

Children and Vulnerability in Tanzania: A Brief Overview

Approximately 50% of the Tanzanian population – over 18 million are aged under 18 years, with 77% living in rural areas.¹ A large proportion of them are poor, malnourished and in ill health. The experience of districts which have identified the most vulnerable children within the context of HIV/AIDS programmes suggests that overall about 6-8% of children may be identified as the most vulnerable children – about 1 million children.²

This brief highlights the key issues of children and vulnerability³ in Mainland Tanzania. It provides an overview of mortality, malnutrition, ill health, disability, orphanhood, HIV/AIDS, education, child labour and abuse. It is a summary of REPOA Special Paper 07.25 'Children and Vulnerability in Tanzania: A Brief Synthesis' by Valerie Leach, a paper which was published with the assistance of UNICEF.

Child Mortality and Malnutrition

Children in Tanzania face a high risk of death at an early age, with more than 1 in 10 Tanzanian children dying before they reach their fifth birthday.

This rate of under-five mortality means that 160,000 children under the age of five years die every year. Newborns face the greatest risk, with almost 30% dying within one month of birth.

Under-five mortality is estimated to be 112 per 1,000 babies born, infant mortality 68, and neonatal mortality 32 per 1,000 babies born.⁴

Access to quality health services and skilled care in health facilities at birth are critical in preventing these deaths. Improvements in emergency obstetric care are urgently needed to address the high maternal death rates, especially in the rural areas, where only 39% of births take place in a

¹The 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

²Under international convention, as ratified by Tanzania, a child is someone under the age of 18 years.

³Vulnerability refers to the risk of something negative happening, as well as the ability that the person can cope with the unfortunate event. 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. All children, especially young children, are vulnerable because they depend on others to provide for their basic needs. (This definition is derived from REPOA Special Paper 06.19 'Developing Social Protection in Tanzania within a Context of Generalised Insecurity' by Professor Marc Wuyts).

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

health facility. 44% of rural women and 28% of urban women said that they have problems getting money to access health care.⁵

The majority of child deaths under the age of 5 occur in the rural areas, at 162 per 1,000 live births, as compared to 123 for urban children.

Malaria is the single most important disease that causes child mortality and malnutrition, affecting both children and adults. In addition to malaria, diarrhoeal diseases and respiratory infections are also common among children in Tanzania.

As with mortality, malnutrition is much more prevalent among rural children than their urban peers. 38% of all children under five – 2 million children in total - are stunted. 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%. The rate of stunting among urban children is 26%.

Research shows that loss of stature at an early age has long-lasting negative impacts on a person's physical and cognitive development which are extremely difficult to overcome. The long-term consequences of malnutrition can reduce the height of an adolescent by 4.6cm, reduce schooling

results by 0.7 grades, and result in the loss of 7 – 12% of lifetime earnings.⁶

Rural and Urban Rates of Under - Five Mortality and Malnutrition		
	Under-Five Mortality Rate (per 1,000)	Percentage of Children Under Five Who Are Stunted
Rural	162	40.9
Urban	123	26
Dar es Salaam		16.9
Other Urban		29.1

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

Geographical Aspects of Child Mortality and Malnutrition

Young children are at greater risk of mortality in some regions and districts than in others. For example, the under-five mortality rate is four times higher in Lindi and Mtwara than 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 the districts of Arusha and Kilimanjaro record 40 – 50 deaths per 1,000 live births. Analysis suggests that there are important geographic area specific factors, beyond the common determinants such as level of education, income and risk of malaria.⁷

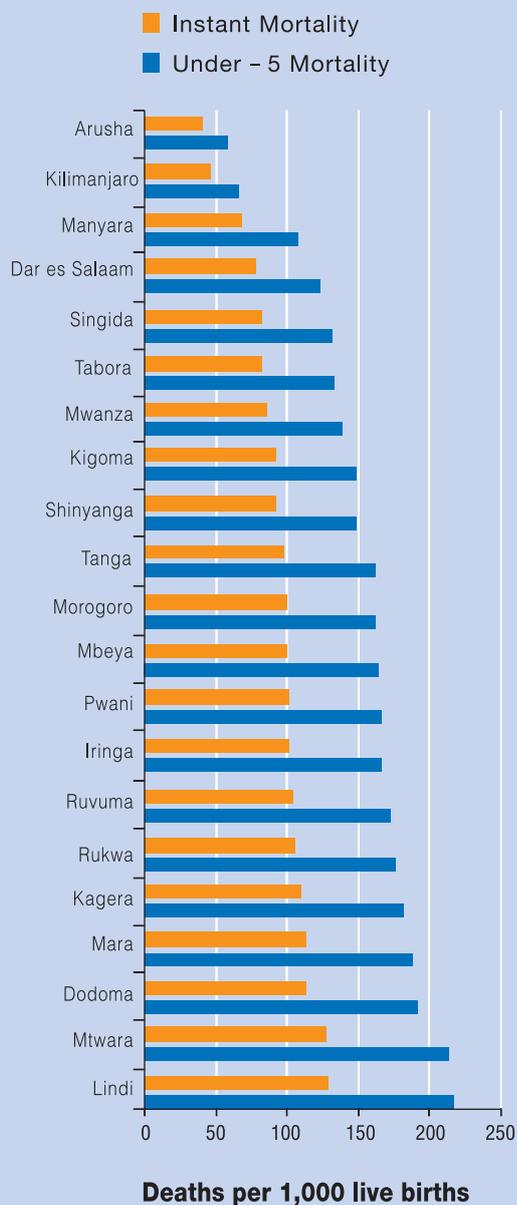
⁵The United Republic of Tanzania, 'Vulnerability and resilience to poverty in Tanzania, the Tanzania Participatory Poverty Assessment Main Report, 2002/03'; Christiaensen L, and A. Sarris (eds) 'Understanding and Reducing Household Vulnerability - Evidence from Rural Tanzania', report prepared for REPOA, December 2006; .Christiaensen, L,

'Towards an Understanding of Vulnerability in Rural Kenya' a presentation to the PADI Conference, Dar es Salaam, February 2004

⁶Alderman H, Hoddinott J, Kinsey B. 'Long-term Consequences of Early Childhood Malnutrition', Dalhousie University, Canada, November 2003

⁷Smithson, P. 'Fair's Fair', Women's Dignity Project and Ifakara Health Research and Development Centre, 2006.

Infant & Under - 5 Mortality Rates by Region



Sources: Population Census, 2002

The Mainland Regions with the highest rates of child mortality tend also to have 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. It should be noted that analysis has shown that

geographical patterns of mortality and malnutrition do not correspond with the geographical distribution of poverty. Any programme aiming to address high rates of child mortality and malnutrition in specific geographic areas needs to investigate the specific factors relevant to that particular area.

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.

Closer inspection reveals that 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, and experience periodic drought conditions. Therefore it seems likely that high rates of stunting may be closely associated with inadequate caring practices, including feeding practices.

Stunting in Children Under 5 Years, by Region, 2004



Sources: Tanzania Demographic and Health Survey, 2004/05

Other Aspects of Vulnerability for Children:

Orphanhood and HIV/AIDS

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.

At an individual level, analysis 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. However, no differences were found in household living conditions and school attendance.

HIV/AIDS has focused much attention on the plight of orphaned children, but increasingly it has been recognised that children are 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.

Children in Households Headed by Children, or in Households with Elderly Adults Only

According to the 2002 Census about 1.2% of the households were headed by a child. Children who head the household are on average between 14 and 15 years of age. Close to 3% of all households are occupied by children and the elderly (age 60 years and above) only. These are households without any adult aged between 18 and 60 years of age. Urban children in such households are worse off than their peers in other urban households.

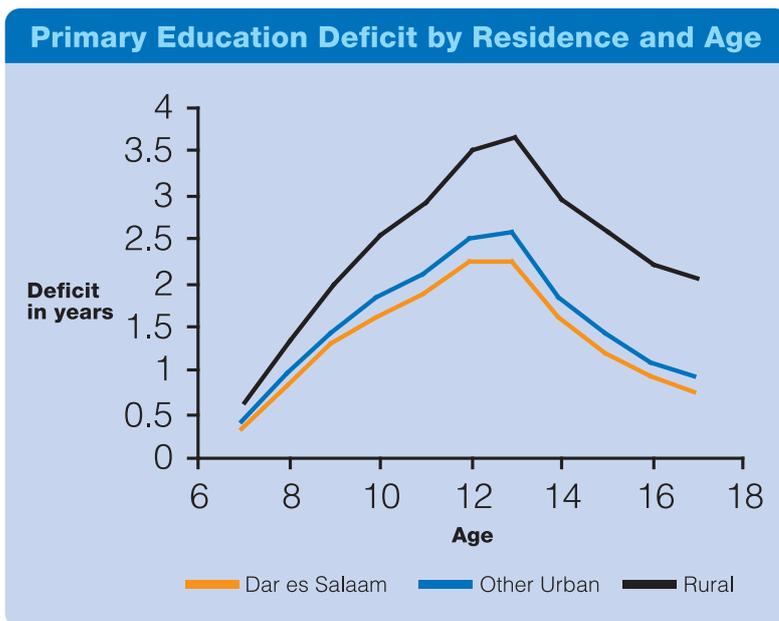
In urban areas just over 30% of 15 year olds living in child-headed households are working. In adult-headed households the corresponding figure is 11% in Dar es Salaam and 18% in other urban areas. In rural areas 44 and 34% of the 15 year olds in child and adult headed households respectively are working.

Even though they are more likely to be working, the attendance rate in school of children in these households is not different from children in other households.

District correlates show higher probabilities of child-headed households in the least poor districts, an association which is strongly influenced by the impact of HIV/AIDS.

Education and Child Labour

Rural children miss more years of schooling than their urban peers.



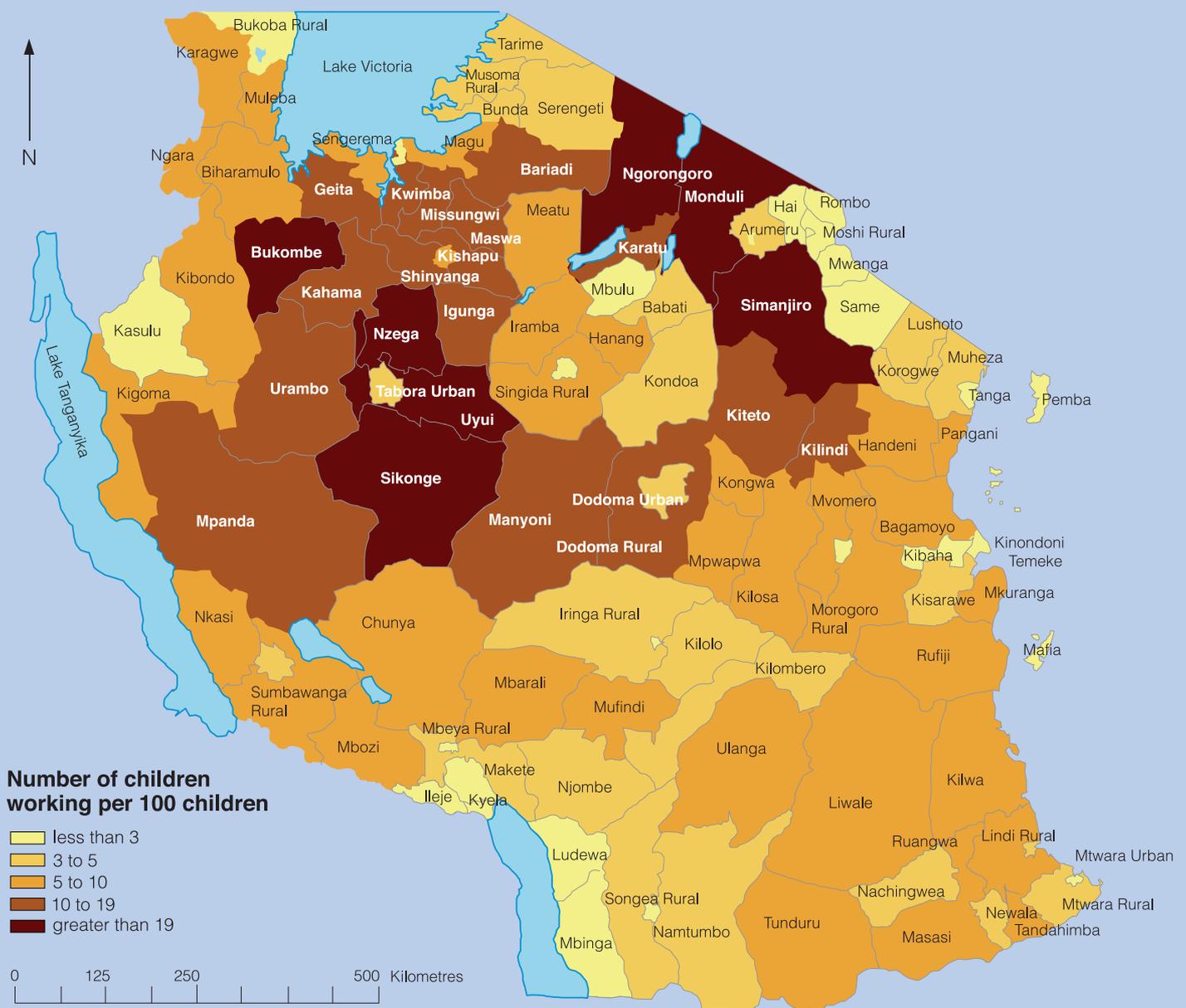
Sources: Lindeboom, et al, 2006

Children with disabilities attend school on average two years less than children without a disability.

The 2002 Population Census reported that 2% of the population has some form of disability, though this is believed to be an under-reported figure. The most common form being physical loss of use of limbs.

Areas of the country with relatively higher proportions of working children who are not attending school tend to be in areas where pastoralism and mining activity are more prevalent.

Children 7 to 13 Years Who are Working and Not in School, by District, 2002



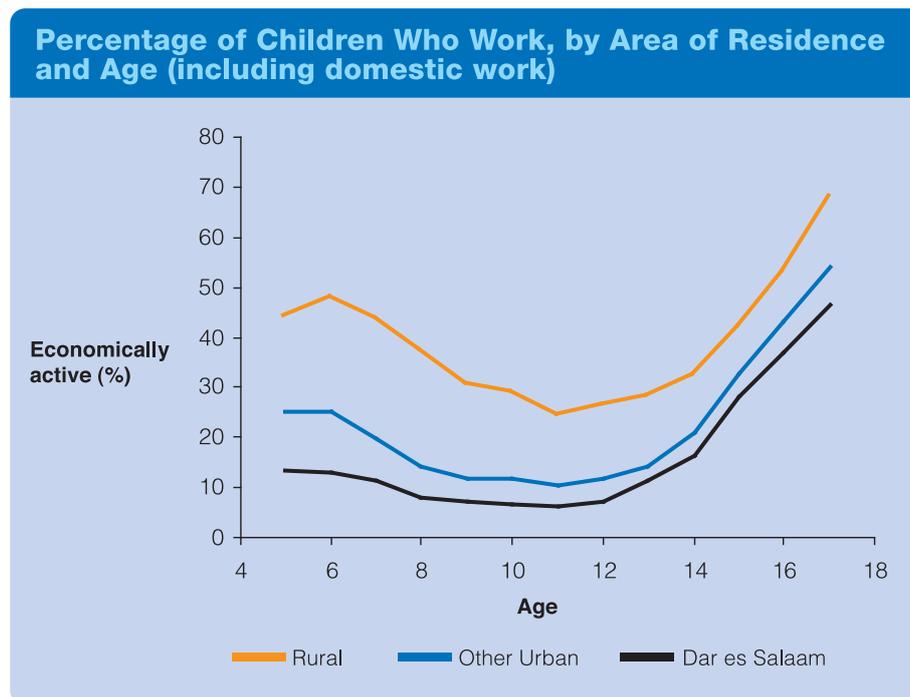
Sources: Calculations from the Census 2002

There is no significant difference in the proportion of girls and boys who work, but there are geographic differences – a greater percentage of rural children work, especially at an early age, compared to their urban peers, and proportionately fewer of Dar es Salaam's total children population work.

were purposely chosen as those which were likely to have the most prevalent forms of child labour.

Abuse

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.⁹

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 when travelling to or from school.

Sources: Lindeboom, et al, calculation using 2002 Census, NBS 2003

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.⁹ The districts selected for this survey

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

⁹United Republic of Tanzania and International Labour Organisation, 'Baseline study and attitude survey on child labour and its worst forms', June 2003.

⁹Krug 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)

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 no stitching.¹⁰

Conclusion

The poverty and generalised insecurity which is the condition of so many Tanzanians, especially rural Tanzanians, inevitably affects children. A national framework for social protection must address these overwhelming facts of life for large numbers of children.

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.

Caring and feeding practices need to improve.

Universal access to basic services is essential.

While these universal provisions are necessary conditions, vulnerable children and their households need additional support.

Equally as important, serious attention is needed towards the social attitudes towards children and young people and to the caring practices of children

¹⁰National Bureau of Statistics and ORC Macro, Tanzania Demographic and Health Survey 2004-2005, December 2005.

This brief is a summary of REPOA Special Paper 07.25 '**Children and Vulnerability in Tanzania: A brief synthesis**' by Valerie Leach; a paper published with the assistance of UNICEF. The publication is available from REPOA and on REPOA's website: www.repoa.or.tz

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Research on Poverty Alleviation, REPOA

P.O. Box 33223, Dar es Salaam, Tanzania
Plot 157 Mgombani Street, Regent Estate, Dar es Salaam
Tel.: +255(0) (22) 270 00 83
Fax: +255(0)(22) 277 57 38
Email: repoa@repoa.or.tz
Website: www.repoa.or.tz

