# TANZANIA AIDS PROJECT

# NATIONAL ASSESSMENT OF FAMILIES AND CHILDREN AFFECTED BY AIDS

Executive Summary

Revised Draft

August 10, 1994

# TANZANIA AIDS PROJECT
# NATIONAL ASSESSMENT OF FAMILIES AND CHILDREN AFFECTED BY AIDS
## Executive Summary

## I. Introduction and Background

This report summarizes the findings of the National Assessment of Families and Children Affected by AIDS conducted by the Tanzania AIDS Project in conjunction with the Ministry of Labor and Youth Development, Social Welfare Division, the National AIDS Control Programme of the Ministry of Health, and the Ministry of Community Development, Women and Children. The Tanzania AIDS Project (TAP) is a five-year, $20 million project signed by the United States and Tanzania Governments in July 1993. The Project's goal is to reduce the impact of AIDS on Tanzanian society by reducing the HIV transmission rate and reducing the social and economic consequences of the epidemic. TAP is one of the first US-funded AIDS projects to include programs to alleviate the social and economic impact of AIDS on individuals, communities and families in Africa. Since this is its first year of operation, TAP staff are gathering information on the status of the epidemic in Tanzania, including baseline information on how it affects families.

TAP staff first discussed their concept for a National Assessment with the Division of Social Welfare, Ministry of Labour and Youth Development, in October 1993. In February 1994, TAP staff initiated meetings among concerned organizations and researchers from the University of Dar es Salaam to develop a research protocol that would meet the Project's need to formulate intervention guidelines. The meetings culminated in a presentation of a concept paper for this Assessment at a meeting hosted by Division of Social Welfare on April 13, 1994. At this meeting, the objectives and methodology of the Assessment were discussed and endorsed by the Ministry of Labor and Youth Development, Social Welfare Division, the National AIDS Control Programme of the Ministry of Health, the Ministry of Community Development, Women and Children, UNICEF, the National Social Welfare Training Institute, the University of Dar es Salaam faculties of Law and Sociology, and the Muhimbili University College of Health Sciences.

Participants suggested that TAP coordinate its work with other organizations collecting related information (World Bank, World Health Organization, and UNICEF) so a shared national data base can be developed. Other potential partners are the Ministry of Education, the Planning Commission, and the Social Workers Association of Tanzania. The Assessment will be a useful source of information for collaborating Ministries and organizations interested in developing policies to mitigate the impact of the AIDS epidemic on families and children in Tanzania. It will be expanded and updated annually by the Tanzania AIDS Project in cooperation with the participating Ministries, UNICEF, and WHO.

The objective of the Assessment was to gather information in four areas:

1. Family systems for caring for persons with AIDS and children orphaned or made vulnerable by the epidemic;

2. Problems and needs of children affected by the epidemic;

3. Resources available to families affected by the epidemic, including institutional resources (government, health facility, NGO); and

4. Government activities, including guidelines, policies, regulations and training, supervision and monitoring of children, and data collection and needs assessment strategies.

The National Assessment includes three components:

1. Institutional Needs Assessment. This is an inventory of all organizations providing assistance to families affected by AIDS in each region of Tanzania.

2. Statistical Profile. This component reviews existing Census and statistical information on families and children for each region of Tanzania.

3. Rapid Family Assessment. This component includes more detailed qualitative information on the situation of families and children affected by AIDS in six regions of Tanzania: Dar es Salaam, Dodoma, Iringa, Morogoro, Mwanza, and Tanga. These regions were selected on the basis of HIV seroprevalence, orphan rates, and to maximize potential regional and ethnic contrast. Three regions have relatively high HIV seroprevalence estimated from blood donor data (Dar es Salaam, Iringa, Tanga). Three of those regions have some of the highest rates of orphaning in Tanzania according to the 1988 census (Iringa, Morogoro, and Tanga). Four of the regions were also chosen as sites for implementation of TAP prevention program in 1994 (Dar es Salaam, Dodoma, Iringa and Tanga), and a fifth, Morogoro, has hosted a number of TAP prevention initiatives.

The team of researchers for the Assessment included: senior consultants Dr. Z. Tumbo (Kiswahili Institute, University of Dar es Salaam) and Dr. George Lwihula (Muhimbili University College of Health Sciences); and researchers Dr. Fred Kaijage (History), Mwanza; Dr. Andrew Kiondo (Political Science) - Tanga; Dr. Patrick Masanju (Sociology) - Dar es Salaam; and Dr. Pamela Maack (Anthropology) - Dodoma, Morogoro and Iringa. Field work for the institutional and ethnographic assessments was conducted in May and June, 1994.

This first draft of the Assessment was prepared by USAID's AIDS Sector Advisor for distribution to Ministry and organizational collaborators for review in July

and August. A review meeting will be held in August, and final release of the Assessment is scheduled in September, 1994. Additional regions may be selected for assessment in the near future, and others will be added as the Tanzania AIDS Project begins programming in other regions of the country.

The main purpose of the National Assessment of Families and Children Affected by AIDS was to develop observations which would stimulate dialogue among policy makers and support policy development. It does not represent all that may be known about family and community adjustments to AIDS. It is hoped that collaborating researchers will add to the information it contains. For example, UNICEF has conducted an assessment of care and counselling activities in 15 districts, and could provide expanded data for those areas. Danida has just completed an evaluation of its program to develop HIV counselling. Additions to this document are encouraged by the relevant Ministries and through review by Regional and District personnel who participated in the study. All are invited to contribute.

## II. Family Structure in Tanzania

Fostering children is not uncommon in any region of Tanzania. According to a national survey completed in 1992, almost one quarter of Tanzanian households (22.8%) include children under the age of 15 whose mother, father or both parents is not present. This figure varies widely in different regions, from 16.7% of households in Dar to 38.6% of households in Lindi.

Almost the same proportion of Tanzanian households (23.1%) include children who are orphaned (one or both parents dead). Some 7% include children whose mother has died (single orphan, maternal), 11.6% are households with children whose father has died (single orphan, paternal), and 4.4% include children with both parents dead (double orphan). The proportion of households with single and double orphans varies from a low of 15.1% in Dar es Salaam to a high of 39.4% in Arusha. Since it is unlikely that these variations are due to AIDS mortality, other cultural practices are coming into play. Some regions and communities may view fostering or adoption as more commonplace and handle the results more routinely.

Some 26.4% of Tanzanian children under 15 live in households without their mothers, fathers or both parents. A total of 9.3% live without either of their parents, i.e., are foster children, and the majority (59%) are cared for by their grandparents. About 7% of children under 15 are orphans, 2.1% maternal, 4.6% paternal, and .4% double orphans. This is slightly higher than the base estimate of 5% from all causes except AIDS estimated by Ainsworth and Rwegarulira, but it is not possible to know if the additional orphan burden is the result of AIDS or a technical underestimate. Coast and Mara Regions report the highest proportion of single and double orphans (over 11%), while Dodoma and Ruvuma report the lowest levels (under 5%). Rates of double orphaning (both parents dead) are highest in Tabora and Mwanza.

Half the children whose mother has died are living with their father (63%), and another quarter with a grandparent (23%). Those whose fathers have died are in households with their mother or grandparent (64%). When both parents die, most children are taken in by their grandparents (42%), or another relative (41%), although almost 12% are cared for by an older sibling.

Other household characteristics which might be determinants of the status of children and care for persons with AIDS also vary widely by region. For example, household size, which may condition the ease with which households absorb orphans, varies from an average of 4.0 in Mtwara to 7.1 in Shinyaga. The proportion of men and women in polygynous relationships also varies within and between regions. In general, approximately twice as many women (27.5%) are in polygynous marriages as men (16.1%), which is to be expected because each polygynous man takes at least two wives. Rates for men are lowest in Morogoro (5.3%), but in two regions, Singida and Iringa, more than 32% of the men are polygynously married. This suggests that the proportion of children who are paternal orphans is likely to be higher in these regions.

Two thirds of women (65%) live with their husbands or partners, but rates vary widely by region, from 50% in Kilimanjaro to 74% in Mbeya. This is correlated to some degree with the proportion of women who have never married, in turn related to the age structure of the female population. On a national level, 7.1% of all women are divorced, and the rates vary from a low of 3.1% in Mara to a high of 12.2% in Lindi, partially explaining the higher rates of fosterage in this region.

## III. Summary of Findings from the National Assessment

Observations and recommendations from this assessment on the care of persons with AIDS, support for orphans of AIDS, responses of families and communities, the roles of government personnel, NGOs and community leaders in developing responses are summarized in this section. Those and the programming recommendations which they suggest are consistent with the findings of prior studies and assessments of programmes in Tanzania and other Sub-saharan African countries (see Section II above).

**A. The Impact of AIDS on Society and Family Life.** AIDS-related social problems are growing quickly and creating profound demands and social stresses on families and communities across Tanzania. While there is tremendous variation across Tanzania, some generalizations are possible concerning the impact of the epidemic on family and social life:

1. HIV infections rates, AIDS mortality rates, and the related distribution of social problems is highly uneven across small geographic distances. Cities, towns, and places of commerce are the most heavily infected to date because they attract

businesses which place individuals at high risk of contracting HIV infection. In these areas, the social problems faced by families and children affected by AIDS are likely to be worse because people are mobile and lack family support.

2. It is difficult to separate the problems families face due to AIDS from those caused by other conditions. Many families are suffering from the consequences of poverty and underemployment. However, AIDS creates some distinct, additional, stresses on families, including:

a. The change in roles and relationships which occur in a family when a member is ill for a prolonged period;

b. The financial demands prior to death (diagnosis, treatment from health facilities and traditional healers) and those after (burial);

c. The loss of external, wage income and loss of household and agricultural labor due to illness and death;

d. Stigma, affecting the person with AIDS and his or her family members and children;

e. Lack of positive diagnosis and information about the disease, so the provision of safe, humanitarian care is impaired;

f. Emotional stress for patients and families from prolonged illness, multiple deaths, and concern for the care of orphans.

3. Changes in family structure and economic trends have created conditions where more families are vulnerable to HIV infection and less able to cope with the consequences of long term illness, medical costs, or the need to support orphans and fostered children. Although it has become popular to say that AIDS is destroying the extended family system in Sub-saharan Africa, it is more accurate to say that it is hastening its evolution. The extended family was stressed and changing in response to many challenges prior to AIDS, such as labor migration. These trends are important contextual factors for AIDS prevention and care, because changes in families are not short term and are not necessarily preventable or avoidable by AIDS-related programming.

4. One very vulnerable type of family is that headed by a single woman. Historically, it is difficult to say if the proportion of female-headed households has increased due to AIDS. Economic trends had made this type of family more prevalent in recent years independent of the epidemic. In fact, the extent of mobility and migration in present day Tanzania might have been matched earlier in the century or in centuries before. It is clear, however, that male and female Tanzanians are

often discharged without diagnosis. Where testing is available, results are often delayed and patients do not return to get them. Referrals are also hindered for this reason and because physicians are not clear about what treatment to recommend or are rushed by heavy job responsibilities. Lack of a definite diagnosis, as well as undying human hope, encourage patients to go to traditional healers, many of whom are not trained in treating the symptoms of AIDS. In some cases, however, traditional healers are known to be using efficacious preparations with scientifically verified active ingredients which are locally available, relieve AIDS-related conditions, prolong life and improve its quality. These healers could be encouraged to work with others to improve the effectiveness of traditional healers in the country.

**2. Home Care.** Health care providers are inhibited in their counselling and the advice they can give to family care givers by their inability to make a specific diagnosis without testing and lack of clear guidelines for home care. Some home care counsellors say that the family begins to reject their visits because they don't have equipment or supplies and can offer only advice. In the absence of testing, which is not likely to become widespread in the near future, government officials might consider developing a general manual and advice for families based on the idea of "universal precautions" or generally sound hygiene and sanitation advice to facilitate family training. AMREF has just finished a Kiswahili manual for home care givers the distribution of which may be of assistance. Additionally, it may be possible to develop a series for newspaper, radio, and television to provide families information on home care for AIDS patients and others with prolonged terminal illnesses.

Persons with AIDS who are at home tend to be isolated by their families and from the community, in part because of their immobility and diminished ability to communicate. In some cases, too, families are too poor to purchase basic supplies for cleaning, which makes management of a person with AIDS very difficult. In any prolonged illness, including AIDS, caretakers can lose patience over time because they are tired and have persistent, competing work demands. Hostels or day center for persons with AIDS could be useful to reduce the sense of isolation, stigmatization, and loneliness in patients and their families, and increase community acceptance and awareness.

**3. Counselling.** Counselling is generally provided by NGOs or volunteers who may also be hospital personnel, but provide assistance on their own after work hours. It is not widespread because providers are confused about their roles and have extremely heavy workloads. Physicians and nurses often have not discussed their division of labor, lines of authority, or responsibilities for counselling. There is great variation between hospitals in the nature and extent of services. In many cases, professionals are making dedicated efforts above and beyond the call of duty, and are emotionally fatigued by these efforts.

Where counselling and assistance for home care is available, it has an important

positive impact in increasing family and community acceptance of persons with AIDS and the orphans they may leave behind. Counsellors assist patients in thinking about the future of their children before their death, and in extending quality of life where they can advise on proper care and nutrition. Without counselling, many hospital patients feel they are being told to go home and die, and their survival chances are reduced. In general, people with AIDS are more worried about the future welfare of their children than about their own death, and counselling can help them in planning for their future.

Most training for counsellors has been geared to pre and post test counselling, and is not generally applicable to advising people about how to live with AIDS. Health care providers are giving the best advice they can as professionals, but could use assistance and training, and support in learning to cope with the grief they experience in dealing with the personal tragedies AIDS often generates.

**C. Assistance for Orphans.** Social Welfare Officers have the following responsibilities:

1. Licensing and supervision of orphanage conditions and admission;
2. Counselling families and parents on care and support of children;
3. Advise and assist applicants for adoption;
4. Counselling parents and children for behavior problems;
5. Probation;
6. Prevention of child abuse;
7. Tracing relatives for placement of children from orphanages.

Because of the nature of these responsibilities, Social Welfare Officers are viewed as powerful. Their Ministry is very poorly resourced and in many cases the researchers had difficulty locating and meeting with Social Welfare personnel. They are the first step before court and provide advice on social problems. Their traditional role in AIDS related matters is quite small, and lack of new definitions has created friction between Social Welfare Officers and AIDS Control Coordinators. If a new role in assisting families with AIDS were defined, Social Welfare Officers could work with RACCs and DACCs and be more effectively involved, but many officers would need additional training.

While an orphan can be defined as a child with one or both parents dead, lay people define an orphan as a child who has lost both parents. Maternal orphans generally suffer more than paternal because men are not practiced in child care, housekeeping, and generally do not show children much affection. In the event of remarriage, step mothers frequently mistreat children badly, sometimes without the awareness of their father.

In most cases, researchers found that families are accepting persons with AIDS

and orphans, and will not refuse to take children in because they do not want to lose face with their families. Unfortunately, the general levels of poverty mean that most families must struggle to survive, and cannot provide easily for additional children. Children who are adopted after their parents' death may suffer from malnutrition and lack of health care. In some cases, they may even be deliberately neglected or abused as economic pressures build up. Girls are easy to place because they can be used as housegirls, which accounts for the preponderance of male street children. Both male and female children are expected to help with all facets of household work, and are also expected to work in place of or in addition to schooling.

One of the researchers advocated development of street children's homes because:

> Evidence strongly indicates that orphans are extremely mobile. They flee bad memories and bad situations looking for other relatives or economic opportunity. They end up abused and neglected on the streets of major towns. Street children's homes across Tanzania would like to start a cooperative network so relatives can be traced and notes compared. Perhaps a meeting between representatives of existing and planned homes can be arranged.

Orphanages have primarily served children under the age of 3 whose mothers have died. These children are placed as quickly as possible with family members when they are old enough to feed themselves. Children who are physically or mentally handicapped sometimes have to stay in the orphanages for most of their childhood. Most individuals feel very strongly that families should be the first line of response, that most family members want to help, and that limitations are primarily economic. Institutionalization is regarded as undesirable, and most Tanzanians do not regard it as an option. In the absence of institutional care, direct assistance, recommended in many previous studies and programs, may be necessary to help a family during the most difficult periods of shortage. The greatest difficulties are experienced by single or widowed mothers, who not only have difficulty providing for children economically, but also report having difficulty controlling older children emotionally and psychologically.

Guidelines exist for formal adoption under Tanzanian law according to which a potential parent must make application to the court for adoption. Legally, parents or guardians can give a child up for adoption if they agree to do so before the court. In any adoption proceeding, the court appoints a guardian ad litem who investigates the situation on behalf of the court to ensure that there are no living parents or relatives who want the child, and if the conditions of the adoption are in the child's best interest. This investigation is usually conducted within two weeks to a month, according to the Ministry of Labor and Youth Development's Division of Social Welfare. Social Welfare also indicated that formal adoption by a non-relative was

viewed with less suspicion than formal adoption by a relative. Traditionally, formal adoption by a relative was not actually necessary, and if a relative took the steps to formally adopt a child, his or her motives were viewed suspiciously. Now, however, Social Welfare feels it may be important for the government to encourage relatives to use formal adoption mechanisms so the rights and responsibilities of adoptive parents and children are made explicit. Despite its clear definition in Tanzanian law, researchers found that the legal procedures for adoption are not very well known among members of the general public, perhaps because it is not often used. One researcher found that

> [most people believe that] children cannot be given up for adoption if any relatives remain alive. Couples [are] waiting to adopt but...unable to find any children without relatives...[In one town], a neighbor was interested in adopting one of the toddlers [in an orphanage]. It could not be done because the father had stated he would come for her one day. He had not been seen again since leaving the child with Social Welfare...there should be a way relatives can legally renounce claims to children they don't want so others may take them in.

According to the Children's Home Act Number 4 of 1968, a child under 18 years of age can remain in an orphanage if necessary, as is sometimes the case if a child is physically or mentally handicapped. However, institutions were strongly advised to return children to their families or relatives between the ages of two or three because children adapt better if they are taken into a family while they are still young. Researchers observed that this policy advisement may need to be reviewed:

> With the growing number of orphans, relatives may not be able to bear the cost of looking after them. Some may not be able to be returned to their families at the age of two without facing abuse and neglect. In the coming years, there may need to be a little more flexibility in orphan care arrangements. There may need to be an ideal of returning children to families but a more practical recognition that it may not always be possible. Some orphanages are working to make the integration of the child into the Tanzanian community smoother and this should be encouraged.

**D. Community Responses.** Villagers are well informed about the signs and symptoms of AIDS, but are slow in labeling people until there are a series of severe bouts with identifying illnesses. In cities, reactions may be harsher. Persons who are thought to have AIDS have been evicted by landlords who feared stigma would lower property values. Some employers are screening employees on the basis of symptoms and firing them to avoid long term medical expenses. The worst affected are the self-employed because they lose their ability to work and have no forms of social

assistance to fall back on.

It is very important to develop some measures of how well families and communities are coping, and more information about what constitutes both positive and negative coping. However, lack of community responses to AIDS in the areas studied limited the researchers' ability to make specific recommendations about development of indicators. Community responses were not common for many reasons, among them the following:

1. Poverty and the competing concerns of survival;

2. The belief that AIDS is not as serious or any more serious than other common fatal illness;

3. Beliefs that AIDS is primarily an urban disease, and that most AIDS cases in rural areas are persons who have returned to their homes after contracting the disease in the city;

4. Denial that AIDS can take a foothold in rural areas;

5. In some cases, diminishment of local leadership.

Researchers felt that competing concerns made it hard to mobilize communities unless AIDS cases or growing numbers of orphans reached a crisis level. Health workers were disappointed by the lack of community support for their work and surprised by the lack of response by families. However, they are better informed about the disease than laymen, and can understand its long term impact and implications better. Despite the lack of community response, the researchers felt that there are people of good will everywhere who want to be mobilized, and that local political or traditional leaders might be stimulated to take a broader view and lead community responses:

> Teachers and village government leaders were often well-informed and conscientious individuals. It was very encouraging to note that almost every one interviewed had a sympathetic understanding of the circumstances of single mothers, understood that nearly anyone can get AIDS, and realized that children should not be made victims of AIDS stigma.

Most villagers were not willing to stigmatize families with AIDS, to ignore children who need assistance, or to condone families who leave widows and their children destitute following death of a husband. Some are making contributions as individuals to maintain children in school, take them to the dispensary for health care, or ensure they have enough to eat. Teachers in some instances have provided

assistance or shelter to abandoned children.

In some cases, local political leaders were well informed and concerned even when the general populace was not. Some villages had plans for day care or for income generating schemes, but these were not AIDS-related responses. In most cases, community development workers were not functioning because of confusion about party viability and relationships. Responses by religious groups were most common. Researchers felt that dissemination of ideas and examples might stimulate community responses. According to one researcher:

> Developing a set of readily available guidelines in Swahili for villagers to form their own NGOs, targeted at women of all ages and at young men, would be met with enthusiasm in many areas. Supportable projects should be suggested in the guidelines so villagers have a sense of what will be accepted. Villagers often do not have the economic experience necessary to judge the success or failure of a development project so the decision should not entirely be up to them. For example, many times women think of knitting or sewing projects because that is something with which they are familiar, but there would be little to no market for these finished items and the project would fail. Instead, perhaps, the concentration should be on the one activity that all engage in even if to a small degree -- farming.
>
> Empowering women without providing support to men would be a mistake. Young men need to have the opportunity of being able to feel there is a viable existence for them in the village. They need to be able to see themselves as responsible fathers, not sperm donors. Their productive labor and support are desperately needed. Elders in the community are often village leaders of various types. They often still hold the mores and values of community life in great esteem. Perhaps there is a way to suggest that they take a stand on abuses of tradition and irresponsibility. In those areas where orphans' inheritances are threatened the only protection may be the moral censorship of the community. The benefits of village-based NGOs may be that highly visible groups give support to help orphans will serve as an example to those exploiting or neglecting orphans and may make their behavior subject to village censorship.

One researcher felt that communities could be provided development assistance in the long term, but relief assistance might be needed by individual families in the short term:

> Resources for orphan support should target communities rather than individual households. The problem...is a breakdown in service

> delivery systems at the level of the communities. Besides, family-level support has high manpower requirements and transportation costs, and presents problems relating to monitoring and determination of eligibility....Forms of intervention which would build the basic resource base of communities and strengthen their service delivery capacities [are recommended]. Interventions might be in the form of upgrading school education levels, supplying school meals, improving sanitation and water supply, providing recreation facilities, introducing health programmes or initiating a community productivity drive.
>
> Community and household approaches need not be mutually exclusive. One obvious virtue of the community approach is that, other things being equal, it would lay a foundation for long term self-sustainability of communities. But field experience has revealed so much want, so many crises of human survival on a day-to-day basis, that the mundane issues of day-to-day existence for individuals and households can only be ignored at heavy cost to humanity. The starving widows and orphans, the families evicted for rent default or the children sent out of school for non-payment of school fees cannot wait for community projects, which cost much money, have a long gestation period, and are likely to be fraught with managerial complications.
>
> It is therefore recommended that the approach to orphan assistance be double-pronged, targeting communities as well as affected families. At the level of families, support should benefit whole households rather than single out the orphans...Informants generally agree that if caregivers were to receive general support meant to boost their household economies, they would willingly and responsibly perform their caregiving function.

The community could help individual families in several ways in relation to facilitating education, including reassessing their expectations for fees from all children; simplifying procedures for orphans to receive waivers of school fees and reducing the embarrassment children experience in doing so; and requesting NGO assistance in projects which reduce the overall need for fees, such as repair and construction of classrooms, and provision of furniture and study materials.

There are traditional forms of inter-familial assistance which are still important, including shared labor for agriculture, or assistance with household chores on a temporary basis in the event of sickness or death. There are mutual assistance organizations, which loan or give money to help with members' hospital and funeral expenses or to assist at weddings or with other enterprises. These are not segregated by gender except among Muslims. One researcher suggested that support from family members and friends may be more available during the early phases of illness, but that

they are exhausted by the illness and funeral and unavailable to meet the needs of surviving children. "Orphans garner much less support from neighbors and kin. Thus, more direct material support may be required for orphaned children than for AIDS patients."

One researcher advised that official company communities and their surrounding service communities cannot be separated in realistic AIDS prevention and care programmes because "surrounding communities may need more help than company communities" with which they continuously interact. The company needs to ensure that the wider community is incorporated in prevention campaigns. In addition, company actions and policies towards workers who become ill may also need re-examination:

> Many workers and their families are sent "home" where they may be viewed as dangerous outsiders. Sending them home ends the company's problems, but it does not end the patient's and family's problems.

E. **Residence and Ethnicity.** The most important determinant of a family's response to AIDS is its economic condition. Unfortunately, the illness of a family member due to AIDS further diminishes family resources through reduced earnings, and increased expenses for hospital care, drugs, or traditional healers. By the time a person dies, in many cases, there are no resources left for the survivors. Urban residence often makes it harder for a family to cope because they may not have supportive family members close by. There is greater nucleation of families, and people are not as well known to their neighbors and communities. There also might be rapid shifts in settlement in market towns.

There is little ethnic variation in family and community response to persons with AIDS or orphans, but ethnicity does determine rules of property inheritance and the treatment of widows in many cases. In groups where women can own property, their welfare following the death of their husbands is more secure. In areas with high bride price, the situation is less secure because the husband's relatives felt entitled to recover property. Muslim communities were the most organized because the Koran is specific about inheritance and about protecting orphans. Women can inherit property, although their share is very small. Community leaders also have the responsibility to follow up and ensure that inheritance rules have been followed by the family.

Many personal factors have a strong effect on the situation of persons with AIDS and their families. People who have good relationships with their relatives, friends or workmates will receive help more readily, which is true of any crisis. Gender makes a difference, as well. Men with the disease will generally receive loyal care from their mothers and sisters, while women may be abandoned by their

husbands when they are ill with AIDS.

**F. Government Role.** Researchers worked with government personnel closely whenever they were available and contacted many local Ministry representatives. All government personnel visited by the researchers operate with many constraints, including lack of materials, supplies, time, fuel, and vehicles. The effects of these constraints are variable, determined by several factors:

1. Availability of Government Resources. In some regions, government resources are available and personnel are in place and functioning, but in others they are not;

2. Individual Leadership. There was great variation in individual effectiveness depending on individual drive, commitment and leadership. Some government personnel were doing well because they had both a clear vision of their role and a strong commitment to creative approaches to problem solving, including developing public contributions for programs;

3. NGO Resources. The most effective government personnel had aligned themselves with an NGO providing support for government activities.

Researchers felt that the general public did not have much confidence in the ability or willingness of government personnel to help. According to one:

> The crisis of confidence in relation to the role of government in social service-related activities is so serious that it would be ill-advised to channel resources for orphan support through the government. Families invariably rejected direct involvement of government in their support. Their perception of government, rightly or wrongly, is one of an institution which has little sympathy for their problems and where some of the resources meant for their support would line the pockets of private functionaries. The objective reality may be different from the above perception, but these sentiments cannot be ignored in formulating an assistance policy.
>
> However, the government has an important role to play, especially in the following areas:
>
> (1) Reform of inheritance laws in order to protect the property rights of widows and orphans. Against the backdrop of a rapidly changing economic and social environment, traditional law relating to inheritance, which was premised on trust, is frequently distorted to benefit the powerful and aggressive and to disadvantage the socially disempowered -- the women and children. In order to lend effectiveness to such legislative intervention, judicial and bureaucratic procedures for

processing inheritance matters should be simplified;

(2) Exemption of orphans from cost sharing charges in education, health and other social welfare related needs;

(3) Logistical support to NGOs and community based initiatives in the areas of orphan assistance.

The antagonism toward government is, due, in part, to the government's lack of resources or tangible signs of their ability to help. In other cases, the traditional roles of government personnel have been antagonistic to individuals. In most cases, village and ward level leaders are trusted and still respected, and may be successfully involved with stimulating community responses to AIDS. Researchers found that government personnel were committed and hard working, although they found great variation in the roles played by regional and district personnel. This was due, in many cases, to the fact that government personnel are not clear about their roles in relation to persons with AIDS or to orphans, so they develop roles according to their inclinations, backgrounds and relationships with other officials. However, lack of guidelines is problematic:

> The virtual paralysis of government AIDS control activities is positively damaging. Since government is an important agency of social change and since it already has a well-established system of reaching the public, it is important that its resources be beefed up...in order to advance the cause of AIDS control. Such interventions ...should target specific, identified gaps in order to avoid resources going to fund general administrative expenses. Actual implementation of what is recommended will be done by NGOs and community-based bodies under the general supervision of government.

Lack of guidelines for roles or training to develop new roles in areas of overlapping responsibility has lead to confusion and contention in some areas between Regional AIDS Control Coordinators and Regional Welfare Officers. One example is in establishing responsibility for orphans of AIDS. Social Welfare Officers have overall responsibility for the welfare of children requiring institutional support. RACCs and DACCs, on the other hand, have no mandate to care for orphans; however, because of their position (usually associated with regional and district hospitals) and knowledge of NGO programs, they are frequently informed of cases of PWAs whose children will be left in difficult circumstances. Several concrete steps can be taken to promote collaborative relationships:

1. Clear delineation of roles and responsibilities by central Ministry personnel in collaboration with regional and district personnel;

2. In some cases, workshops to raise the awareness of the problem among top bureaucratic and political leaders at the regional, municipal, and district levels;

3. Development of planning workshops to identify problems and create joint plans in regions and districts. These might be based on prior NACP plans, broadened to include new prevention approaches and to address the concerns of families and children affected by AIDS;

4. Training for Social Welfare Officers to sensitize them to conditions of families with AIDS and how to assist them. SWOs could also be reoriented to work more closely and aggressively with NGOs in design and implementation of programmes for families affected by AIDS;

5. Regular meetings of all personnel involved in AIDS issues at the regional and district levels to discuss problems. This also might be useful to generate new ideas or anticipate upcoming situations.

Lack of consistent policy and clear directives for government representatives reduces the opportunities they have to create and implement positive social interventions for families and communities. This is also seen at the local level in the lack of awareness and leadership in villages and wards. Community awareness could be raised and their participation encouraged. This would be useful to increase local peer pressure or property protection mechanisms to ensure that widows and orphans retain their property.

Many NGOs are expanding their activities in response to the progress of the epidemic, adding caregiving activities to their original prevention programs. This is a logical progression that mirrors the current pattern of the epidemic in many parts of Tanzania, and the increase in number of persons with full blown AIDS. Government response to NGO operations has been of two kinds. In the positive cases, government officers have aligned themselves with NGOs which resource them so they are better able to execute their responsibilities. In the negative cases, the fact that NGOs have resources that government workers lack has generated bad feelings and jealously. In one case, an NGO claimed that a government official had blocked their NGO registration for this reason.

In general, the infusion of new resources into a community can have this effect, not only between government and non-government personnel, but also between branches of government, who receive variable support. Most actual work for families affected by AIDS is done by NGOs, but government personnel have an important coordinating role to play and can stimulate collaboration by adopting a positive attitude. In addition, donors should develop mechanism which encourage or require the NGOs they fund to work in full collaboration with government. Collaboration can be improved both by NGOs and government personnel through information sharing, regular meetings, recognition of appropriate roles, and sharing of resources.

## IV. Opportunities to Assist Families and Children Affected by AIDS

The findings of this National Assessment of Families and Children Affected by AIDS suggests a number of programming opportunities for the government, donors, and NGOs. The activities which might could be undertaken to address the needs of families and children affected by AIDS are presented below by main subject area.

### Dissemination of the Results of the Assessment

1. Distribute the Executive Summary of the National Assessment of Families and Children Affected by AIDS to relevant Ministries, and provide a summary to regional and district government representatives, donors and NGOs with programming interests in these areas;

2. Prepare a brief, popular version of the findings for translation into Kiswahili for distribution to interested organizations and individuals;

3. Publicize findings to government decision makers and the general public so they are more aware of the magnitude of the problems AIDS creates;

### Support for Home Care and Counselling

4. Support mass popular education in care and counselling as well as prevention using newspapers, radio, television, and folk media. Campaigns should be in Kiswahili, and could be conducted in cooperation with religious organizations, political parties, and civic groups;

5. Support the development of national guidelines and lay manuals on home care, counselling, and the needs of families and children affected by AIDS;

6. Clarify national policy on testing and counselling for persons with AIDS in the absence of test kits. Facilitate diagnosis on the basis of signs and symptoms, and encourage broader counselling for families providing care for the terminally ill;

7. Increase support to hospital and NGO programmes providing counselling, home care, and community education for families and children affected by AIDS;

### Increase Coordination and Collaboration

8. Develop Ministry training programs to examine and update the role of Social Welfare Officers in assisting families affected by AIDS;

9. Examine improvement of orphanage programming, including subsidies, training opportunities, development of programmes to integrate children into the

community, enhanced interaction of management and Social Welfare Officers, incentives for fostering parents;

10. Encourage and support regional and district planning and strategy development sessions with R/DACCs, R/DSWOs, and NGO representatives;

11. Require NGOs with TAP subcontracts to coordinate with government personnel in program development and encourage their participation through consultations and meetings;

12. Require TAP field coordinators to be thoroughly familiar with prior regional and district plans in AIDS prevention and care developed through the efforts of the NACP;

**Access of Communities to Resources**

13. Prepare guidelines on community response, income generating projects, and NGO development for villages;

14. Encourage community philanthropy in larger cities and towns, both in terms of donations to assist families and children affected by AIDS and to develop facilities or provide materials for assistance;

15. Work with NGOs in TAP clusters and with UN organizations, such as UNICEF or UNDP, to identify community projects for support;

16. Ask NGOs in TAP clusters to work with communities to increase awareness, identify community needs, and develop income-generating projects;

17. Develop other media programs to stimulate community response;

18. Start small-scale, revolving credit funds through the TAP clusters, and link them with the Social Action Trust Fund once developed;

19. Promote teacher education and development as community resources persons and link them with Social Welfare Officers in identifying needs and providing assistance;

20. Encourage communities to review educational access and waivers for children in difficult circumstances;

21. Support development of programmes for street children in smaller urban areas served by TAP clusters and development of a national street children's network;

**Legal Changes**

22. Identify and implement needed changes in law and policy in regard to orphanages and adoption;

23. Support revision of laws or other legal programming and education to protect the inheritance of widows and children orphaned by AIDS;

24. Support the creation of local "legal defense funds" which women can use to defend themselves against claims on their property;

25. Publicize the condition of widows and children by distributing the film Neria nationally. Use other media to stimulate public discussion of women's and children's rights, inheritance, and family responsibility under traditional law;

26. Support efforts to review business laws and practices concerning persons ill with AIDS, and provision of prevention and care programmes;

27. Develop a media campaign to stimulate business support of these programmes among workers and in the surrounding community;

**Multisectoral Interventions**

28. Support training of traditional healers to promote efficacious traditional treatment of HIV/AIDS-related symptoms. Support their training and incorporation in AIDS prevention and care campaigns generally;

29. Work with the Ministry of Agriculture to identify viable agricultural interventions to increase productivity through improved technology and storage. Promote development of an "early warning" system to target communities where loss of productivity may be especially critical;

30. Examine, with the Ministry of Labor and Youth Development, the need for relief or crisis interventions as identified by TAP clusters. Those might include short term food aid, medical care, emergency housing, day care centers, funding basic education and vocational training, and peer counselling for caregivers;

**On-going Research and Monitoring**

31. Review 1994 and 1996 DHS findings on family structure by region to determine changes in household composition and growth in orphan population;

32. Support additional research on variation in family structures and orphaning practices by region.

Figures and Case Studies
To be Integrated into the Main Body of the Executive Summary

Figures and Case Studies
To be Integrated into the Main Body of the Executive Summary

*The Pace of the Epidemic and Social Response*

*"There is a feeling among social workers and health workers that the pace of the pandemic is not being matched by efforts made at the moment. No government ministry is able to cope with the epidemic's growth. The National AIDS Coordinating Committee is doing its best, but the pace of the epidemic calls for more government planning to deal with the increasing number of AIDS affected families and orphans. This would entail a clear policy and strategy formulation. There should be clear guidelines and standards for NGOs, for example, and there should be machinery to monitor activities. NGOs would thus be guided to work in complementarity, not in competition."*

*Diagnosis Without Testing*

*"Currently no patients at the Regional Hospital are being told they are suffering of AIDS. They are simply treated for their specific illnesses. Deaths are not written up as AIDS because of the stigma associated with the disease. Test kits for diagnosis are not available. Because no diagnoses are being made no counselling is done. The consequence of a lack of any diagnosis is that AIDS sufferers continue to seek a diagnosis and treatment of their condition. This involves travel to other hospitals in the region, including several private mission hospitals, and the use of traditional healers. By the time most AIDS patients die they have completely exhausted the resources of their immediate and extended families. Most patients are dying at home, particularly those in rural areas. Those dying in the regional hospital tend to be town residents.*

*"The physician in charge also argued that since they weren't doing counselling they couldn't be expected to make a diagnosis of AIDS since NACP policy was that no AIDS diagnosis can be made without prior counselling. Interviews with orphans in town indicate people are dying at home cared for by their immediate families. Some die in the care of traditional healers and some in hospital if they are too ill to be discharged. For the most part AIDS patients in both hospitals are discharged and sent home to die. Many will eventually give up their search and do not return to hospital. Some patients in the private wards have enough money to remain there until their deaths."*

*Families With AIDS*

*"One woman has lost a husband and child over the course of the last two years. She has three remaining children: one eleven, one eight, and a small sickly baby. Her oldest has only just started school. While her husband was sick there was no one to care for him. She has no family because her own parents died long ago. She has one sister who lives in a village about 60 kilometers away. She herself is ill. She started being sick at planting time. She was not able to plant her normal amount and now is worried about her harvest. The house and shamba she uses belongs to her husband's family and they are allowing her to use it but they offer her no other help. They are poor themselves. Village leaders are very worried about her.*

*"Women are overwhelmingly responsible for the care of the sick and orphaned children. They are the poorest members of society and those with the least resources at their disposal. The mobile nature of the population in business centers and migrant labor areas means women must engage in serial relationships with men to get any assistance. Iringa is a region of patrilineal people and women have no access to the resources of society. They do not own their own houses and land. They do not keep cows or goats. Essentially, large numbers of women live the lives of single mothers, whether they are single or not. Many must rely on their own abilities to raise their children. The economic options available to them are extremely limited: beer brewing, food preparation, bar work, petty trade for those with some small capital. Those who do have a husband must look the other way when their husband acquires a girlfriend. The house they are living in and the land they are farming to feed their children is not theirs. In the long run such couples may have settled down to a more stable existence in their middle years. For many, because of AIDS, this opportunity will not come."*

*Traditional Healers*

*"Many patients seek treatment from traditional healers particularly in rural areas. In Dodoma, at least, traditional healers are relatively benign, encouraging things like good eating habits and rest. The RACC and DACC keep a registry of traditional healers and maintain good relations with them. Traditional healers apparently come to the hospital seeking patients. On the other hand, traditional healers can cost quite a bit of money demanding anything from 30,000/= to many goats. They also serve to reinforce the idea that AIDS is linked to spiritual beliefs. One traditional healer in Dodoma town interviewed argues that illness is cause by various spirits and some spirits can be called forth to destroy others. He claims to be able to rid the body of the AIDS virus within 21 days for a fee of 4,000/=."*

*Government and NGO Coordination*

*"Some problems are by no means unique to Tanzania, [including the difficulties inherent in] coordinating and interacting with other branches of government and NGO's. The specific problem began when the sisters at the town orphanage expressed concern over the number of babies that were dying of AIDS and their worries about caring for the children. Social Welfare offered to test the children so the sisters would know which children might need special care and contacted the regional hospital which agreed to do the testing. When the RACC heard about it, he became very upset and demanded to know on whose authority the tests were ordered. This jurisdictional dispute was actually solved in a way which brought further problems. The founder of an NGO which provides AIDS counselling services volunteered to go to the orphanage and conduct some seminars to inform the sisters and show them how to safely care for babies in the final stages of the disease. The end result was that everyone involved felt others were trying to control the situation.*

*"These jurisdictional arguments have persisted. The NGO director had begun to do home counselling but was told by the RMO and the RACC that she should not because that is what they wanted to do. She says they refuse to refer hospital patients to her, but she has organized her own system whereby she holds day long seminars for ten-cell leaders in how to recognize problems and what to do about them and encouraging them to send people to her. Meanwhile her solution to the hostility is to pay the RACC and Urban DACC per diems to accompany her on the many prevention seminars she gives in town. It seems to work well. The problems are by no means solved."*

*Community Response*

*"In 1990-91 there were several AIDS cases returning to the Kondoa area at the same time. People became frightened. They associate the disease with witchcraft even though they know how it is spread. They have become very suspicious of outsiders. Grain and vegetables are sold only to traders from Kondoa and although the area is known for sewing kofia, and thus a potential business center, residents will only sell them to a few known traders. Residents are afraid of those returning from travelling in other areas. Men and, especially, women find it difficult to marry if they have returned from living in towns. In general only a few young men now travel; most stay and farm. Women continue to travel but many don't return. Parents look after returned AIDS patients but they are very cautious in the amount of resources expended on their care. When one who has travelled becomes sick and claims to have TB or malaria they demand to see their health certificate to see if the doctor has recorded HIV before taking them to the hospital. Otherwise, the fact that a person has HIV is deeply hidden. For this reason, it was extremely difficult to get people to admit to any problems."*

*Community Response*

*"There was a fair amount of complaining from a few village elders that those who were dying were the wealthiest ones in the village, and people just took the children in to get the wealth left to them and when they had used it up they kicked them out. Those dying may have made plans and made their wishes known, but these were not followed after their death. In most cases such plans are made very quickly because few patients admit their disease until the very end. The safeguarding of an orphan's inheritance is entrusted to family members, and some are not trustworthy. The death of a "businessman" often results in a great deal of dispute over the property and children. Village elders are not pleased with the behavior of fellow villagers."*

*"Ward and village government leaders are often concerned, caring individuals. They are often impressive in their knowledge of local problems and genuinely upset when they feel people are behaving improperly but they are also unsure of their jurisdiction in these matters. In Mvumi Makulu, for example, they were concerned about relatives stealing orphans' inheritances and about ill-treatment of orphans in general. With some directive from the government, elders and leaders in the community could be empowered to speak out and condemn such practices. Teachers would soon add their voices. In the process they would restore some of the moral balance that many elders and teachers feel is being lost in their communities. Also schools need to be apprised of the procedures for waiving school fees, both national government fees and locally assessed fees, for orphans. There is great variability in the way schools choose to handle financing problems. While material support is needed in Dodoma, to some extent burdens could be lightened by solving these problems at local levels without outside financial assistance. First, however, there needs to be clarification of what is and is not accepted by national policy and local leadership may need encouragement."*

***Community Response***

*"Residents of one community have a "council" which ensures that the right person inherits the property of his or her deceased relative. A similar thing is done for an orphan, however for young orphan the council entrusts the property to an adult relative and guardian who has to hand over the property to the orphan once he or she is over 18. The elders did not think that religious beliefs and actions affect the care of orphans. The advantage of taking care of an orphan only comes when the latter is mature, has good character and remembers to help you as his or her care giver. They also admit that it is a great burden to take care of an orphan, especially because of the expense of medicine and education."*

***Estate Communities***

*"The population of estate communities are not only large but diverse both in their ethnic origins and in their reasons for being there. First, there are those inhabitants who are there with direct links to the employer. Retired workers often do not return to home regions but settle down on very small plots in the surrounding communities. Workers making a relatively good salary may have multiple wives, families, and girlfriends who they provide housing for in the community after installing their one permitted family in company-assigned housing. In most cases, these employees may be from diverse regions within Tanzania and may not maintain significant ties with their home region. Reliance on extended family relations for help is problematic.*

*"Second, immigrants from all over Tanzania also come to these areas to engage in petty business. At most estates, seasonal laborers arrive by the thousands. For a period of time they make relatively good money. Petty business men hope to sell them consumer commodities. Petty business women hope to sell local beer, food, and sexual services. Even village women from distant villages may bring their produce to sell on designated market days and stay to earn a little extra money or gifts in exchange for sex. Village leaders in these areas report many people dying from AIDS and many orphans living on their own.*

*"Most temporary workers will have returned home before they exhibit symptoms. If they become sick on the job, they are terminated and sent home. They will not be hired back. Permanent employees are also terminated and sent home, a place they may not have returned to for years. Those who choose to may be permitted to remain in the company hospital until well enough to be discharged or until death. Wives and children who grew up on the estate are given tickets "home". Older daughters and sons of employees are common victims of AIDS. They will be cared for in company hospitals. Private companies provide no support for surrounding communities, except for occasionally hiring day labor. Government owned parastatals may provide basic medical care for local communities but hospital staff are instructed to give better care to employees. In addition, parastatals in Tanzania are rapidly being privatized; and agreements to share company facilities may be overturned."*

***Caretakers of Families***

*"Woman in Tanzania are bearing much of the burden of AIDS. Many are dying without being able to afford to go to the hospital for even minimal care. In Iiula, Iringa one woman died by the side of the road waiting for a ride to the regional hospital. She did not have the money for bus fare. Older women, reaching the time of life when they expect to rest, are having to find the strength to start over. In Morogoro town, one grandmother had to leave her country home to move to the city to care for the children her daughter left behind when she died of AIDS. Every day this elderly lady carries loads of rocks from the river behind her house to her front yard where she sits breaking them into smaller pieces. In three months she can break enough to fill a lorry. One load will earn her 12,000/=. She says she will continue to do that for her two grandchildren until her body breaks down, even though her head pounds from the pounding of the rocks and her neck and shoulders ache from the effort."*

*Caretakers of Families*

*"One elderly couple had taken in 6 grandchildren from two different daughters who died of AIDS. The family were all originally from the mountains and the grandfather had worked in the regional hospital for 22 years before retiring. They were living a fairly middle class existence before he took in his two unmarried daughters' children. It cost him a lot of money when his daughters got sick. They first went to hospital and then traditional healers. They and his wife (who looked after them) had to stay a long time with the traditional healer while he went looking for money to pay the healer. He and his wife had planned to retire to their shamba but instead he has had to find work as a night watchman to buy food for the children. He has not been able to afford school fees for all the children. The oldest has dropped out and sells peanuts. Others are old enough to have started but he has no money to enter them. The second oldest boy is at the head of his class and sells peanuts on the weekends to get enough money. He is behind in his fees but not his studies. The grandfather is 71 years old. He earns enough money at his job to buy food for all the children. Should he die his oldest son will take care of the children. He has a large family. The family is well respected in the neighborhood and has many family ties in town and in the mountains. Nevertheless, these days they are living in comparative poverty."*

*Family Changes*

*"The Assistant Social Welfare Officer says the city has many problems with children living in poverty. There are many single mothers and children with broken homes. His office sees 2 new cases almost every day of women coming to the office and complaining of being kicked out or not receiving support from men. When he calls the men in he finds that they have another wife someplace else and many other girlfriends. He spends much time working on child support cases. The women who come to his office sometimes mention that they are afraid of AIDS but he notes that there are many more women than men and women are scrambling for me.*

*"There are many children living on the streets. Many are the victims of broken homes and parental abandonment and death. There are many single mothers whose current boyfriend may not like children around. Many are the victims of abuse and hunger. Some who come to the street children's center have lost their parents to AIDS and have been neglected by their guardians. Boys most often show up on the street; girls are taken in to be house girls or trade sex for a place to sleep. It is difficult to get detailed family histories from the children but some 200 children may be moving in and out of street life. The center has 34 boys; approximately 20 of these report that their parents are "divorced"; 9 report that they are orphaned; 17 boys report that they do not know where their fathers are, almost all the others report their fathers as at distant places like Dar es Salaam and Arusha. Two of the boys have been identified as AIDS orphans. Others may be but the information is difficult to obtain. Many of the boys have travelled around the country a good bit."*

*Orphans of AIDS*

*"Those suffering without respite from AIDS are the children of those afflicted. Many have watched their parents die. Some have nursed them alone. While many children are taken in by relatives who genuinely care for the children, love them, and try to do the best they can for them, most people view the taking in of additional children as a burden. Few can afford to send their own children to school, let alone fostered children. Even providing food for additional mouths is difficult for most people in Tanzania.*

*"In all three areas, there were still strong social norms for fostering relatives' children, but the circle of responsible relatives is decreasing and the costs of raising children are increasing. The stigma associated with AIDS also undoubtedly plays a role in people's decisions to foster children but in all three areas this was difficult to assess. The strong normative pressure to foster children may operate in the days after the death of the parent(s) but cannot continue when faced with the day to day realities of feeding, clothing, and caring for additional children. Children are universally viewed as an mzigo, a burden (a load). In all three regions, school teachers reported that the standards of living of orphaned children dropped drastically upon the death of their parent(s). Most orphans came to school dirty, unfed, and embarrassed by their condition. Orphans are often the last to pay their school contributions and have high absentee rates. Most are forced to engage in petty business, selling peanuts, ice cream, and cigarettes to support themselves. Eventually, most stop coming to school, some for non-payment of contributions, some out of sheer humiliation. Helping these children will be a matter of easing the burden on the families who have taken them in."*

*Orphans of AIDS*

*"One ten year old boy fled Bukoba in fear two years previously after his parents had died of AIDS. His slightly older brother and he were living alone. His brother, also very young, was making money taking fish back and forth to Dar. He had told his younger brother that his parents were killed by evil spirits that lived in their house. The evil spirits had been brought by Idi Amin and his brother had seen them. When his brother left to go to Dar, the boy was terrified to stay in the house alone so he followed his brother, sneaking and hiding the whole way. In Dar he ran away from his brother, not entirely intentionally. He wandered until finding the bus stand and snuck on one, it deposited him in Iringa. He stayed at the bus stand until he was given a job "calling" the passengers to the bus. He spent his life on the Kwacha Video Coach. The bus leaves Iringa at 10:00 AM and arrives in Mbeya at 4:00 PM. It departs almost immediately for Kiera arriving at 6:00 PM and leaves again to return to Iringa the next morning at 4:00 AM. Eliasi was responsible for calling the passengers to the bus at every stop and assisting them with their luggage. Passengers like young amusing children and Eliasi's job was to get them to choose the Kwacha Video Coach. Eliasi seldom had enough food to eat or clothes to wear. He spent nearly two years living on the bus. He was constantly in motion and constantly working. When he was taken in he was malnourished and afflicted by various parasites.*

*The boy's story, while unique, mirrors the experiences of other boys who have no one to care for them and take to the road. Some are searching for relatives to care for them. In Ilula, Iringa orphaned children often start hanging out in the local hotels looking for small jobs to earn food. Then one day, village leaders say, they just disappear. Most of the boys in the street children's centers are from diverse regions. They travel very far in search of a home. Hopefully, intervention strategies will prevent increases in street children but street children's centers need to be supported to help those children who fall through the cracks."*

*"Perhaps the work on the Kwacha Video Coach will be taken by Nasibu, if he is already not too old. Nasibu attends primary school in Iringa town. His mother died of AIDS in 1992 and his father died 4 months ago. Nasibu lives in the house his parents died in with his 15-year-old sister and two younger brothers. He has no money, no food in the house, and no plans for the future. No relatives have come to take them in. He comes to school because the teachers have so far been ignoring the fact that he cannot pay his fees. Mr.Njuyuwi has agreed to look in on Nasibu to try to keep him from life on the streets."*

*Orphans of AIDS*

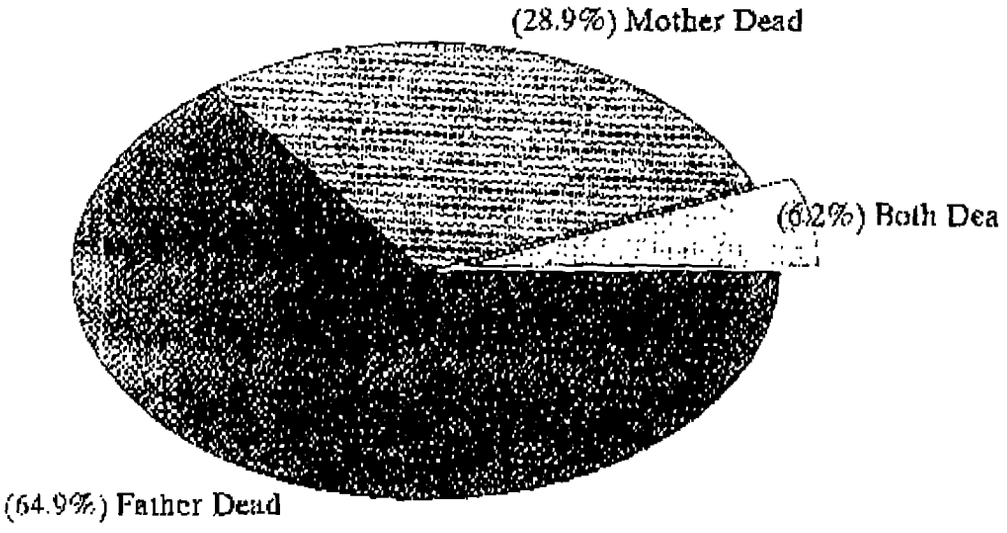
*"In all three regions specific examples were collected of children abandoned and neglected. In Dodoma relatives have taken children in, squandered their inheritance and kicked the children out of the house to fend for themselves. In Kilombero, Morogoro a young girl is left alone to care for her younger siblings. The only way she can earn any money is through cooking pombe, the occupation which her mother, now dead of AIDS, had formerly engaged in. The village leadership fear that this girl will suffer the same fate as her mother.*

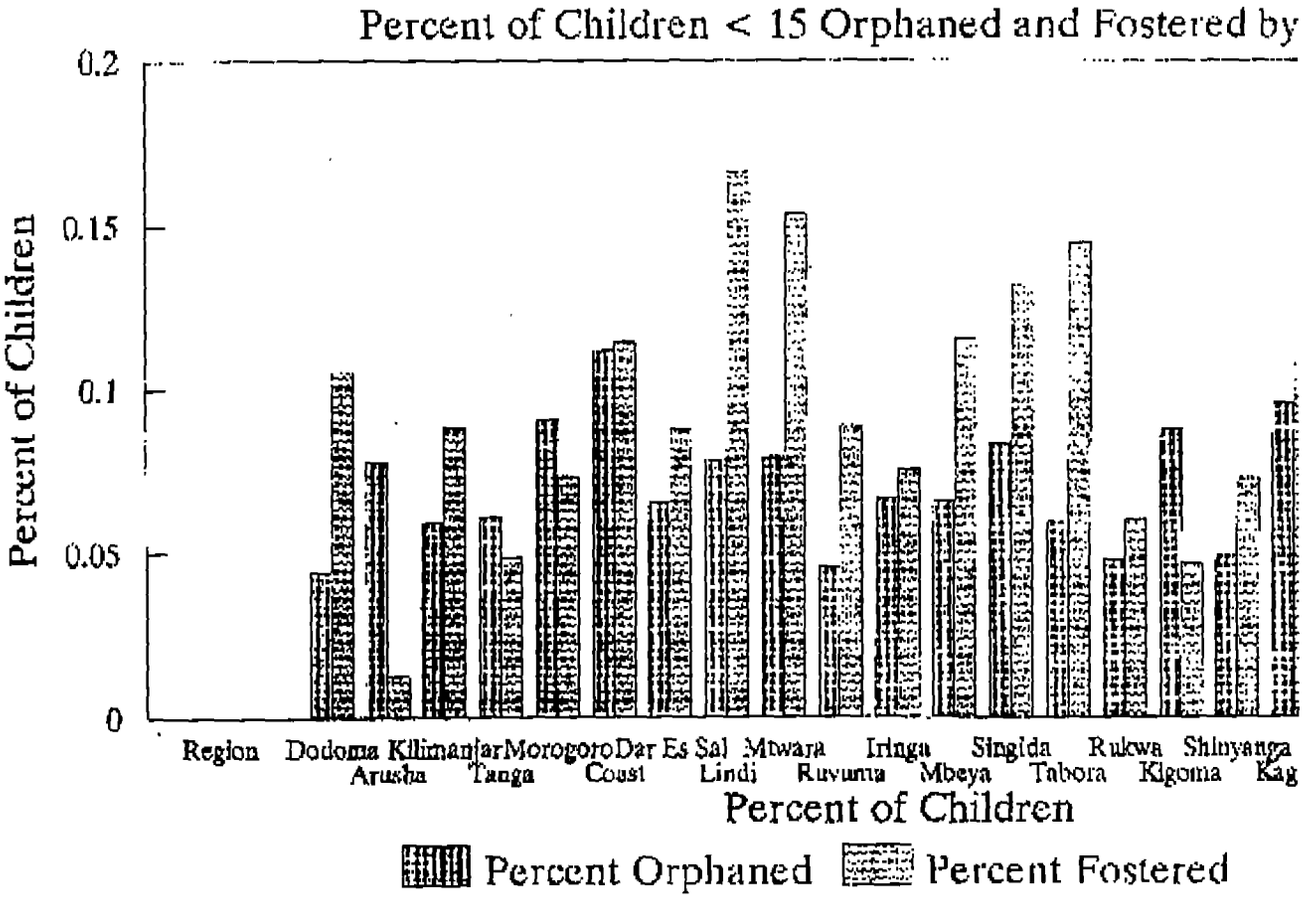
*"Near Iringa town a 13-year-old boy, his 15-year-old sister and their two younger siblings have been living alone since the death of their father in February. Their mother had died two years previously. Their father's last wish to his son was that the children should stay together and not quarrel with each other. He left them no money and no food. No relatives have come to care for them although they know of the father's death. An elderly neighbor, a woman, gives them some food when she can. Some days they don't eat. The 15-year-old sister has begun to disappear for periods of time; when her brother asks her where she has been she shouts at him. Communities need to assert moral pressure to assist these children."*

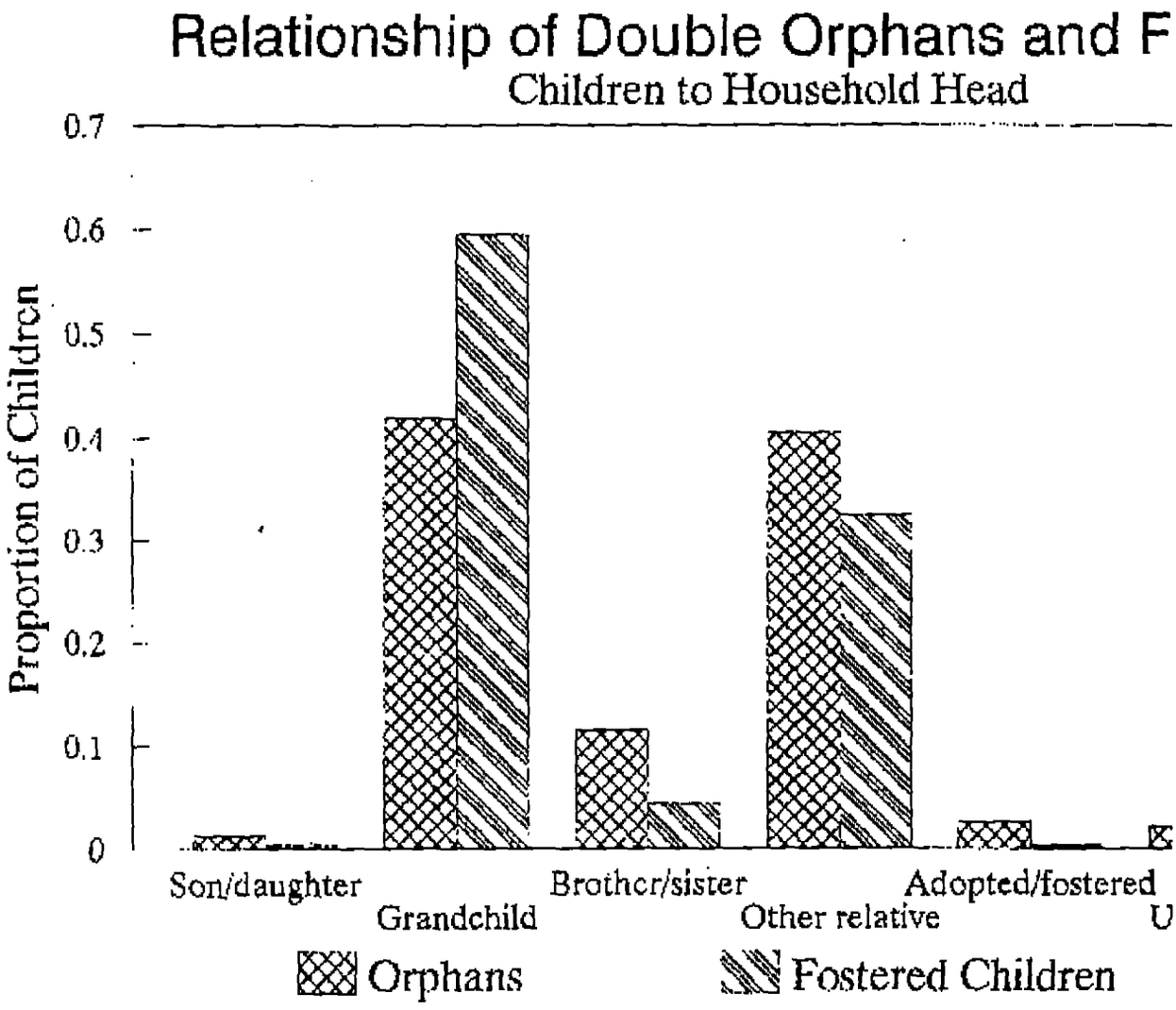
*Orphans of AIDS*

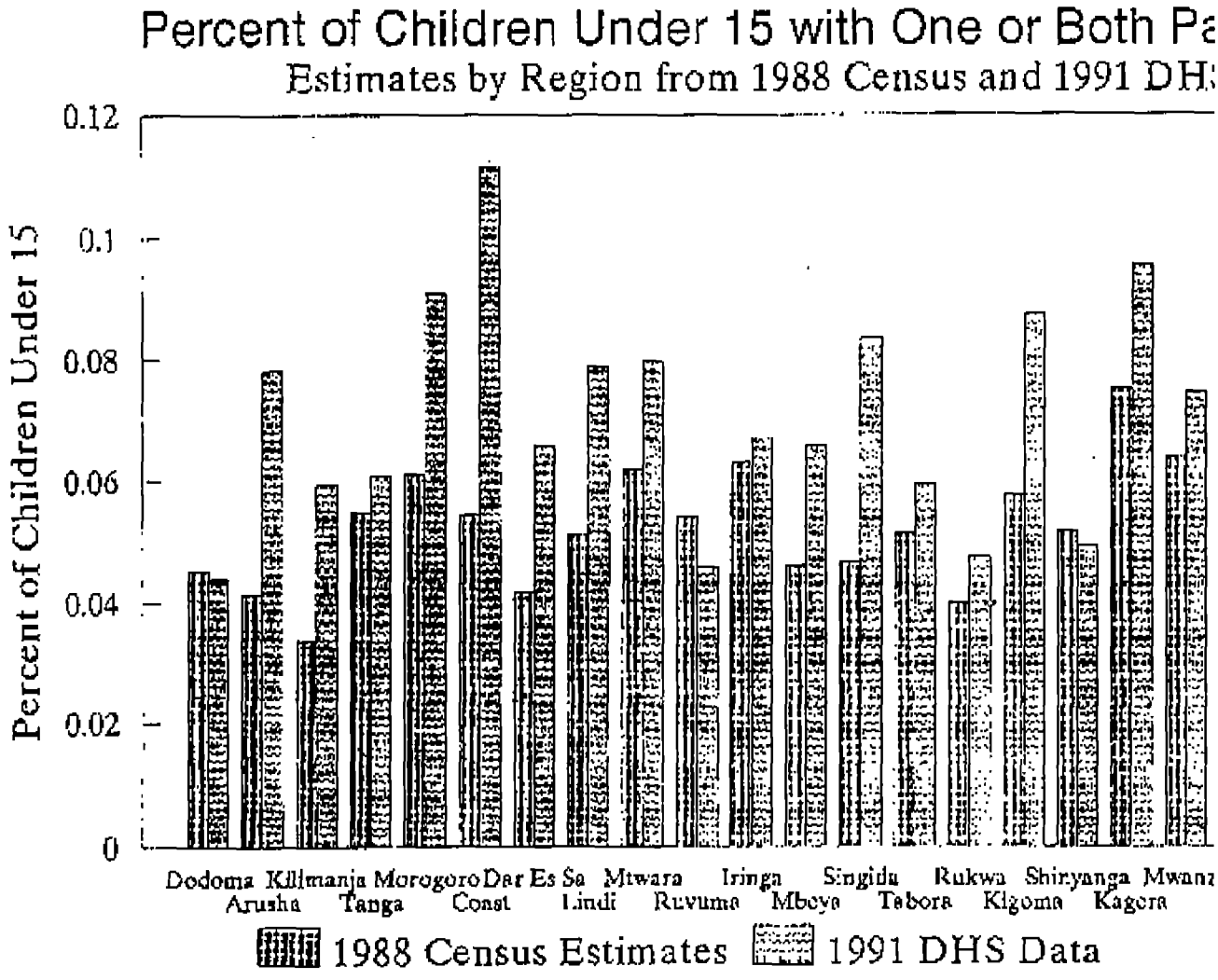
*"Those orphans who have lost both parents have great difficulty. An example is given of a boy who had good attendance and was doing well in school. First his mother got sick for a long time and then died. Then his father got sick. During the time his father was sick the boys material condition declined. He continued to wear the same worn out uniform, he was dirty, couldn't pay his school fees and was hungry. His behavior also changed. He was unhappy, lonely, and ashamed. He and his three brothers were taken in by his sister who finished primary school on 1988. She has three children of her own and her husband is making very little money doing petty business. His attendance became erratic. Schoolchildren often know when a classmate's parents have died of AIDS and they will tease them. Teachers notice many emotional changes in orphans who have often seen their parents die of AIDS. Many seem confused, some act as if retarded."*

Percent of Proportion of Maternal, Paternal and Double Orphans



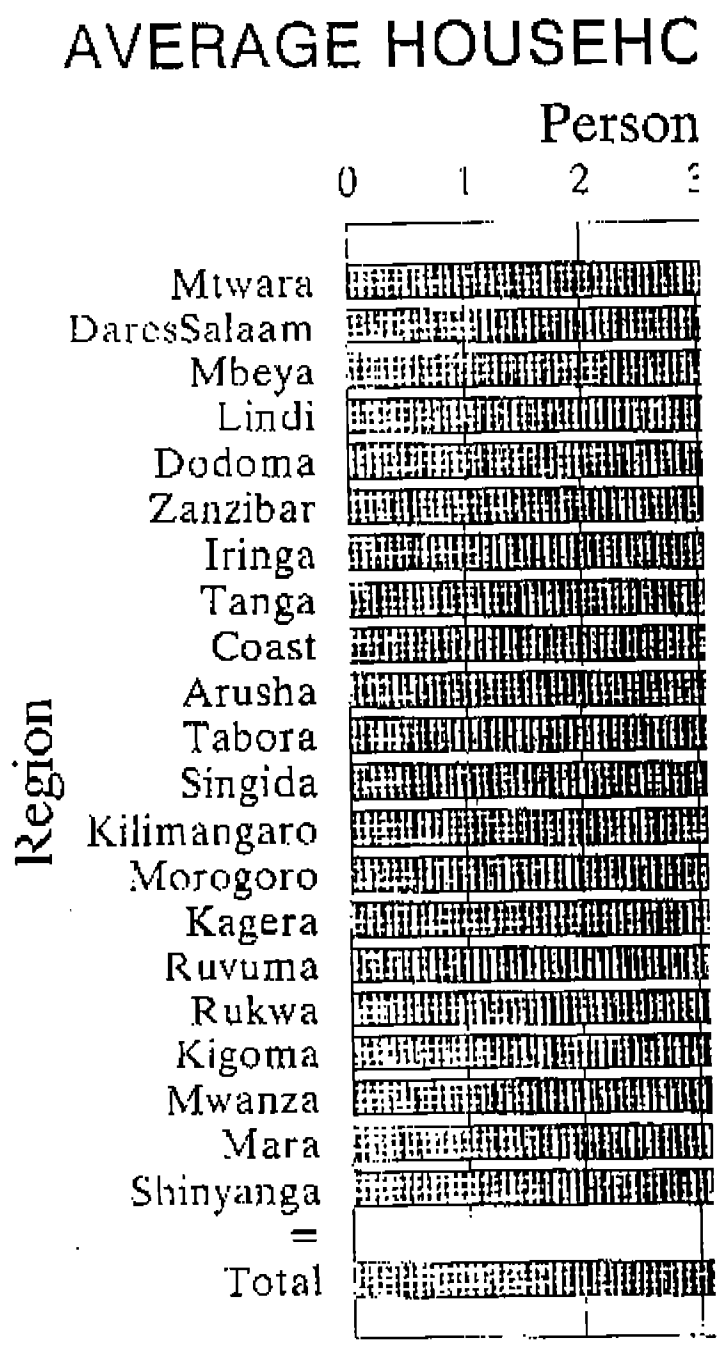

Percent of Children < 15 Orphaned and Fostered by
Percent of Children
0.2
0.15
0.1
0.05
0
Region
Dodoma
Kilimanjar
Arusha
Morogoro
Tanga
Dar Es Sal
Coast
Lindi
Mtwara
Ruvuma
Iringa
Mbeya
Singida
Tabora
Rukwa
Kigoma
Shinyanga
Kag
Percent of Children
Percent Orphaned
Percent Fostered


Relationship of Double Orphans and F
Children to Household Head
Proportion of Children
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Son/daughter
Grandchild
Brother/sister
Other relative
Adopted/fostered
U
Orphans
Fostered Children


Percent of Children Under 15 with One or Both Pa
Estimates by Region from 1988 Census and 1991 DH
Percent of Children Under 15
0.12
0.1
0.08
0.06
0.04
0.02
0
Dodoma
Arusha
Kilimanja
Tanga
Morogoro
Const
Dar Es Sa
Lindi
Mtwara
Ruvuma
Iringa
Mbeya
Singida
Tabora
Rukwa
Kigoma
Shinyanga
Kagera
Mwanz
1988 Census Estimates
1991 DHS Data

Household Size by Region

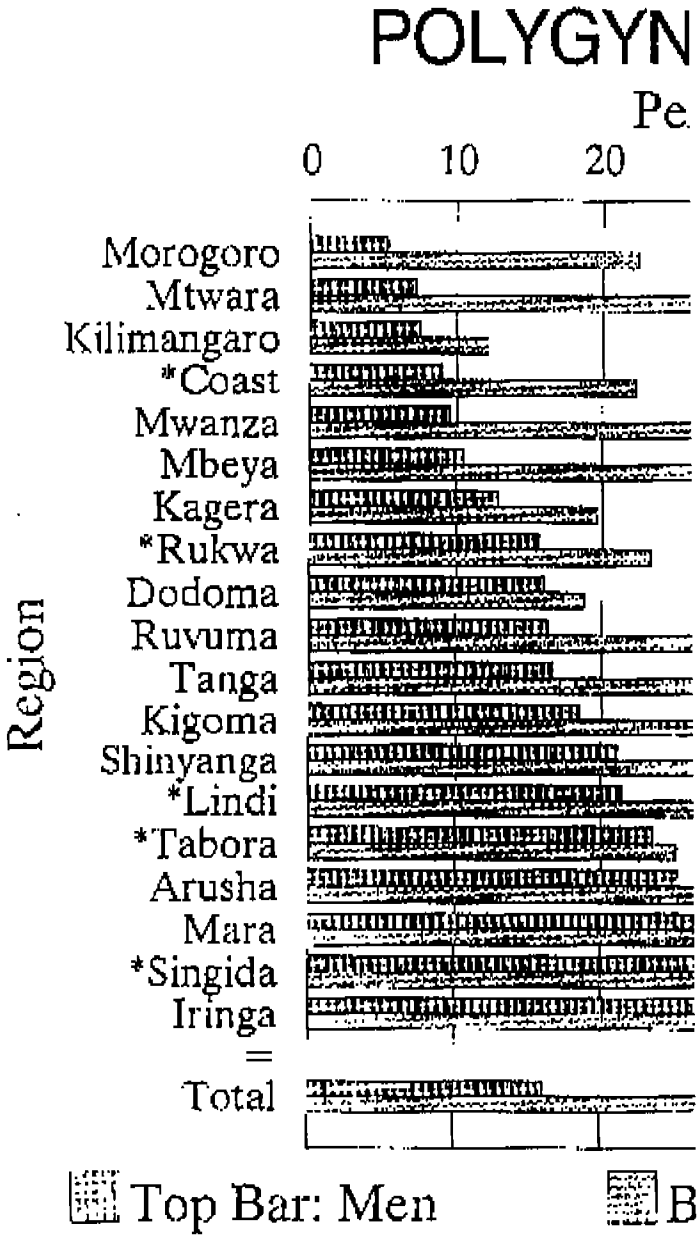
| Region | Mean Household Size |
|---|---|
| Mtwara | 4.0 |
| DaresSalaam | 4.4 |
| Mbeya | 4.5 |
| Lindi | 4.7 |
| Dodoma | 4.7 |
| Zanzibar | 4.8 |
| Iringa | 4.8 |
| Tanga | 4.9 |
| Coast | 4.9 |
| Arusha | 5.2 |
| Tabora | 5.2 |
| Singida | 5.3 |
| Kilimangaro | 5.4 |
| Morogoro | 5.4 |
| Kagera | 5.6 |
| Ruvuma | 5.6 |
| Rukwa | 6.0 |
| Kigoma | 6.2 |
| Mwanza | 6.6 |
| Mara | 6.7 |
| Shinyanga | 7.1 |
| Total | 5.3 |



PROPORTION OF POPULATION IN POLYGYNOUS UNIONS

| Region | % Men In Polygynous Union | % Women In Polygynous Union |
|---|---|---|
| Morogoro | 5.3 | 22.5 |
| Mtwara | 7.2 | 26.5 |
| Kilimangaro | 7.5 | 12.2 |
| *Coast | 9.0 | 22.3 |
| Mwanza | 9.6 | 31.2 |
| Mbeya | 10.6 | 26.6 |
| Kagera | 12.9 | 19.7 |
| *Rukwa | 15.7 | 23.3 |
| Dodoma | 16.1 | 16.8 |
| Ruvuma | 16.3 | 29.8 |
| Tanga | 16.7 | 28.5 |
| Kigoma | 18.5 | 30.2 |
| Shinyanga | 21.1 | 36.0 |
| *Lindi | 21.4 | 33.1 |
| *Tabora | 23.5 | 26.2 |
| Arusha | 25.8 | 31.1 |
| Mara | 29.3 | 48.9 |
| *Singida | 32.7 | 28.2 |
| Iringa | 32.3 | 34.6 |
| Total | 19.1 | 27.5 |

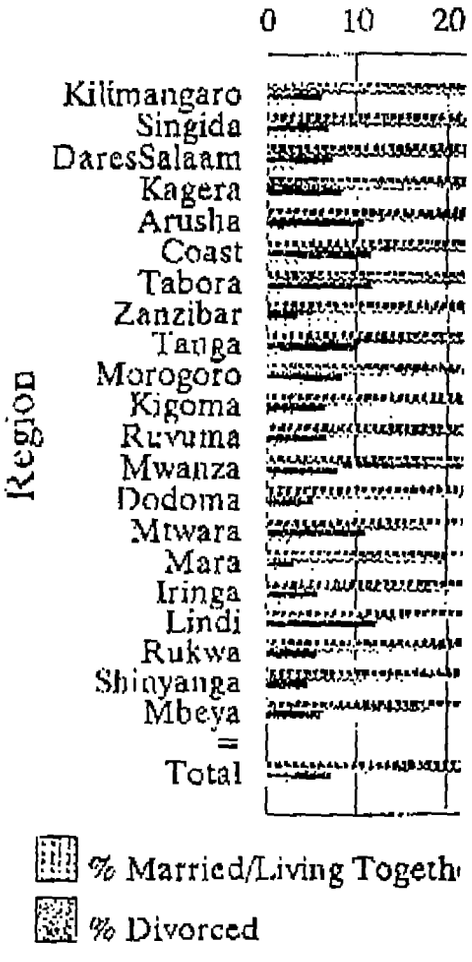
*Figures are taken from small populations of men, from groups ranging from 25 to 49.



# MARITAL

MARITAL STATUS OF WOMEN AGED 15–49 BY REGION

| Region | Married/Living Together | Never Married | Divorced | Widowed |
|---|---|---|---|---|
| Kilimangaro | 50.0 | 41.0 | 6.1 | 2.9 |
| Singida | 53.6 | 36.7 | 6.9 | 4.8 |
| DaresSalaam | 59.7 | 30.2 | 7.2 | 2.9 |
| Kagera | 61.0 | 27.2 | 8.4 | 3.4 |
| Arusha | 61.1 | 25.9 | 10.7 | 2.4 |
| Coast | 61.7 | 23.2 | 11.6 | 3.6 |
| Tabora | 64.2 | 22.7 | 11.7 | 1.3 |
| Zanzibar | 64.6 | 23.4 | 3.4 | 8.6 |
| Tanga | 66.1 | 23.2 | 10.2 | 1.6 |
| Morogoro | 65.3 | 22.2 | 8.4 | 4.1 |
| Kigoma | 65.3 | 24.8 | 6.6 | 3.8 |
| Ruvuma | 65.7 | 26.1 | 6.7 | 1.6 |
| Mwanza | 68.7 | 23.6 | 7.0 | 1.8 |
| Dodoma | 68.5 | 23.3 | 5.2 | 3.0 |
| Mtwara | 68.7 | 17.7 | 11.0 | 2.6 |
| Mara | 70.5 | 20.1 | 6.1 | 6.2 |
| Iringa | 71.1 | 20.1 | 5.7 | 2.9 |
| Lindi | 71.3 | 16.2 | 10.8 | 1.3 |
| Rukwa | 72.7 | 21.0 | 5.6 | 0.7 |
| Shinyanga | 72.8 | 21.2 | 4.0 | 1.3 |
| Mbeya | 74.1 | 18.0 | 5.0 | 1.9 |
| Total | 65.4 | 24.5 | 7.3 | 2.8 |



# FEMALE HE

PROPORTION OF HOUSEHOLDS WHICH ARE FEMALE HEADED

| Region | Female Headship |
|---|---|
| Rukwa | 11.5 |
| Shinyanga | 13.0 |
| Mwanza | 13.2 |
| Ruvuma | 13.7 |
| Mbeya | 14.0 |
| Kigoma | 14.1 |
| Kagera | 14.1 |
| DaresSalaam | 17.0 |
| Tabora | 17.4 |
| Arusha | 17.5 |
| Coast | 18.2 |
| Morogoro | 18.7 |
| Kilimangaro | 19.0 |
| Mtwara | 19.0 |
| Tanga | 21.5 |
| Zanzibar | 22.4 |
| Lindi | 23.4 |
| Dodoma | 23.9 |
| Mara | 24.5 |
| Singida | 25.6 |
| Iringa | 27.1 |
| Total | 16.5 |