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Special Paper 07.25

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## Children and Vulnerability in Tanzania:

### A Brief Synthesis

Valerie Leach

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RESEARCH ON POVERTY  
ALLEVIATION

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# **Children and Vulnerability in Tanzania:**

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Special Paper 07.25

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# Table of Contents

**List of Tables, Figures and Maps** *page iv*

**Foreword and Acknowledgements** *page v*

1. **Introduction to Children and Vulnerability in Tanzania** *page 1*

2. **Mortality** *page 3*

3. **Malnutrition** *page 6*

4. **Vulnerability and Ill Health** *page 11*

5. **Vulnerability, Orphanhood and HIV/AIDS** *page 12*

6. **Education, Work and Vulnerability** *page 15*

7. **Other Aspects of Vulnerability** *page 18*

Children in Households Headed by Children,  
or in Households with Elderly Adults Only *page 18*

Children with Disabilities *page 18*

Abuse and Neglect *page 19*

8. **Conclusion** *page 20*

**References** *page 22*

**Publications by REPOA** *page 23*

# List of Tables, Figures and Maps

## List of Tables

Table 1	Rural and urban rates of under-five mortality and malnutrition	6
Table 2	Food poverty, under-five mortality and child malnutrition, by region	9
Table 3	Regions classified by rates of food poverty, under-five mortality and malnutrition	10

## List of Figures

Figure 1	Population pyramid	2
Figure 2	Age specific death rates	3
Figure 3	Trends in child survival	4
Figure 4	Infant and under-5 mortality rates by region	5
Figure 5	Z-scores for height for age by age in months, 1991-1999	7
Figure 6	Primary education deficit by residence and age	15
Figure 7	Percentage of children who work, by area of residence and age	16

## List of Maps

Map 1	Stunting in children under 5 years, by region, 2004	8
Map 2	Children 7 to 13 years who are working and not in school, by district, 2002	17

# Foreword and Acknowledgements

The intention of this paper is to highlight the key issues of children and vulnerability in Tanzania. This special paper includes information from a report commissioned by UNICEF Tanzania from REPOA in 2006, and we are grateful to UNICEF for subsequently granting permission to REPOA to summarise information from this report. Also included is information from other recent work by REPOA.

In addition we would like to thank Carol Watson and Mikala Lauridsen from UNICEF who gave constructive comments on the content of this special paper, and to UNICEF for the photographs throughout this document. Wietze Lindeboom, of REPOA, is thanked for his technical assistance.

We have also produced a popular version brief which relates to this special paper, it can be downloaded from REPOA's website, or obtained from REPOA.

REPOA has a Children's Research Programme which focuses on children's rights, with the aim to improve children's lives in Tanzania through the use of research to influence policy. The two key objectives of this programme are to generate high quality research about children which can influence relevant policy processes in Tanzania, and strengthen the capacity to research for and with children, through support to targeted capacity building initiatives. UNICEF contributes to the funding for this research programme.

REPOA provides research grants for matters relating to children, further information can be obtained from our website: [www.repoa.or.tz](http://www.repoa.or.tz) and from REPOA.

If you have an interest in children's rights and researching with children then please contact REPOA to be put on our mailing list and you will be advised when further publications relating to children are produced.

REPOA's library contains material relating to children's issues, including research findings, reports, journals, and research methodology for researching with children. The library is open to all members of the public and the online catalogue can be accessed via REPOA's website.

Valerie Leach  
March 2007



# Introduction<sup>1</sup>

Ensuring social protection for vulnerable people is a goal of MKUKUTA (the National Strategy for Growth and Reduction of Poverty) in Tanzania, and children are commonly considered to be among the most vulnerable. REPOA has been involved in analytic work on the vulnerability of children, in part to provide evidence for Government's efforts to develop a national framework for social protection. This special paper synthesises the analysis and draws some conclusions based on this and closely related work.

## **Vulnerability**

Vulnerability refers to the risk of adverse outcome, such as impoverishment, ill health, social exclusion. It reflects not only the likelihood that an untoward event occurs, but also capacity to cope with it. It is therefore the result not only of individual mishap, but also the social conditions which follow from systematic differences in the flows of resources and opportunities which themselves influence capabilities.<sup>2</sup>

If vulnerability is a reflection of lack of control, then all children, and especially young children, are vulnerable simply because of their age - they depend on others to provide for their basic needs. Increasing physical and mental maturity usually leads to growing capability for self-provisioning, but during the period of childhood and adolescence, children and young people continue to need special care and support. While most children in Tanzania are cared for and protected by their families and communities, many are not so fortunate.

Poverty is pervasive in Tanzania, with over a third of households living below a basic needs poverty line, set in 2000/01 at TShs 259 per adult equivalent per day, even in purchasing power parity terms well below \$1 per day. Nearly 20 % live below the even lower food poverty line. This implies that such households do not command income sufficient even to provide enough food to satisfy their basic minimum nutritional requirements, with consequences for physical and mental development, economic and social wellbeing, and their contribution to national development.

Many children are therefore clearly affected by this generalised insecurity, but there are also groups of children who may be considered to be particularly vulnerable. MKUKUTA (see above) specifically aims to ensure the protection of children with disabilities, orphans and other most vulnerable children - child labourers, street children. Much attention has been focused on children orphaned by HIV/AIDS. This characterisation in itself is usually stigmatising, adding to vulnerability.

Thus the issue of children and vulnerability is complex. Much of REPOA's work has been undertaken with data sets covering nationally representative samples of households and children: from the Population Census of 2002, the Tanzania Demographic and Health Survey

<sup>1</sup> The data and research cited in this synthesis refer to the Tanzania Mainland.

<sup>2</sup> This characterisation is derived from REPOA Special Paper 06.19 (2006) *'Developing Social Protection in Tanzania within a Context of Generalised Insecurity'* by Professor Marc Wuyts.

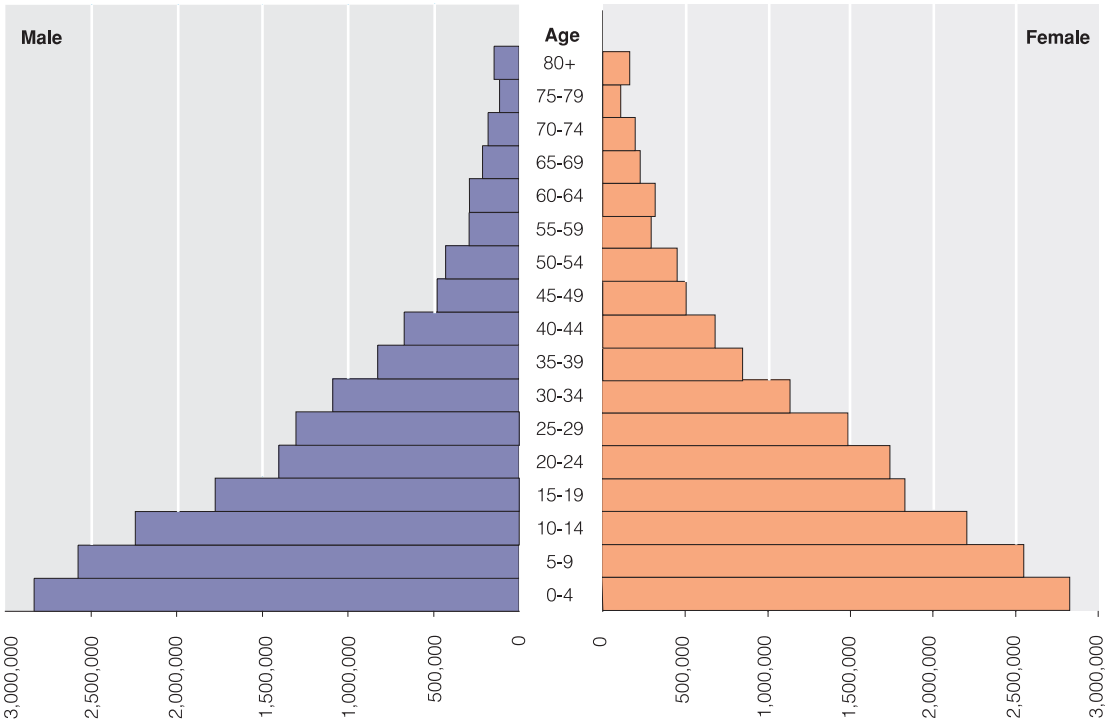


of 2004/05, the Household Budget Survey of 2000/01 in particular. Other evidence comes from more specific parts of the country where in-depth research has been undertaken. The aim is to provide information which will help in the development of a national framework for social protection which is transformative in nature, providing opportunities for all to contribute to development to their full potential and fully to benefit from it. Such a framework must be built on principles of equity, without stigma. It must also acknowledge the fiscal limits of any underlying government obligations to provide for protection measures.

**Age Demographics of Children in Tanzania**

Tanzania's child population is large - half the total population is under the age of 18 years. This age limit is the legal limit of childhood according to international convention, and as ratified by Tanzania. Current projections are that over 18 million Tanzanians are below the age of 18. The population is predominantly rural - 77 % of the total lives in rural areas<sup>3</sup>. The chart below shows how the bulk of the population is concentrated in young age groups.

**Figure 1: Population Pyramid**



Source: Population Census, 2002

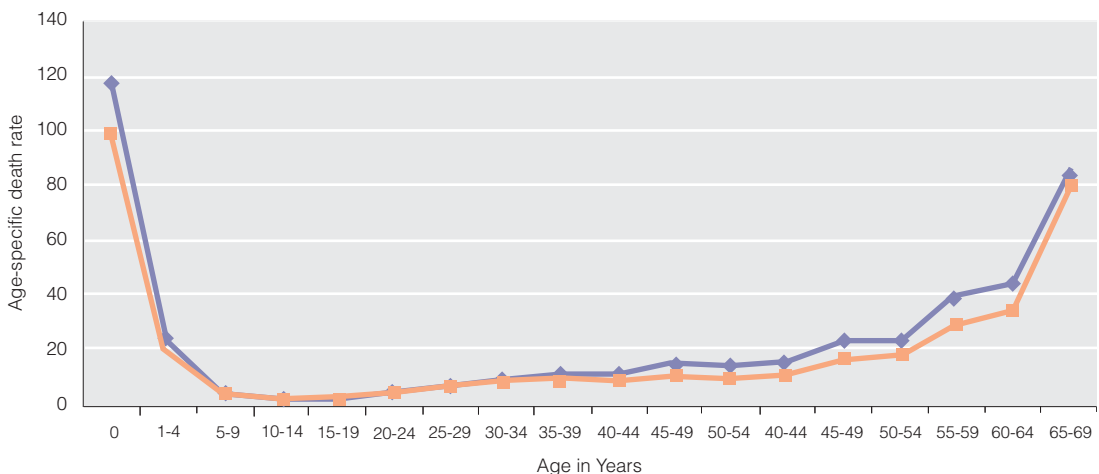
<sup>3</sup> The United Republic of Tanzania Population and Housing Census, 2002, Analytical Report, Volume X, National Bureau of Statistics, Ministry of Planning, Economy and Empowerment, Dar es Salaam, August, 2006.

## Mortality

Children are at a high risk of death at an early age; with more than 1 in 10 Tanzanian children dying before they reach their fifth birthday; newborns are at the greatest risk. Under-five mortality is estimated to be 112 per 1,000 babies born, infant mortality 68, and neo-natal mortality 32<sup>4</sup>. This means that almost 30% of all the deaths of children under five years of age occur within one month of birth<sup>5</sup>. Risk of death estimated from an African data set suggests that 75% of these occur within the first week of life, and 50% within the first day after birth. Access to quality health services is critical in preventing these deaths, including access for their mothers. Babies are at higher risk of death or malnutrition if their mothers are themselves undernourished and in poor health, and if they are young.

Over half of maternal deaths take place within the first day of the birth of the child. Maternal mortality rates have not improved over the past 10 years, and improvements in emergency obstetric care are urgently needed. Access to skilled care at birth is essential, and it is most critically needed in rural areas, where only 39 % of births take place in a health facility. Over 80 per cent of urban births take place in a health facility. Age-specific death rates are shown in Figure 2 below.

**Figure 2: Age Specific Death Rates**



Source: Population Census, 2002, Analytic Volume X

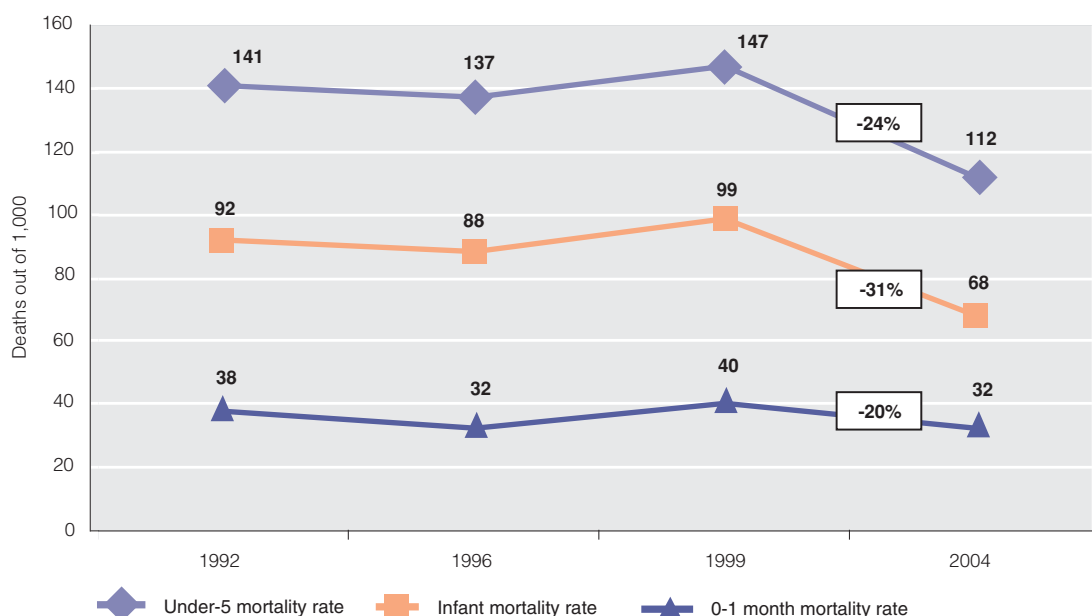
There have been some improvements; infant and child mortality rates have been reduced over time, reflecting progress in the delivery of health services. In addition, the high rates of immunisation achieved in the 1990s have been maintained. The likely major causes of the decline in under-five mortality during the past few years have been improvements in the control and treatment of malaria, as well as a higher rate of vitamin A supplementation. Refer

<sup>4</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.

<sup>5</sup> Partnership for Maternal, Newborn & Child Health (PMNCH), Opportunities for Africa's Newborns, Geneva.

to Figure 3 for a portrayal of the trends. Nonetheless, this rate of under-five mortality means that 160,000 children under the age of five years die every year.

**Figure 3: Trends in Child Survival, Tanzania**



Note: The observations have been charted as the year of the survey.

Source: *Infant and Child Health in Tanzania: Data from the 2004-05 TDHS, and UNICEF.*

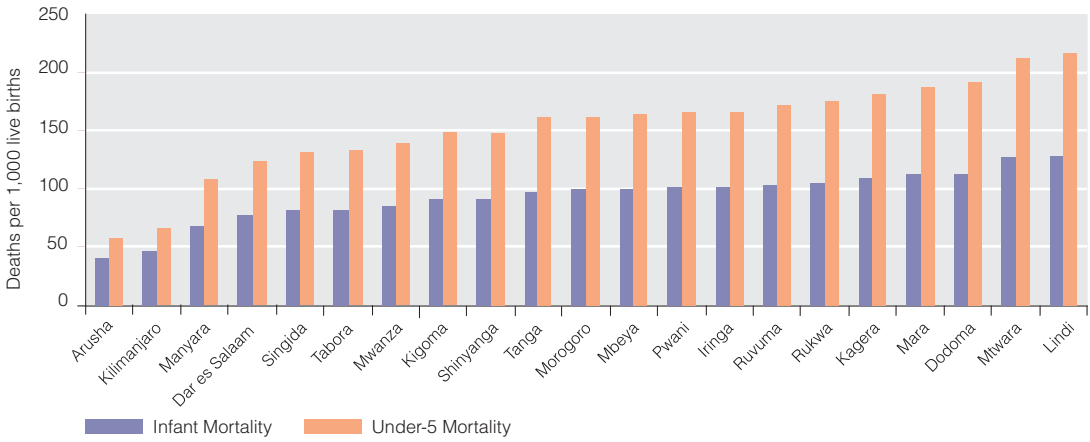
### Geographical Location

A much greater proportion of rural children die than urban children, and so the vast bulk of this number of 160,000 deaths of children under the age of five represents the deaths of rural children. The under-five mortality rate for rural children is 162 per 1,000 live births, for urban children it is 123.

Young children are at greater risk in some regions and districts than in others. Under-five mortality rates are four times higher in Lindi and Mtwara than they are in Arusha and Kilimanjaro. One in four to five children born in districts in Lindi and Mtwara die before their fifth birthday - under-five mortality rates there are 220-250 deaths per 1,000 live births; while in contrast in districts of Arusha and Kilimanjaro there are 40 - 50 deaths per 1,000 live births. Analysis suggests that there are geographic area-specific factors which are important, beyond common determinants such as level of education, income and risk of malaria.<sup>6</sup>

<sup>6</sup> Smithson, P. *Fair's Fair*, Women's Dignity Project and Ifakara Health Research and Development Centre, 2006.

**Figure 4: Infant and Under-5 Mortality Rates by Region**



Source: Population Census, 2002





# Malnutrition

The regions with the highest rates of child mortality tend also to be the regions with the highest rate of stunting in children under five years; those with the lowest rates of mortality also have low rates of stunting in children. As with mortality, child malnutrition is much more prevalent among rural children than among their urban peers. This geographic pattern of mortality (refer to the prior chapter on mortality) is mirrored by that of malnutrition.

**Table 1: Rural and Urban Rates of Under-five Mortality and Malnutrition**

	<b>Under-five Mortality Rate</b>	<b>Percentage of Children Under-five Stunted</b>
<b>Rural</b>	162	40.9
<b>Urban</b>	123	26
<b>Dar es Salaam</b>		16.9
<b>Other urban</b>		29.1

*Sources: National Bureau of Statistics, Populations Census 2002 and Tanzania Demographic and Health Survey 2004/05.*

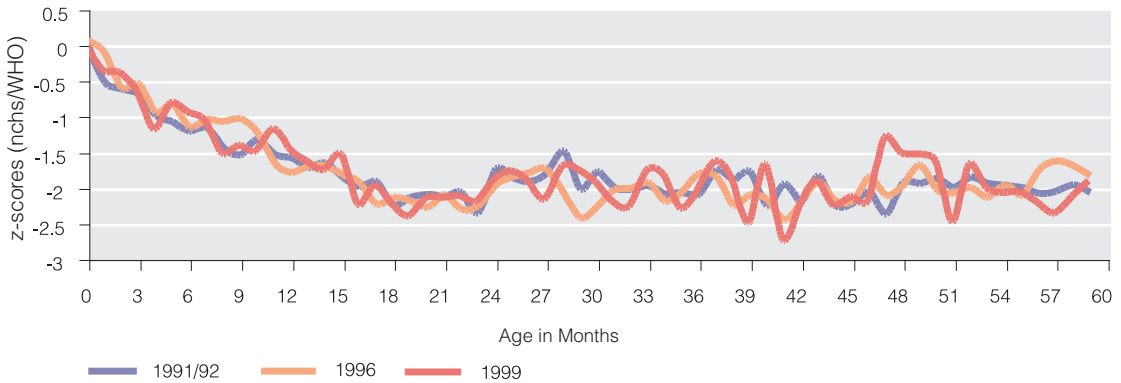
## Stunting

While there has been some improvement in the last few years, the rate of malnutrition in children under five years is still very high - 38 % of all children under five - 2 million children in total are stunted. There is a great deal of research which shows that loss of stature at this early age has long-lasting negative implications for a person's physical and cognitive development which are extremely difficult to overcome. It has been demonstrated, for example, that long term consequences of early malnutrition, can reduce the height of an adolescent by 4.6 cm; schooling by 0.7 grades and results in the loss of 7-12 percent of lifetime earnings.<sup>7</sup>

Stunting sets in at a very early age. After they have been intensively breastfed, children are fed a diet which does not satisfy their requirements for energy and other nutrients. Young children need such a small part of the household's requirements for food that it is extremely unlikely that a shortage of food per se causes such prevalent chronic child malnutrition. While this might be expected to be the case for the 19 % of households who are living below the food poverty level, the evidence is that the rate of stunting is about 40 % among all children except those who are in the least poor 20 % of households, where the rate of stunting is 16 %. Most of these households are urban - the rate of stunting among urban children is 26%. Thus vulnerability to malnutrition is again a generalised phenomenon affecting especially large proportions of the rural population.

<sup>7</sup> Alderman H, Hoddinott J, Kinsey B. "Long-term Consequences of Early Childhood Malnutrition," Dalhousie University, Canada, November 2003.

**Figure 5: Z-scores for Height for Age by Age in Months, 1991-1999**



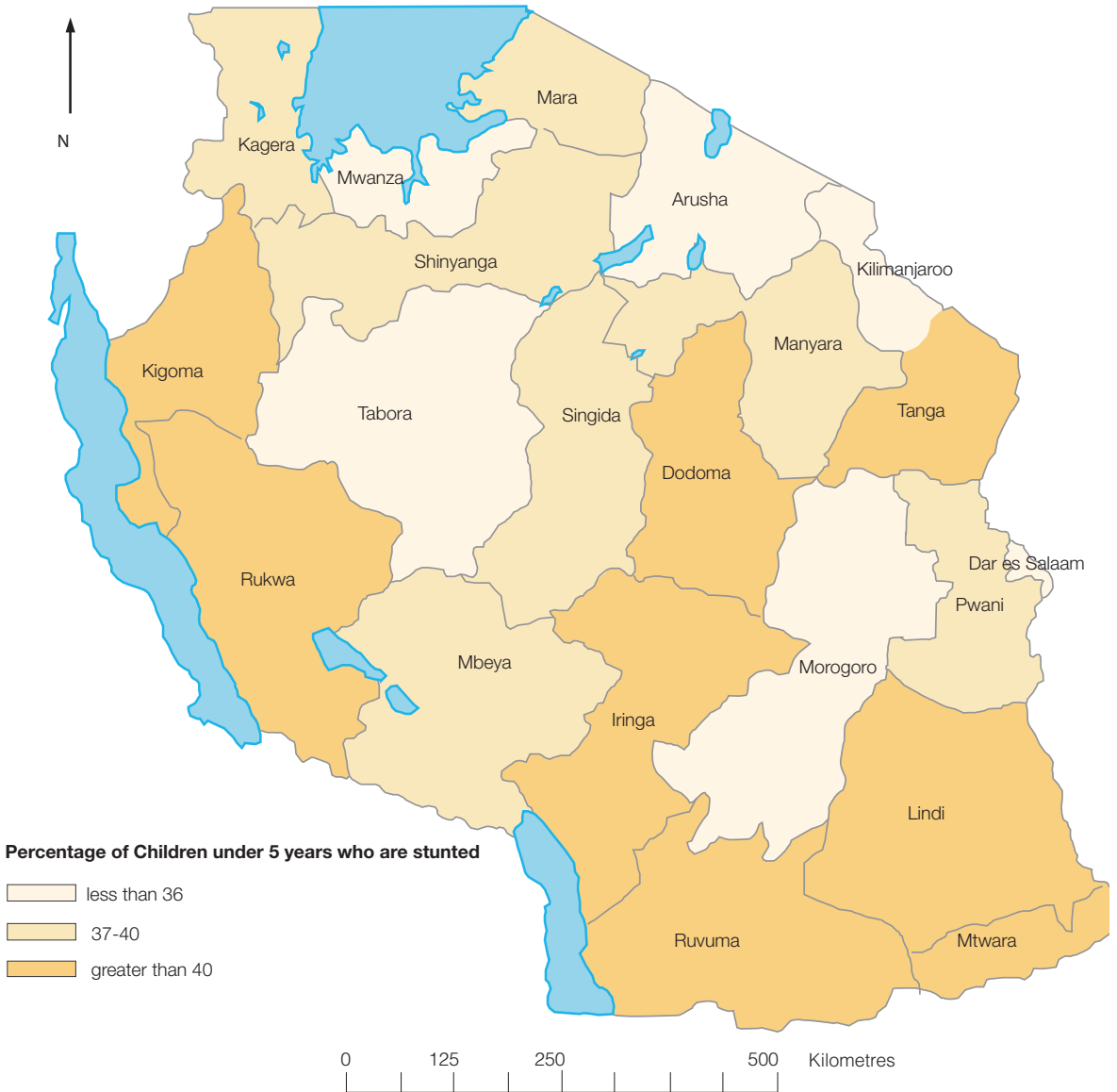
Source: MACRO and National Bureau of Statistics, Demographic and Health Surveys in Tanzania.

Child malnutrition is the result of three main clusters of factors: food, health and care. At an aggregate geographic level, food production is high in several of the regions with high rates of child malnutrition, and rates of malnutrition are low in many of the regions which are commonly associated with low food production, experiencing periodic drought conditions. Similarly there seems to be little association at this level of aggregation between child malnutrition and access to health services. Unfortunately there are few data in the usual household surveys and census about caring practices, and this is clearly an area which needs much better information.

While both parents bear responsibilities for provisioning the household, it is still the norm in Tanzania for women to bear the responsibility for caring for children, especially young children. Gendered divisions of work apply to agricultural tasks as well as domestic work. With much to do, women have little opportunity to provide time, attention and feeding for their children. Children are fed with the rest of the household, and with a similar diet, however they need more frequent feeding - including snack foods, bananas and similar locally available food items -and they should have a diet which is denser in energy and other nutrients than for the common adult diet.

Representative and reliable data on child malnutrition available from the demographic and health surveys may be disaggregated geographically at regional level - the sample cannot provide district-level estimates. Map 1 below shows the regional pattern of malnutrition.

**Map 1: Stunting in Children under 5 years, by Region, 2004**



Source: Tanzania Demographic and Health Survey, 2004/05

**Regional Patterns of Poverty, Under-five Mortality and Malnutrition**

A general pattern of rural dependence on low-productivity agriculture with strong, persistent gendered divisions of work and social practices of caring for children results in a state of generalised insecurity and generalised vulnerability for children. In this context, identifying particular processes which lead to greater vulnerability for some children is difficult. Analysis has been undertaken based on ongoing spatial poverty mapping work in order to assess the extent to which there are marked geographic areas of Tanzania - districts or aggregations of districts - where there is a congruence of characteristics which would suggest children are more vulnerable there than elsewhere. The following data sources were explored: 2002 Population Census data; 2000/2001 Household Budget Survey; Demographic and Health

Survey data from 1996, 1999 and 2004; and routine statistics from the Ministry of Education and Culture. The analysis shows clearly that geographic patterns of mortality and malnutrition do not match in aggregate the geographic distribution of poverty. The table below shows the regional estimates and the ranking of regions which follows.<sup>8</sup>

**Table 2: Food Poverty, Under-five Mortality and Child Malnutrition, by Region**

Region	Food Poverty Rate		Under-five Mortality		Stunting	
	Value	Rank	Value	Rank	Value	Rank
Arusha	25.1	14	58	1	27.2	3
Dar es Salaam	7.5	1	123	3	16.9	1
Dodoma	13.0	8	191	19	44.4	15
Iringa	10.3	4	166	14	50.5	19
Kagera	18.0	11	182	17	37.3	8
Kigoma	21.0	12	148	8	50.1	17
Kilimanjaro	11.1	5	67	2	23.4	2
Lindi	33.3	19	217	21	54.0	21
Mara	36.0	20	188	18	38.7	11
Mbeya	8.3	2	165	12	37.6	10
Morogoro	14.0	9	163	11	35.8	6
Mtwara	16.9	10	212	20	52.7	20
Mwanza	30.0	18	139	7	30.6	4
Pwani	27.5	15	166	13	36.8	7
Rukwa	12.0	7	175	16	45.1	16
Ruvuma	27.4	17	171	15	50.4	18
Shinyanga	22.0	13	149	9	37.4	9
Singida	28.0	16	132	5	39.2	12
Tabora	9.0	3	133	6	34.0	5
Tanga	11.4	6	162	10	43.3	14
Manyara	n.a.	n.a.	107	3	39.6	13
<b>Tanzania Mainland</b>	<b>19.0</b>		<b>162</b>		<b>38.0</b>	

Sources: National Bureau of Statistics, Household Budget Survey 2000/01, Populations Census 2002 and Tanzania Demographic and Health Survey 2004/05.

This classification in table 3 shows clearly how mixed is the picture of food poverty and rates of under-five mortality and malnutrition by region. For example, the regions of Iringa and Rukwa which are among those regions considered to be the highest producers of food in Tanzania have relatively high rates of child mortality and malnutrition. In comparison, regions which are among those frequently considered to be short in food, Singida and Arusha (which at the time of the Household Budget Survey in 2000/01 included those districts which are now in Manyara Region), have relatively high rates of food poverty (not enough food and not enough money to buy food), but they also have relatively lower rates of under-five mortality and malnutrition.

<sup>8</sup> Estimates for these variables for all districts are reported in Poverty and Human Development Report 2005, Appendix Table A.9.



**Table 3: Regions Classified By Rates of Food Poverty, Under-Five Mortality and Malnutrition**

Rate of Food Poverty	Under-five Mortality and Malnutrition Rates		
	High	Average	Lower than Average
<b>High</b>	Lindi, Mara (a) Ruvuma	Pwani	Arusha (b) Mwanza Singida (c)
<b>Average</b>	Dodoma Kagera (d) Kigoma (e) Mtwara	Morogoro Shinyanga	
<b>Lower than Average</b>	Iringa Rukwa	Mbeya Tanga	Dar es Salaam Kilimanjaro Tabora

Note: Regions with relative rankings of 1-7 are classified as having lower than average rates of poverty and under-five mortality and malnutrition; regions with relative rankings of 14-20 are classified as having higher than average rates. Other regions are classified as having average rates.

- (a) The rate of under-five mortality in Mara ranks the regions among the worst, although the rate of stunting is average.
- (b) At the time of the Household Budget Survey which provides the data for classification of households by poverty levels, Manyara Region had not yet been established. Therefore in this table, Arusha includes the districts which are now in Manyara Region.
- (c) The rate of stunting in children under five in Singida ranks the region as average, although the rate of under-five mortality is among the best.
- (d) The rate of under-five mortality in Kagera ranks the region among the worst, although the rate of stunting is average.
- (e) The rate of stunting in children under five years in Kigoma ranks that region as among the worst, although the rate of under-five mortality is average.

Source: National Bureau of Statistics, Household Budget Survey 2000/01 and Tanzania Demographic and Health Survey, 2004/05.

Other regions with high rates of under-five mortality and malnutrition are Lindi, Mara and Ruvuma which also have high rates of food poverty, and Dodoma, Kagera, Kigoma and Mtwara which record average rates of food poverty.

Dar es Salaam, Kilimanjaro and Tabora have consistently high rankings; Morogoro and Shinyanga have average rankings on all the indicators.

Any programme aiming to address high rates of child mortality and malnutrition in specific geographic areas needs therefore to investigate further the specific factors which may be most important in those particular areas.

## Vulnerability and Ill Health

One major cause of child mortality and malnutrition is malaria, which is the single most important disease affecting children and adults in Tanzania. In addition to malaria, diarrhoeal diseases and respiratory infections are also common among children in Tanzania. All of these diseases affect appetite - food intake - as well as the body's use of energy and other nutrients, consequently undermining the child's nutritional status and threatening death. Demographic and health surveys show how commonly children in Tanzania are affected by such illness. Among all children under five years, during the two weeks before the 2004 TDHS survey, 24 % had experienced fever, 13 % had suffered from diarrhoea and 8 % had symptoms of acute respiratory infection (coughing accompanied by short rapid breathing). Of those children surveyed those aged 6 to 23 months were affected to the greatest extent. Among these young children, 35 % had a fever, one quarter had diarrhoea and 11 % had symptoms of acute respiratory infection.

Geographic patterns show relatively high percentages of children with fever along coastal regions, as to be expected, and in Mara and Kigoma, both regions situated on large lakes. However, Mwanza and Kagera show relatively low prevalence of fever in children, likely because larger proportions of the population of children in these regions live further away from Lake Victoria. Regions with high rates of fever and low reported percentages of children sleeping under a mosquito net are Kigoma, Lindi and Dodoma. On the other hand, Mara, Mtwara, Pwani and Ruvuma all had relatively high rates of fever and relatively high percentages of children sleeping under a net. It should be noted that these seven regions are categorised in Table 3 above as having high to average rates of poverty and high to average rates of under-five mortality and malnutrition.

Ill health reduces capacity to work and learn. Vulnerability is exacerbated not only by the loss of production and income, but also by the costs of treatment. A large percentage of women reported that they have problems getting money to access health care - 44 % of rural women and 28 % of urban women. Ill health and malaria in particular, was identified as a major cause of vulnerability in the Participatory Poverty Assessment in Tanzania, and in other analytic work related to vulnerability in Tanzania and in rural Kenya.<sup>9</sup>

Stronger preventive measures, especially in malaria control, with more wide spread access to and use of impregnated mosquito nets, would help reduce vulnerability. Ensuring universal access to essential health care should be a priority in a national programme of social protection.

<sup>9</sup> The United Republic of Tanzania, Vulnerability and resilience to poverty in Tanzania, the Tanzania Participatory Poverty Assessment Main Report, 2002/03; Christiaensen L, and A. Sarris (eds) "Understanding and Reducing Household Vulnerability - Evidence from Rural Tanzania", report prepared for REPOA, December 2006; Christiaensen, L, "Towards an Understanding of Vulnerability in Rural Kenya" a presentation to the PADI Conference, Dar es Salaam, February 2004.

## Vulnerability, Orphanhood and HIV/AIDS

HIV/AIDS has focused much attention on the plight of children orphaned by HIV/AIDS, but increasingly it has been recognised that children are also profoundly affected by living with, caring for parents and other family members who are sick, dying. There are no nationally representative data to document the scale of the psychological toll on children or its impact on them and their subsequent development.

The last population census in 2002 showed that nearly 10 % of all children in Tanzania had been orphaned - close to 2 million children. Paternal orphans are more common - 7.4 % of children had lost their father, 3.4 % had lost their mother, and 1.1 % had lost both parents. Orphanhood was most common in areas with high current or past prevalence of HIV/AIDS. The 14 districts where more than 14 % of children had lost either mother or father were in parts of Kagera and Mara, as well as Iringa and Mbeya.<sup>10</sup> In Makete almost one-quarter of all children had been orphaned. Generally the rate of paternal orphanhood was about double that of maternal orphanhood. It is not possible to know from these data directly whether orphanhood is the result of HIV/AIDS or of other causes. Indirect demographic analysis by UNAIDS, WHO and UNICEF in 2005 estimated that 44 % of orphanhood in Tanzania was the result of HIV/AIDS. This would suggest that about 1 million children have been orphaned as a result of HIV/AIDS.<sup>11</sup>

Overall, the particular geographic areas with higher prevalence of HIV/AIDS are not those with the highest rates of child mortality, nor are they the areas with highest prevalence of poverty, though Mara is the exception. Even among the 14 districts where the greatest proportion of children had been orphaned, it is only Serengeti which is among the districts with the highest rates of poverty. With the exception of Serengeti, none of these 14 districts is among the districts with the highest rates of under-five mortality or other key indicators available from the national data sets.<sup>12</sup>

At an individual level, however, analysis which applies poverty mapping techniques to the census data indicates that orphaned children are poorer than children who are not orphaned, and that the difference between the two groups is larger in Dar es Salaam than in other parts of the country. No differences were found in household living conditions, however, and orphaned children, overall, tend to be in school at the same rate as children who are not orphaned.<sup>13</sup>

More specific data are needed to illustrate the particular effect of orphanhood on individual children, and some information about this is provided by a study of orphanhood in Kagera.

<sup>10</sup> The districts, with the percentage of children orphaned in brackets, are: Makete (24.2), Kyela (19.4), Iringa Urban (18.7), Bukoba Rural (18.2), Rungwe (17.4), Bukoba Urban (16.3), Mbeya Urban (16.2), Mufindi (15.8), Serengeti (15.5), Iringa Rural (15.0), Tarime (14.9), Njombe (14.3), Ludewa (14.2), Muleba (14.1).

<sup>11</sup> UNAIDS and UNICEF Africa's Orphaned and Vulnerable Generations, 2006.

<sup>12</sup> United Republic of Tanzania, Research and Analysis Working Group, 'Poverty and Human Development Report 2005', Table 18, page 75 and Appendix Table A.9.

<sup>13</sup> Lindeboom, et. al., "Vulnerable Children in Tanzania and where they are", a report for UNICEF Tanzania, REPOA, February 2006.

This study started in 1991-1994 at a time when Kagera was very much affected by HIV/AIDS. Children who were not orphaned at that time were followed up again in 2004. By then, 23 % of them had lost one or both parents before they reached the age of 15 years. Maternal orphans were more likely to be stunted and have missed out on years of education; paternal orphans were less affected. Older children and those already in school were less likely to suffer from these adverse nutritional and educational outcomes than children who had been orphaned at a younger age and who had not yet started school.<sup>14</sup>

Research has also been undertaken by the National Institute for Medical Research (NIMR), Mwanza Centre to compare the circumstances of orphan and non-orphan children and their care providers in Mwanza. The researchers found that, across most indicators, orphans appear to be more vulnerable than children living in nuclear families. Also found was that foster children are relatively less vulnerable to disadvantages than orphans, but they show evidence of reduced wellbeing across most indicators compared to children in nuclear families. Certain subgroups of orphans were found to be more vulnerable than others, their sex and age, the sex of the deceased parent and the sex and age of the principal caregiver are determining factors. Nonetheless, the researchers note that the level of relative disadvantage of orphans and foster children is slight compared to the level of need of all children.<sup>15</sup>

The experience of orphans in Kagera, where HIV/AIDS was first spotted in Tanzania, is quite different from that of orphans in Makete. Field research in a study sought to identify the impacts of concurrent shocks on communities in Kagera and Makete, and the local capacities for resilience in the face of these crises. The study identified two kinds of shock, namely chronic strains (notably HIV/AIDS) and acute shocks (drought, floods, sharp declines in the price of marketed cash crops).<sup>16</sup>

The study found no evidence for a general nationwide crisis of AIDS-induced impoverishment and hunger. However, it found clear evidence for two kinds of vulnerability related to HIV/AIDS:

- the emergence of a structurally-vulnerable category of people, specifically most vulnerable children and women impoverished by AIDS in the household, and
- localised crises of interlocking vulnerabilities, where HIV/AIDS has combined with other sources of vulnerability and lack of community resilience and coping capacity.

In the Bukoba Rural district, a wealth of community organisations provides various forms of social insurance that help to mitigate the adverse impacts of HIV/AIDS at household level. HIV/AIDS-related programmes there face challenges of sustainability, coordination, overcoming a dependency syndrome, lack of supplies, and poor data collection, utilisation and monitoring.

Existing data from a large number of surveys undertaken in Kagera region from the 1980s onwards indicate that the epidemic initially affected better off (more mobile, more affluent, and larger) households, and that the measurement of the social and economic impacts of HIV/AIDS is complicated by the fact that some urban people 'go home' to die, so that their

<sup>14</sup> Beegle, K, J De Weerd and S. Dercon, 'Orphanhood and the long-run impact on children', September 2005.

<sup>15</sup> 'Operational Research to Compare the Circumstances of Orphan and Non-orphan Children and their Care Providers in Mwanza, Tanzania', The National Institute for Medical Research (NIMR), Mwanza Centre, for UNICEF Tanzania.

<sup>16</sup> 'Changing Vulnerability to Crisis in Tanzania: Implications for Children and UNICEF Activities', Report to UNICEF Tanzania by Alex de Waal, Joseph Tumushabe, Masuma Mamdani, Blandina Kilama, REPOA, Dar es Salaam, September 2004.

final illness and death are registered in their host household rather than their own household. Partly for these reasons, affected households in Bukoba Rural often have more assets and higher income and are larger than non-affected households.

In Makete, on the other hand, the socio-economic impacts of HIV/AIDS seemed to be found in the richest 20 % and the poorest 20 % of households. The district suffers from remoteness and difficulties of access, contributing to poor staffing of public institutions, which has been exacerbated by AIDS-related morbidity and mortality. At the time of the survey (2004), there was a lack of income from local sources, notably a decline in the farm gate price of pyrethrum, contributing to high levels of seasonal migration by youth. The household survey distinguished between households affected by adult morbidity and mortality since 2000 (a proxy indicator for HIV/AIDS, n=124) and those not affected (n=162). There was an appreciable difference in livelihoods between affected and non-affected households. While both non-affected and affected households were highly reliant on farming, the affected households were also more reliant on gifts and food, and selling of labour for food - with the small number of child workers exclusively found among these affected households. In the more extreme cases they tended to re-locate household members. This would seem to imply that the rural affected households are adopting 'coping strategies' that leave them more vulnerable.

There were also differences between households fostering orphans and those not; though fostering households were poorer. Orphan fostering households were disproportionately represented in the poorest quintile of the population, few of them in the richest quintile. They were eating fewer meals per day. Two thirds of all fostering homes were female headed. The combination of fostering an orphan and suffering adult morbidity or mortality showed starker differences. All the major responses to stress, including diversion of adult labour, loss of income, assets and food, were heightened in this group.

This study underscores the importance of understanding local and circumstantial factors which determine the extent to which communities, households, children will be affected by the combination of chronic stress (generalised insecurity, HIV) and shocks (incapacitating illness, sudden loss of income). The study confirms that the combination of HIV/AIDS and other stresses is having calamitous impacts in Makete, while Bukoba Rural has generally managed to absorb much of the stress associated with HIV/AIDS. The HIV/AIDS epidemic is a major reason for crisis in Makete, when it is taken together with a range of compounding factors and the absence of significant mitigation capacities. The sheer magnitude of the proportion of children who are orphaned and the strains on households and communities in the absence of strong organised support is overwhelming, and may well be mirrored in similar communities where the proportion of children who have been orphaned is high and community organisations do not have capacity to provide the requisite support.

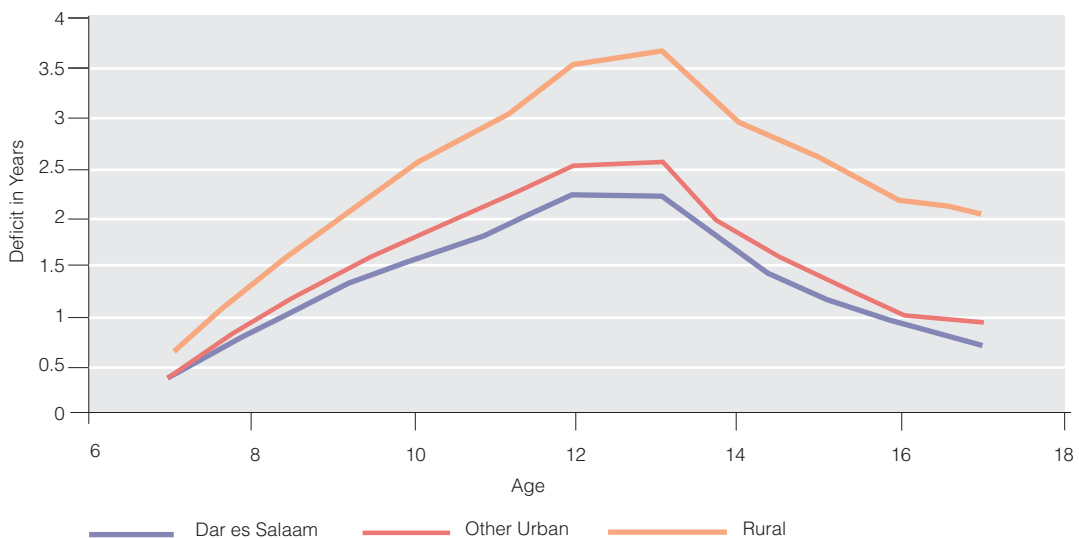




## Education, Work and Vulnerability

Levels of schooling are clearly important in reducing children's vulnerability. Children of well educated mothers are much less likely to die or to be malnourished.<sup>17</sup> Being well educated - having at least some secondary level of education - also means that girls stay at school until they are older, are less likely to be married or give birth to a child until they are older<sup>18</sup> - all factors which have a positive influence on their own well-being and that of their children. Clearly, investments in education - ensuring that all children go to school, improving the quality of the education they receive, improving opportunities for secondary, technical and higher levels of education - are critical elements of a framework for social protection to reduce the vulnerability of children. Again, these investments are needed more for rural children, who miss more years of schooling than their urban peers, as is shown in Figure 6 below.

**Figure 6: Primary Education Deficit by Residence and Age**



Source: Lindeboom, et al, 2006.

Analytic work which has attempted to isolate particularly important correlates of vulnerability has indicated that there are few statistically significant relationships between household income, education and differences in primary school attendance or likelihood that children will be engaged in work. Many children in Tanzania work, most of them engaged in work related to domestic provisioning, but they also attend school for the most part. There is no significant difference in the proportion of girls and boys who work, but there are

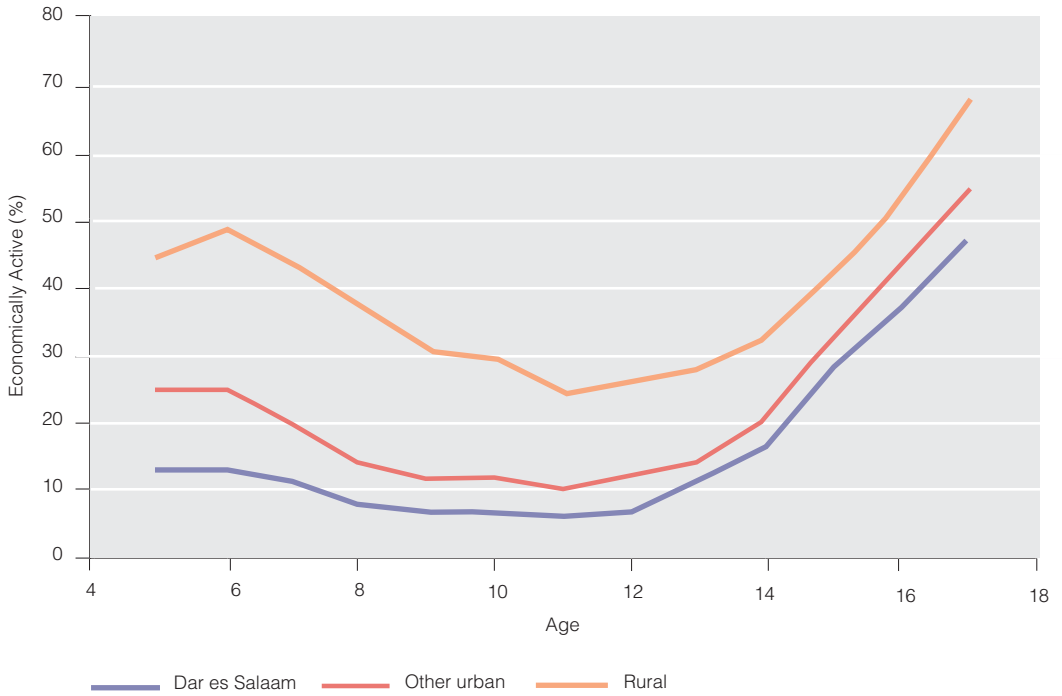
<sup>17</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.

<sup>18</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.



geographic differences - a greater percentage of rural children work, especially at an early age, than their urban peers, and proportionately fewer of Dar es Salaam's total child population work.

**Figure 7: Percentage of Children Who Work, by Area of Residence and Age (including domestic work)**

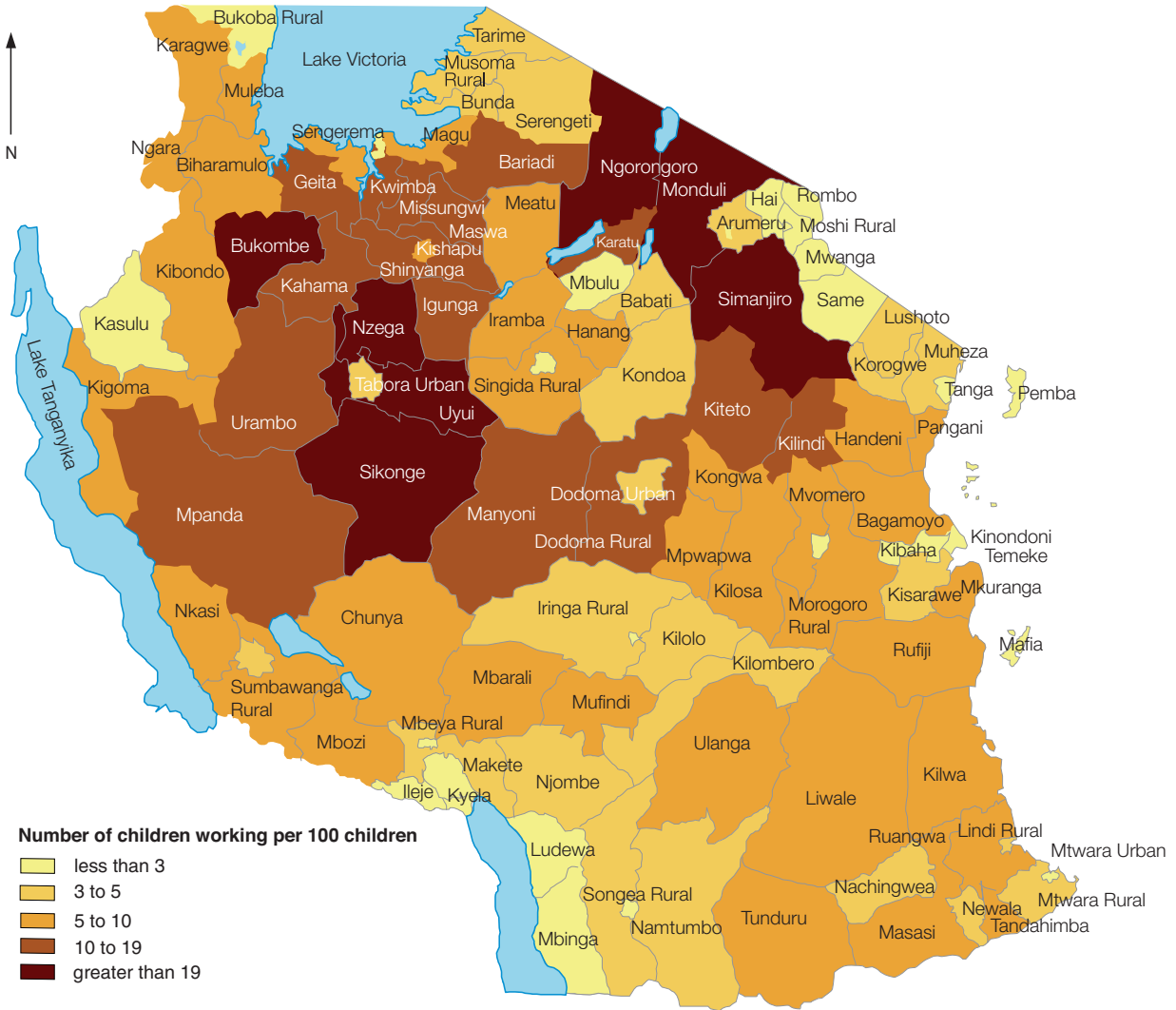


Source: Lindeboom, et al, calculation using 2002 Census, NBS 2003.

There are a few areas of the country with relatively higher proportions of working children who are not attending school, and these tend to be areas where pastoralism and mining activity are more prevalent.



**Map 2: Children 7 to 13 years Who are Working and Not in School, by District, 2002**



Source: Population Census 2002

Much of the work most children are engaged in is considered normal. It is part of their socialisation and regarded as discharging their responsibility to their households. For some children, however, the conditions of their work are exploitative and abusive. This condition is defined to be child labour. The precise numbers of children in such conditions is not known, though certainly some categories of labour are exploitative. They include mining, sex work, employment in commercial agriculture and in domestic work. A baseline study in 11 districts undertaken for the International Labour Organisation showed that most of the children employed outside the household were 14 years of age or older - that is beyond the primary school leaving age - though almost one-quarter of employed children in this survey were below 14 years of age.<sup>19</sup> The districts selected for this survey were purposely chosen as those which were likely to have the most prevalent forms of child labour.

A new national survey into children who work and child labour is being undertaken by the National Bureau of Statistics and is expected to be reported in 2007. This will provide more information.

<sup>19</sup> United Republic of Tanzania and International Labour Organisation, 'Baseline study and attitude survey on child labour and its worst forms', June 2003.





## Other Aspects of Vulnerability

### **Children In Households Headed by Children, or in Households with Elderly Adults Only**

Increased concern about the impact of HIV/AIDS has also led to greater attention for the plight of children in child-headed households, and for those whose main caregiver is an elderly adult - those living in households where there are no adults of prime working age present. According to the 2002 census about 1.2 % of the households were headed by a child. Children heading households are on average between 14 and 15 years of age. District correlates show higher probabilities of child-headed households in the least poor districts.

Children's educational performance does not seem to suffer in households headed by a child, even though children in child-headed households tend to be economically more active than those in adult-headed households, especially among urban households. In urban areas just over 30 % of 15 year olds living in child-headed households are working. In adult-headed households the corresponding figure is 11 % in Dar es Salaam and 18 % in other urban areas. In rural areas 44 and 34 % of the 15 year olds in child and adult headed households respectively are working.

Close to 3 % of all households are occupied by children and the elderly (age 60 years and above) only - they are households without any adult between 18 and 60 years of age. They are, as may be expected, more prevalent in districts with higher rates of orphanhood. Urban children in such households are worse off than their peers in other households. However, there seems to be little difference in indicators of poverty between rural children in such households and those in households with adults 18-60 years. There are no significant differences in years of primary education, nor in the proportion of children working between children living in households with no adults age 18-60 and those in households where adults of this age are present.

### **Children with Disabilities**

One group of children who are particularly vulnerable are those with disabilities. In the national data sets, the clearest indication that they are more likely to be denied the opportunities of their able-bodied peers is provided by their much lower rates of school enrolment. The largest deficits in schooling are of children with disabilities, who attend school on average 2 years fewer than children without a disability. Overall, the national data sets under-report the population with disabilities. This includes the Population Census, which in 2002 attempted to establish the extent to which the population experienced disabilities. It reported that 2 % of the population has some form of disability, the most common forms being physical loss of use of limbs.

With sustained immunisation programmes, the proportion of children and adults who suffer from polio will be reduced over time. Nonetheless, much more is needed to be understood about experiences of disability. More information will be available from a survey of disability, including children, which will be undertaken by the National Bureau of Statistics in 2007.

## **Abuse and Neglect**

Neglected children do not thrive. Unfortunately many children in Tanzania suffer from active abuse and violence. 30 % of adolescent girls in Mwanza reported that their first sexual experience was a forced one.<sup>20</sup>

Many children report that they are abused by adults, including teachers. Discipline at home is frequently meted out with physical chastisement, and this practice is socialised - children report being bullied by older children at school or travelling to or from school. In a survey about travel to school of over 200 schoolchildren in Magu and Ilemela, Mwanza, the most commonly reported bad experience, by 70 % of them, was harassment, fighting among other students and young people.<sup>21</sup>

Reports of abuse by bus conductors of schoolchildren in Dar es Salaam are clearly not only the result of the lower fare to which schoolchildren are entitled. There are more general social attitudes towards children which are at play, and they are reflected also in the high level of gender violence. The issues most commonly cited as important by Tanzanian children in a poll for presentation to the United Nations' General Assembly's Special Session on Children in 2002 were education and then neglect and abuse.

In 2004/05, a majority of both men and women reported that it is acceptable for a husband to beat his wife in some circumstances.<sup>22</sup> An indication of the extent to which gendered violence is accepted is that fact that proportionately more women (60 % said it was justified) reported this than did men (42 %). A noteworthy aspect of the analysis of these responses is that the proportion of both women and men who said that it was acceptable was higher among young men and women than among the older.

An aspect of gendered violence is female genital mutilation/cutting, which affects 15 % of all women in Tanzania. The practice is still common in particular regions, for example in Manyara, 81 % of women reported that they had been circumcised. More than half the women in Dodoma (68 %) and in Arusha (55 %) reported having been circumcised. In almost all cases the form of circumcision involved cutting, with some flesh removed, but with no stitching. Circumcision was more common among the poorest and older women.<sup>23</sup>

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<sup>20</sup> Krug et al (2002: 151-3, quoted in 'Growing Up Global: The Changing Transitions to Adulthood in Developing Countries'; Cynthia B. Lloyd Editor, Committee on Population Board on Children, Youth and Families, Division of Behavioural and Social Sciences and Education, National Research Council and Institute of Medicine of the National Academies, The National Academies Press, Washington D.C. (2005).

<sup>21</sup> Sokoni, C.H., and H. Hambati, "Transport Services for Primary School Children in Tanzania, Implications for Children's Education. A Case Study in Ilemela and Magu Districts, Mwanza Region", a research report submitted as work in progress to REPOA, October 2006.

<sup>22</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.

<sup>23</sup> National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.



## Conclusion

The poverty and generalised insecurity which is the condition of so many Tanzanians, especially rural Tanzanians, inevitably affects children. Most Tanzanian children are rural, large proportions of them are poor, malnourished and in ill health. A national framework for social protection must address these overwhelming facets of life for large numbers of children. A framework which aims to reduce vulnerability, strengthen capabilities must therefore put priority on improving the rural economy and rural conditions of life, and on improving health care and other services in rural areas to reduce the toll of ill-health on children and their caregivers.

Pre-natal and obstetric care must be improved so that at birth babies and their mothers are provided health services which minimise their risk of death. In infancy, caring and feeding practices need to improve and this requires more time and attention of adults - which means improved childcare arrangements. Universal access to quality schooling is essential.

While these universal provisions are necessary conditions, particularly vulnerable children and households need additional support. Individuals who require special support may be identified through a combination of community and local government systems, with strengthened organised community groups to care for the most vulnerable. Financial support may be provided through grants to local authorities allocated according to accepted formulae which are based on the national data available.

Communities are now being asked to identify the most vulnerable children in the context of programmes of support largely funded as a result of concern about the impact of HIV/AIDS. Those who are so identified are absolutely destitute, and not always as a result of HIV/AIDS or orphanhood. The experience in districts which are undertaking this work suggests that overall about 6-8 % of children may be identified as the most vulnerable children - about 1 million children.

But the support provided in some cases single children out in ways which jeopardise social cohesion and cause envy among their peers who are almost as destitute. The level of support provided by several programmes to a relatively small number of children, for clothing, for example, is far in excess of the average expenditures by the majority of households on their children. The challenge is to provide support mechanisms which are not stigmatising, nor discriminatory, but which ensure that all children, no matter what their circumstances, benefit from and contribute to their own development and that of the nation to their fullest capacity. Such programmes of support can be implemented through reformed local government processes and caring community groups. Research elsewhere indicates that the financial costs to Government of such support are well within its budgetary capacity, especially with stronger co-ordination within national planning and budgeting systems of the external support which is now being provided for orphans and most vulnerable children and community and district HIV/AIDS programmes.

The implications of this analysis suggest that investments are most critically needed to ensure that there is equitable access to quality health care, and that much more serious attention is needed towards the social attitudes towards children and young people and practices of caring for children, not only as infants, but also as older children. This requires research beyond the quantitative analysis of large data sets, on which much of the analysis reported here is based. More complementary qualitative work is needed to better inform conscious approaches to changing views of adults towards their children and young people, who are not only the future of Tanzania, but the majority of Tanzanians now. If this can accompany improvements in the conditions of life and the rural economy, then the vulnerability of children will be much reduced and they will grow up in a truly protective, nurturing society.



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6	<i>"The Use of Technology in Alleviating Poverty in Tanzania"</i> A.S. Chungu and G.R.R. Mandara	TGN1 What is the Tanzania Governance Noticeboard?
5	<i>"Environmental Issues and Poverty Alleviation in Tanzania"</i> Adolfo Mascarenhas	LGR 12 Trust in Public Finance: Citizens' Views on taxation by Local Authorities in Tanzania
4	<i>"Implications of Public Policies on Poverty and Poverty Alleviation: The Case of Tanzania"</i> Fidelis Mtatifikolo	LGR 11 Domestic Water Supply: The Need for a Big Push
3	<i>"Who's Poor in Tanzania? A Review of Recent Poverty Research"</i> Brian Cooksey	LGR10 Is the community health fund better than user fees for financing public health care?
2	<i>"Poverty Assessment in Tanzania: Theoretical, Conceptual and Methodological Issues"</i> J. Semboja	LGR 9 Are fees the major barrier to accessing public health care?
1	<i>"Changing Perceptions of Poverty and the Emerging Research Issues"</i> M.S.D. Bagachwa	LGR 8 Primary education since the introduction of the Primary Education Development Plan
		LGR 7 Citizens' access to information on local government finances
		LGR 6 Low awareness amongst citizens of local government reforms
		LGR 5 Fees at the dispensary level: Is universal access being compromised?
		LGR 4 TASAF - a support or an obstacle to local government reform
		LGR 3 Councillors and community leaders - partnership or conflict of interest? Lessons from the Sustainable Mwanza Project
		LGR 2 New challenges for local government revenue enhancement
		LGR 1 About the Local Government Reform project

## Project Briefs

Brief 6 Local Government Reform in Tanzania 2002 - 2005: Summary of Research Findings on Governance, Finance and Service Delivery

Brief 5 Children Participating in Research

Brief 4 Changes in Household Non-Income Welfare Indicators - Can poverty mapping be used to predict a change in per capita consumption over time?

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