to inspect each ECI twice annually. It is a requirement of registration that the registered operator cooperates with the ECC's inspection process. The "registered operator" is defined as the person required to apply for registration of an ECI and may be an individual or a group.

In deciding on the suitability of an ECI for registration under the Early Childhood Act, the ECC will, based on information obtained at inspection visits, determine whether or not an ECI meets and complies with the act and regulations. Where existing provision falls short of the legal requirements, and the shortfall does not present a real and present danger to children, a permit to operate until full requirements are met will be granted, with time scales for institutions to meet requirements. The ECC encourages the promotion of the highest standards of practice by monitoring not only the minimum requirements at inspection visits, but also by monitoring those standards that are not legally binding.

Key Lessons for Zanzibar

- ✓ Consider establishing legally binding requirements for ECCE service provision to guarantee that acceptable minimum standards are met.
- ✓ Consider assigning a special entity with a delineated role to monitor and regulate ECCE service providers. An improved quality monitoring system will ensure that best outcomes are achieved.

Policy Options to Monitor and Ensure ECD Quality in Zanzibar

Data Availability

➢ **A standardized data-tracking system should be put in place to better evaluate the impact of ECD services.** Administrative and survey data are collected for only a few ECD indicators. A computerized and standardized data-collecting system could be put in place to allow data harmonization across all ECD sectors. In this way data would be more useful for evaluation of the impact of the programs, child development outcomes, and planning for future allocation of funds and other necessary resources to the various ECD services.

Quality Standards

➢ **ECD institutions should have standards and guidelines to follow to ensure quality service delivery.** Currently there are only infrastructure standards but no standards on what should be taught in preprimary schools. To guarantee quality of service, standards need to be put in place to have a baseline for quality monitoring. Institutions could be bound by law to follow all minimum standards and could be given incentives for impeccable service delivery to incite them to achieve the highest possible standards. Box 4 illustrates how Jamaica was able to ensure quality in ECCE provision through the introduction of two types of standards: legally binding standards and non-legally binding standards.

Compliance with Standards

➢ **Monitor and enforce compliance to the established standards.** Announced inspections are scheduled to verify compliance with infrastructure standards for all ECE centers. No set time interval is established between each visit, and too much time may pass between two visits, which does not provide proper monitoring. A more formalized and defined way of monitoring compliance with all the different standards (not just infrastructure standards) could be more beneficial. Each ministry could have a specific set of information that should be gathered during an inspection so that all data can be collected in a standardized and timely manner.

Comparing Official Policies with Outcomes

The existence of laws and policies alone does not always guarantee a correlation with desired ECD outcomes. In many countries, policies on paper and the reality of access and service delivery on the ground are not aligned. Table 9 compares ECD policies in Zanzibar with ECD outcomes.

Table 9: Comparing ECD Policies with Outcomes in Zanzibar

ECD policies	Outcomes
Guidelines encourage women to attend at least four antenatal care visits	ANC visit rate(Four or more): 48.9%
Preprimary school is free but not compulsory in Zanzibar	Preprimary school enrollment: 13.8%
Young children are required to receive a complete course of childhood immunizations	Children with DPT (12–23 months): 94.6%
Nutrition interventions reinforce vitamin A supplementation for children	Vitamin A supplementation (6–59 months of age): 72.2%

Preliminary Benchmarking and International Comparison of ECD in Zanzibar

Table 11 presents the classification of ECD policy in Zanzibar within each of the nine policy levers and three policy goals. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges.

Table 12 presents the status of ECD policy development in Zanzibar alongside a selection of OECD countries. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers.

Table 11: Benchmarking Early Childhood Development Policy in Zanzibar

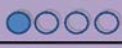
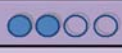
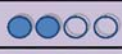
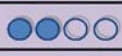
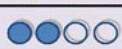
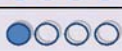
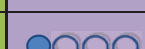
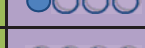
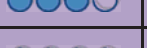
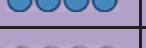
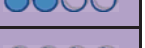
ECD policy goal	Level of development	Policy lever	Level of development
Establishing an Enabling Environment		Legal Framework	
		Intersectoral Coordination	
		Finance	
Implementing Widely		Scope of Programs	
		Coverage	
		Equity	
Monitoring and Assuring Quality		Data Availability	
		Quality Standards	
		Compliance with Standards	
Legend	Latent 	Emerging 	Established 	Advanced 

Table 12: International Classification and Comparison of ECD Systems

ECD policy goal	Policy lever	Level of development				
		Zanzibar	Australia	Chile	Sweden	Turkey
Establishing an Enabling Environment	Legal Framework					
	Coordination					
	Finance					
Implementing Widely	Scope of Programs					
	Coverage					
	Equity					
Monitoring and Assuring Quality	Data Availability					
	Quality Standards					
	Compliance with Standards					
Legend	Latent	Emerging	Established	Advanced		

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities for further development of effective ECD systems. This Country Report presents a framework to compare Zanzibar's ECD system with other countries in the region and internationally. Each of the nine policy levers are examined in detail, and some policy options are identified to strengthen ECD are offered.

Table 13 summarizes the key policy options identified to inform policy dialogue and improve the provision of essential ECD services in Zanzibar. Implementation of more ECD-specific policies geared toward pregnant women and young children to strengthen the already existing guidelines could show a stronger commitment of the government. Also, the MSWYWCD could prioritize the development of intersectoral coordination between all ECD-related ministries and designate entities responsible for establishing standards and monitoring service outcomes. As ECD access increases, better financial management and strict quality control will be necessary to avoid a decrease in the level of service provided. Establishment and compliance with the infrastructure standards is commendable, but learning standards and service delivery standards are lacking.

In Zanzibar room for improvement still exists within each policy goal to better provide an adequate environment for growth and development of children to their full potential.

Table 13: Summary of Policy Options to Improve ECD in Zanzibar

Policy dimension	Policy options and recommendations
Establishing an Enabling Environment	• Finalize and approve the new Children Policy, which includes ECD component • Develop an IECD policy to reinforce the ECD component in the new Children Policy • Establish a law to comply with the International Code of Marketing of Breast Milk • Establish a national policy to encourage salt iodization and promote fortification of cereals/staples with iron • Establish a policy mandating the registration of children at birth for accuracy of data regarding ECD-age children • Set aside a specific ECD budget in each ministry to better track ECD expenditures
Implementing Widely	• Consider reducing the financial burden on poor families to give all children access to ECD • Increase access to skilled attendants at birth • Increase programs for education on ECD for parents and caregivers • Consider reducing the urban-rural disparity for availability of ECD institutions
Monitoring and Ensuring Quality	• Enforce monitoring of compliance with new established standards • Provide training for ECD health professionals • Consider giving bonuses to ECD teachers to incite more teachers toward the ECD field to reduce the child-to-teacher ratio

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Acronyms

CCT	Conditional Cash Transfer
DHS	Demographic and Health Survey
DPT	Diphtheria Pertussis Tetanus
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
EMIS	Education Management Information System
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccines and Immunizations
GoZ	Government of Zanzibar
HBS	Household Budget Survey
HIV	Human Immunodeficiency Virus
ITN	Insecticide-Treated Mosquito Net
KG	Kindergarten
MECTTC	Madrasa Early Childhood Teacher Training Centre
MoEVT	Ministry of Education and Vocational Training
MoH	Ministry of Health
MSWYWCD	Ministry of Social Welfare, Youth, Women, and Children Development
NEP	Nutrition Enhancement Program
NGO	Nongovernmental Organization
PMTCT	Prevention of Mother-to-Child Transmission
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZMRC	Zanzibar Madrasa Resource Center

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