HIV/AIDS and child labour in the United Republic of Tanzania: A rapid assessment

A case study of Dar es Salaam and Arusha

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Preface

The HIV/AIDS pandemic adds a new and tragic dimension to the worst forms of child labour. With the death of one or both parents from HIV/AIDS, millions of children have been orphaned. Millions more will be. Many orphans find security in the households of relatives. The demands of survival require others, however, to drop out of school and look for work. An especially harsh burden is placed on the shoulders of the girl child, who often has to provide care and household services for the entire family. Even children cared for by grandparents or other relatives may have to work to assist guardians and siblings.

A range of initiatives are addressing the issue, from broad national policies and strategic frameworks regarding HIV/AIDS and child labour to small local efforts by committed individuals and groups. All these interventions are contributing to an effective long-term response. The United Republic of Tanzania's responses, however, are so far strongest at local levels. Effective national policy and programme guidance is only beginning to emerge.

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Executive summary

Introduction

Little effort has been made to correlate rises in child labour and HIV/AIDS in developing countries. [1] The existing literature leaves unclear the impact of the HIV/AIDS pandemic on population structure and socio-economic development in the United Republic of Tanzania, particularly in its effects on the labour market and child labour.

This rapid assessment suggests that HIV/AIDS is among the major causes of child labour in the United Republic of Tanzania and other developing countries. The study aims to assess the impact of HIV/AIDS on orphanhood and, in turn, the effects of growing numbers of orphans on child labour in the country. It also proposes intervention strategies aimed at dealing with both HIV/AIDS and child labour.

More specifically, the study aims to:

- examine those systems already in place to address the issues of children affected by and living with HIV/AIDS, including orphans, school dropouts and child workers;
- determine the proportion of HIV/AIDS orphans who have to drop out of school to work;
- investigate the links between child labour and HIV/AIDS, and their relation to the labour market, the social fabric and the school system;
- explore gender dimensions of the HIV/AIDS and child labour crisis, including community reactions and the way they affect the target groups and relate to labour;
- investigate community reactions to children affected by and living with HIV/AIDS, including the way they affect the target groups and how they relate to labour; and
- propose the best way forward within the context of government policy regarding HIV/AIDS-related orphans and school dropouts, and children living with HIV/AIDS and child labour.

Methodology

Data collection involved two main methods: questionnaires and focus group discussions (FGDs) with three types of respondents totalling 191 working children. The study selected four categories of child labour as representative of other forms of child labour prevalent in the country: domestic service; self-employment; children in prostitution; and quarrying. The second type of respondents involved about 40 parents or guardians. The third type comprised about 40 key informants, including local government officials, religious leaders, taxi drivers and employers.

[1] Rapid assessments by UNICEF and the ILO, as well as qualitative studies from the World Bank, have been conducted on the topic or closely related areas recently and may shed light on this new area of study.

Main findings

Orphaned children and child labour

The study revealed that more than 60 per cent of children working in the informal sector were either single or double orphans. Most of the parents, it is believed, died from HIV/AIDS-related complications. Hence, orphaned children are compelled to enter the labour market to meet economic demands on themselves and/or other family members.

Family structure and responsibilities

About 60 per cent of the parents/guardians said they were taking care of at least one orphan. The major reason for supporting such children, reportedly, was the death of their parent(s). Again, most of these deaths were HIV/AIDS related. The majority of the families were too poor to support the extra children, whose needs included schooling. Themselves working in the informal sector, they brought children, especially orphans, into income-generating activities to supplement family income/labour. In so doing, children became accustomed to working and many went on to seek alternative independent employment elsewhere, outside family boundaries. In this way, children were often exposed to the worst forms of employment and to HIV/AIDS infection.

Gender structure of child labour

In the United Republic of Tanzania, it appears, girls are more vulnerable than boys to hazardous child labour and to HIV/AIDS infection.

Most of the girl children respondents were engaged in domestic work or prostitution. Self-employed activities among girls included work in hairdressing salons, kiosks, shops, food vending and quarrying, where they crushed stones and carried pebbles and clay. The majority of children working in quarries or engaged in other forms of self-employment were boys. Girl children also had to shoulder heavy household chores, however, and were thus most vulnerable to dropping out of school to take care of the family whenever the parent(s) fell sick or died. Working environments tended to be most dangerous for girl children, since they often became exposed to forced sex by employers or commercial sex and, eventually, to HIV/AIDS infection.

Education

About 67 per cent of single or double orphans had never attended school; about 61 per cent had dropped out of school. The majority of those dropouts said that they left school before engaging in child labour. Lack of money to meet educational costs was reported as the major reason. Other reasons given included earning money to help support their families. The death of one or both parents due to HIV/AIDS and other causes also contributed much to the school dropout rate. Many children expressed interest in returning to school if the costs of education could be secured.

This report suggests that orphans are most vulnerable in terms of lacking educational opportunities in the first place and, when enrolled, they are most likely to drop out and begin work.

Nature of jobs

The children lacked clear contracts stipulating the relevant terms and conditions of employment. As a result, they typically worked longer than eight hours per day. At the

same time, they received little payment or they were provided only with meals and accommodation plus other basic human needs, such as clothes and medicine when they became ill. In many instances, their employers or customers refused to pay them as (orally) agreed. Some were forced into sexual relationships with their employers or other members of the family. Typical working environments exposed children to health hazards and problems related to physical growth and social-psychological health, diminishing their development as responsible citizens.

HIV/AIDS awareness

Over 90 per cent of the respondents indicated awareness of HIV/AIDS. They reported mass media, friends and workplace sources as the main channels of information.

Abstinence from sex, it was widely reported, was the safest means of preventing HIV/AIDS infection. Condom use was recognized as another measure by the majority of respondents. Girl children in prostitution, however, often found themselves required to bow to customer demands and most customers, it was claimed, resisted using condoms even if asked to use them.

A substantial proportion of the respondents (30 per cent) maintained a belief in supernatural power as one means of HIV/AIDS transmission. Others considered mosquitoes to be a possible channel. This suggests that more community mobilization is needed to ensure people are fully aware of the actual modes of transmission and of the consequences of HIV/AIDS for infected individuals and the community at large.

Recommendations

In dealing with HIV/AIDS and child labour, this study recommends the following intervention strategies.

Orphanages and HIV/AIDS

- Both society and the Government need to develop clear plans to help and support those affected by the scourge – especially HIV/AIDS orphans and children living with the disease.

- Orphanages are overcrowded and facilities are generally inadequate. Existing facilities should be improved and the number of centres increased to provide access to education and skills training for as many orphans as possible.

- Community sensitization programmes should aim at freeing HIV/AIDS orphans and other people living with the scourge, especially children, from social discrimination or stigmatisation.

- Action-oriented social and economic programmes are needed to mobilize communities in working against the spread of HIV/AIDS and in coping with those already infected or those, such as HIV/AIDS orphans, otherwise affected.

- Religious organizations and other social groups need to become more engaged in community mobilization campaigns.

- A national campaign should be mounted to educate communities about the effects of HIV/AIDS, not only on individuals but on society at large.

Child labour and its effects

- Practicable laws against child labour need to be enacted and enforced.
- People need to be educated regarding the social, economic, political and legal aspects of the issues, enabling them to support measures against child labour more effectively.
- Free basic education should be made available at all levels to children who cannot afford to meet the costs.
- The Government and NGOs should increase the number and quality of support centres for orphans, in this way also helping to reduce the extent of child labour.
- Training programmes should be designed for HIV/AIDS orphans and children who have completed basic education before the age of 18 years.

Abbreviations

CBO	Community-based organization
COBET	Complementary Basic Education (Programme) in the United Republic of Tanzania
CSW	Commercial sex workers
ESARC	Eastern and Southern African Regional Consultation on the Commercial Exploitation of Children
FGD	Focus group discussion
GDP	Gross domestic product
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
ILO	International Labour Organization
IPEC	International Programme on the Elimination of Child Labour
KIWOHEDE	Kiota Women's Health and Development Organization
MoLYD	Ministry of Labour and Youth Development
MTP	Medium-term plans
MUTAN	Mradi wa UKIMWI Tanzania na Norway (Tanzania and Norway HIV/AIDS Project)
NACP	National AIDS Control Programme
NGO	Non-governmental organization
SIMPOC	Statistical Information and Monitoring Programme on Child Labour
SPSS	Statistical package for the social sciences
STDs	Sexually transmitted diseases
TACAIDS	Tanzania Commission for AIDS
TAP	Tanzania AIDS Project
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
WFCL	Worst forms of child labour

1. Introduction

This rapid assessment establishes links between HIV/AIDS orphanhood and child labour, often in its worst forms.

In the past two decades, the HIV/AIDS pandemic has presented an enormous challenge, especially in sub-Saharan Africa. The pandemic poses more than threats to health, however. It also undermines the integrity of households and communities, lowers life expectancy and generally weakens the human capital required for effective socio-economic development (Baylies, 2000). The current study – applying the same International Labour Organization (ILO) rapid assessment methodology used in parallel fieldwork in South Africa, Zambia and Zimbabwe – suggests that HIV/AIDS is among the major causes of child labour in developing countries, including the United Republic of Tanzania.

Little previous effort has been made to link HIV/AIDS and the increasing phenomenon of child labour in developing countries. Rapid assessments by UNICEF and the ILO, as well as qualitative studies from the World Bank, have recently investigated this or closely related areas. But, the literature leaves the impact of the HIV/AIDS pandemic on the national population structure and socio-economic development unclear, particularly its effects on the labour market and child labour.

By the end of 2001, an estimated 40 million people worldwide were HIV infected, 37 million of which were adults and 3 million were children under 15 years of age. Of these, 28.1 million HIV/AIDS victims were from sub-Saharan Africa, with this region suffering 20 million of the estimated 24.8 million HIV/AIDS-related deaths around the world (UNAIDS, 2002). Sub-Saharan Africa also had 11 million of the estimated 14 million HIV/AIDS orphans in the world.

In 1990, the United Republic of Tanzania reported a total of 16,250 HIV/AIDS cases to the National AIDS Control Programme (Rwegoshora et al., 1997). Current official figures indicate a total of 130,386 HIV/AIDS cases in an estimated total population of 31,899,749 (NACP, 2000). Yet this might well be an underestimate, given inadequate diagnostic and reporting systems. The latest official figures show a rapid increase in HIV infection among the young and energetic productive labour force. Hence, the HIV/AIDS pandemic, coupled with growing economic hardship and rising unemployment, is shaping the nature and extent of child labour (Kamuzora et al., 1998; ILO, 2001).

Child labour continues to pose serious problems in many developing countries. Of the estimated 352 million children engaged in economic activity, an estimated 330 million children work in developing countries, with sub-Saharan Africa leading in terms of regional distribution incidence. Regionally, out of an estimated 48 million children between the ages of 5 and 14 years, almost one child in three, or 29 per cent, are economically active (IPEC/SIMPOC, 2002:16). Child labour in other regions is less than 20 per cent. Asia and the Pacific have 19 per cent out of 127.3 million children at work; Latin America and Caribbean have an estimated 16 per cent of 17.4 million children; and the Middle East and North Africa have 15 per cent of 13.4 million. Transitional and developed economies estimate work ratios of four and two, respectively, from child populations of 2,400,000 and 2,500,000. Estimates in 1996 indicated that about 250 million children between the ages of 5 and 14 years were working in developing countries (ILO, 1996).

Various factors have been advanced to account for child labour worldwide. In developing countries, the most important causes include, inter alia, high population growth

and deteriorating living conditions due to economic crisis and widespread poverty (Rwegoshora et al., 1997). Other factors are: poor social and economic policies and programmes which assume that the problem may be resolved merely by enacting minimum wage legislation; parental attitudes that view child labour as a necessary part of socialization; and public indifference to the issues of child labour (ILO, 1996).

The study at hand thus seeks to examine the impact of HIV/AIDS on child labour in the United Republic of Tanzania and to suggest intervention strategies, including:

- examining systems already in place to address the issues of children affected by and living with HIV/AIDS, including HIV/AIDS orphans, school dropouts and child workers;
- determining the proportion of HIV/AIDS orphans who have to drop out of school to work;
- investigating the links between child labour and HIV/AIDS and their relation to the labour market, the social fabric and the school system;
- exploring the gender dimensions of HIV/AIDS and the child labour crisis;
- investigating community reactions to children affected by and living with HIV/AIDS, including the way these affect the target groups and how they relate to labour dynamics; and
- proposing the best way forward within the context of government policy regarding HIV/AIDS-related orphans and school dropouts, children living with HIV/AIDS and child labour.

Methodology

Gaining insights into child labour issues – especially in the informal sector in a developing country – requires special skills applied within an appropriate analytic and conceptual framework. If working children are to be forthcoming and truthful in discussing their lives, researchers must first gain their confidence – a challenging task.

Both qualitative and quantitative data and information were collected for analysis. A qualitative approach was employed to assess the perspectives and feelings of the respondents, while an equally important quantitative component provided statistical data regarding the actual number and characteristics of children involved in various informal sector activities. The qualitative and quantitative information have supplemented and complemented one another, enriching the analytical basis and optimizing the study's prescriptive power.

This study applied the rapid assessment methodology, [1] which deploys several data collection methods and strategies. Rapid assessments are quick, low cost, participatory, responsive and effective in seeking qualitative data, in this case about HIV/AIDS orphans and children living with AIDS or suffering a high risk of contracting AIDS.

[1] *Investigating child labour: Guidelines for rapid assessment – A field manual*, draft, Jan. 2000; www.ilo.org/public/english/standards/ipec/simpoc/guides/index.htm .

Site selection

Criteria for the choice of a number of districts and localities within Dar es Salaam and Arusha regions for sampling included:

- sizeable influx of child migrants;
- finding an appropriate balance of urban and rural localities; and
- many children engaged in informal sector and petty business activities, such as food vending, selling of second-hand clothes and street hawking.

Sampling

This study was conducted in both urban and rural areas within Dar es Salaam and Arusha regions. These regions include expanding urban areas, their populations increasing either through normal growth or rural-urban migration. Both densely populated urban centres host a number of formal and informal economic activities. Furthermore, both are places where children engage in informal sector activities such as prostitution and petty business activities (e.g. food vending, selling second-hand clothes and hawking other wares).

In each of these areas, key locations were identified with the assistance of leaders at the district, ward and street levels on the following bases:

- the type or group of children to be studied – i.e. HIV/AIDS orphans, children living with HIV/AIDS and those who had dropped out of school for HIV/AIDS-related reasons; and
- the types of activities in which the members of the aforementioned target groups were engaged.

The sampling frame consisted of:

- HIV/AIDS orphans;
- children living with AIDS and/or those at high risk of infection due to the nature of their work;
- children affected by HIV/AIDS who had consequently dropped out of school to work; and
- a sample of parents/guardians who were either taking care of an orphan or had social and leadership status in the locality.

A probability sample was drawn from this population using population lists from local government offices or other authorized and reliable institutions in both urban centres.[2] Simple random sampling was applied, whereby a single number was assigned to each household/individual in the list, from which random numbers were then used to select elements in the sample. The sample in each urban centre included 70 people: 50 children, ten parents/guardians and ten local leaders/informants. Several other informants, including

[2] Local government leaders usually have a list of all household heads in their respective areas.

teachers, taxi drivers and nurses working with HIV/AIDS groups in the area, also participated in informal discussions.

Data collection

Various methods were used in collecting pertinent information regarding both target groups of working children in the informal sector and current efforts addressing child labour and its elimination. The study also reviewed relevant literature concerning aspects of child labour in the United Republic of Tanzania. The instruments and "portfolios" used in data collection included:

- An ILO-prepared questionnaire was adapted and translated into Kiswahili, the local language. The questionnaire had two parts: one targeted children (Appendix 1) and the other targeted parents or guardians (Appendix 2).

- Key informants were interviewed using a semi-structured questionnaire (Appendix 3). These informants were identified by virtue of their positions or occupations and their knowledge and understanding of the target groups. Key informants included local government officials, teachers, taxi drivers, religious leaders and employers.

- Focus group discussions were conducted with children belonging to the three target groups. Further in-depth study targeted cases of special interest, enhancing understanding of the issues raised in the focus group discussions.

- The study also applied source and social mapping. This powerful tool provides a visual representation of the localities depicting resources such as land and water sources, recreation areas and socio-economic infrastructure including roads, schools, dispensaries and clinics. Groups from the targeted children, with the guidance of the facilitators, were involved in the mapping of existing resources within their localities. Along with resource mapping, social mapping was used to show the arrangement and composition of households within different localities visited. The social maps were extremely useful in providing clues regarding social stratification, inequalities, social problems and coping strategies in the respective localities. Through social mapping, the researchers were able to locate areas with significant incidences of child labour.

- Researchers also directly observed most of the children in actual working situations – together with associated tools, hazards and abuses – gathering relevant information even before interviewing started.

Data analysis

As mentioned above, the information assembled in this study is both qualitative and quantitative in nature. SPSS PC+ (statistical package for the social sciences) was used for both data entry and subsequent analysis.

The next section provides a brief review of the relevant literature on HIV/AIDS and child labour.

2. Conceptual framework and review of the literature

Conceptual framework

Definitions

Increasingly, HIV/AIDS is impeding socio-economic development, particularly in the labour market. Indeed, HIV/AIDS threatens a devastating impact on the economic and demographic underpinnings of development:

- weakening and killing adults in the prime of their lives as workers and parents;
- orphaning millions;
- changing the very structure of households;
- eroding productivity;
- decimating the workforce;
- depleting the national skills-and-knowledge base; and
- consuming savings (Rwegoshora et al., 1997).

HIV/AIDS, then, is more than a health issue. It also represents a problem of social and economic development. Of course it remains a serious health problem, reducing resistance to diseases among the HIV-infected and leading to long illness and eventual death. But this long illness does not merely deprive an HIV/AIDS affected person of productive engagement – it also saps the resources of the many other people who have to take care of HIV/AIDS victims, with potentially disastrous consequences for the economy and the society.

Young parents are those who tend to be most affected by HIV/AIDS mortality and morbidity. Consequently, the pandemic creates severe hardship among children where the household breadwinners die or are unable to work because of protracted illness. As Tanzanian President, Benjamin Mkapa, remarked during the launch of the Time Bound Programme:

> The death of breadwinners or the inability to work due to illness creates severe hardships for children. In the United Republic of Tanzania, we are approaching the 1 million mark in terms of HIV/AIDS orphans. No traditional extended family safety net can take care of such a huge burden and this increases the incidence of child labour – including its worst forms such as commercial sex (Mkapa, 2002:3).

Under these circumstances, children are worst affected. Children experience greater poverty as a result of the loss due to AIDS of adult household members who would otherwise be the breadwinners. These losses affect all children in a household and, where infection rates are high, entire communities. Without adequate care and support, children experience deteriorating health, nutrition, education, affection, security and protection. They suffer emotionally from rejection, discrimination, fear, loneliness and depression (ESARC, 1996).

"Children", in the context of the present report, refers to boys and girls under the age of 18 years. The Minimum Age Convention, 1973 (No. 138), ratified by the United Republic of Tanzania in 1998, requires that the Government sets a minimum age for admission to employment (Tanzania has specified a minimum age of 14 years). In 2001, the United Republic of Tanzania also ratified the Worst Forms of Child Labour Convention, 1999 (No. 182), which requires countries to prohibit a number of worst forms of child labour (WFCL) as well as admission to hazardous work for persons younger than 18 years.[1] Children under 18 years are legally prohibited from engagement in employment ventures.

The nature, underlying causes and consequences of child labour in the United Republic of Tanzania are similar to those in many developing countries. It also displays distinctive features, however, and the design of national policies and programmes must take these into account (Madihi, 2000).

As in most parts of Africa, most of the population lives in rural areas and is engaged in subsistence agriculture. In this context, children have recognized roles. Indeed, growing up is associated with the gradual acquisition of new skills and the specialization of tasks among boys and girls. Work is regarded as an important part of the process of socialization.

In the late 1970s, the United Republic of Tanzania had one of the highest levels of primary-school enrolment in sub-Saharan Africa. Given the economic problems of the 1980s, however, the educational infrastructure began to deteriorate and is now hard pressed to cope with a population under the age of 15 years that is 48.8 per cent of the total and expanding. With educational facilities under extreme strain, even more young children can be expected to drop out of school and enter the labour market during the next decade.

Recent, long overdue educational reforms by the Government recognize this emerging situation. Socio-economic development demands policies and programmes that offset the impact of child labour trends now. One priority for more focused programmes and projects is access to comprehensive statistical data regarding the impact of HIV/AIDS on child employment.

HIV/AIDS and the family

The pandemic is producing an increasing number of HIV/AIDS orphans and of children otherwise living with or affected by HIV/AIDS, including school dropouts. It is thus also continuing to force ever greater numbers of children to join the labour force.

The family lies at the heart of all economic and social processes. To understand the extent to which HIV/AIDS is a major cause of child labour in the United Republic of Tanzania, we must examine how this disease has affected families socially and economically.

In the African context, the family is still perceived as a social unit whose members share among themselves the socio-cultural and economic variables that make them a coherent body (Omari, 1994). As part of this, families serve as a social safety net against external threats. In times of disaster such as famine or war, it is the family members who provide security; in times of illness and death, it is the family that provides care and

[1] This relates to ILO Convention No. 138 on the minimum age of admission to employment, and as defined under section 2 of the Employment Ordinance, Cap 366, of the laws of Tanganyika, 1955 (ILO/IPEC, Tanzania, 2000).

support. In many developing countries today, even where governments, non-government organizations (NGOs), and interest groups provide some kind of support, it is ultimately the family that supplements it. In cases where families fail, community-based organizations (CBOs) and/or NGOs step in to complement the traditional recourses. Without family support, on the other hand, many of these organizations would not function, their spirit of voluntary service requiring the support of the family.

The onus of caring for orphans has traditionally fallen to aunts, uncles and other members of the extended family (Kanywanyi, 1997). Some orphanages and children's homes were set up by missionaries in the colonial period, but they were neither widely used nor generally perceived as relevant to African social needs (TAP, 1994). Until recently, African culture precluded the possibility that a needy child would not find parental substitutes within the kin network. This may partly explain the lack of data regarding orphan numbers in most African countries, including the United Republic of Tanzania.

The peasant economy was and remains, by and large, labour intensive. This in turn has meant that labour supply is a critical factor in economic activities. Since HIV/AIDS mortality is highest among those in the productive age group, family labour is reduced. Consequently, productivity in activities such as agriculture has declined, thereby increasing the level and rate of poverty in most rural areas. A family in which a parent is chronically ill with HIV/AIDS spends progressively less time in economic activities or engaged in other productive work. Hence, family food production falls and cash income dwindles. [2]

The increasing prevalence of HIV/AIDS has also reduced the rate of fertility in most villages. This in turn has aggravated labour shortages and increased rural poverty. Structural adjustment programmes have reduced access to medical care and other social services that would offset changes in family structure and function. This means that many families have to struggle to survive and cannot provide easily for additional children.

That, together with escalating economic problems in the country – including a decline in real wages needed for the provision of social services such as health and education – means that more and more children are forced to work outside the family and in environments that are hazardous and harmful to their health, development and very lives.

The needs of orphans include food, shelter, clothing, soap, access to education and health facilities. Recent adjustment policies, however, have removed subsidies on essential food staples and imposed budget cuts for health and education. This, in turn, has resulted in greater burdens on the poor. HIV/AIDS deaths are highest among those aged 20-45 years, with women typically dying younger than men (UNICEF, 1991).

As noted above, the role of women in families is very significant, and the death of a mother has far-reaching implications for the children left behind. The prevailing economic hardships, coupled with the increasing death rate among the young and productive labour force, leaves the orphans increasingly vulnerable to child labour in order to survive and, consequently, to dropping out of school. Even more serious is their vulnerability to the

[2] Interestingly, however, the concomitantly changing structure of the household and the increased responsibility women tend to have for their own or their families' well-being are not matched by the authority women have over property or their access to it. Women's economic conditions are generally poorer than those of men. They have little access to land ownership and their ability to protect their property, where they do own it, is tenuous. In some rural areas, reportedly, family farming plots have been sold to meet treatment costs for HIV/AIDS patients, thereby exacerbating poverty levels.

WFCL, including child prostitution (ILO, 2002[f]), which exposes them to HIV infection and the danger of becoming victims of HIV/AIDS just as their parents did.

When a parent is infected with HIV/AIDS and suffers prolonged ill health, children in the family are affected both emotionally and physically. Children are forced, out of necessity, to assume adult roles – becoming family breadwinners or care providers for ill or dying parents. Taking up adult responsibilities at very early ages can seriously jeopardize their health, safety, education, morals, dignity and self-respect.

HIV/AIDS orphans lack parental care and guidance. They are frequently forced by circumstances to drop out of school, moreover, which also denies them the guidance of teachers. This increases their vulnerability to malnutrition, illness, abuse, child labour and sexual exploitation (UNAIDS, 2002). Those who engage in prostitution find themselves unable to protect themselves against HIV and sexually transmitted diseases (STDs). Even where they are aware of the dangers and preventive measures, they lack the experience and skills to negotiate condom use with clients. As a result, they may end up not only infected with HIV or other STDs, but may also bear children who themselves risk HIV infection. This situation perpetuates the problem of HIV/AIDS orphans and threatens to further increase the incidence of child labour.

HIV/AIDS and the economy

HIV/AIDS has a negative impact on economic growth. This relationship was difficult to discern when infection rates were low but, as the pandemic advances, the economic impact grows. As long as the incidence of infection remains below 5 per cent, annual per capita economic growth is minimally affected. As the disease becomes more prevalent, however, per capita growth can be expected to decline. The fiscal cost of HIV/AIDS is also significant. Government expenditures to control HIV transmission, to cover increasing medical bills, drugs, training and recruitment of staff, and funeral expenses are enormous. In the 2001-02 fiscal year, the Government allocated 7.2 billion Tanzanian shillings (about $US8 million) to combating HIV/AIDS (TACAIDS, 2002). This, of course, entailed the diversion of scarce resources from other economic and social demands. (For more discussion, see below: Literature Review, Impact.)

Those aged 15-49 years are disproportionately affected by the HIV/AIDS pandemic and, through this and other impacts on the labour force, HIV/AIDS diminishes productivity. All sectors are affected. Investments in agriculture, for example, are reduced, thereby inhibiting agricultural production and productivity. Illness and care siphon time and labour away from other vital work. HIV/AIDS undermines private sector development by removing skilled labour, increasing expenditures and reducing revenues. Health-care systems in many countries are stretched beyond their limits as they deal with growing numbers of HIV/AIDS patients and the loss of health personnel to illness and death.

HIV/AIDS and education

HIV/AIDS overtaxes social systems and diminishes the health and educational development needed to combat poverty. In the educational sector, it has drained skilled human resources – which were limited to begin with – at every level. Teachers and students are dying or leaving school because they can no longer afford it, have fallen ill or because they are needed at home to work or care for the sick. Thus, the problem of caring for orphans is complicated by having to consider children who are forced to drop out of school either because their parents are dead or too ill to earn money for school fees and other amenities. These children are forced to enter the labour market, however reluctantly, to take care of themselves and their young siblings.

Young, inexperienced and unfamiliar with the ways of the mature world, the school dropouts are compelled to join the army of informal workers who engage in a wide variety of petty businesses. Some of these are hazardous activities including, in their worst forms, occupations such as child prostitution. The latter children are often subjected to sexual abuse and most are prone to early pregnancies – all of which contributes to severe and lasting psychological, social and physical damage, impairing the children's development into responsible adults.

HIV/AIDS and poverty

The 1991-92 Tanzania Household Budget Survey revealed that 27 per cent of the population lived in households where total income was insufficient to cover minimum nutritional requirements, while 48 per cent could not meet their food and non-food basic requirements. Recent estimates suggest that 50 per cent of households in mainland Tanzania live below the poverty line. As expected, poverty was more prevalent and more pronounced in rural areas, making rural development a key element in the war on poverty and child labour.

HIV/AIDS has far-reaching repercussions for the poor. Although people at all income levels are vulnerable to HIV/AIDS, the poor bear the brunt of the suffering. Given their limited economic means, costs of care for the sick and for funerals are crippling. The poor also have less access to basic health care. Overall, the pandemic has been found to exacerbate both income disparities and absolute poverty levels.

Among poor families, the probability that children will die from malnutrition or disease is much higher, and parents thus tend to produce more children as insurance. Poor parents also have less access to family planning services. The greater the number of children, some Tanzanians reason, the more income they can contribute to the household. Younger children from large families die more often, but those who survive are more likely to start work earlier and are less likely to attend school. This also puts them at risk of bearing children of their own at even younger ages which, to supplement low household incomes, they end up sending out to work rather than to school. And so the vicious circle of poverty perpetuates itself.

HIV/AIDS and gender

Women in general, and girls in particular, are biologically and socially more vulnerable to HIV/AIDS – they are disproportionately infected and affected by the pandemic. This jeopardizes any gains in health, nutrition and education for girls that may have been achieved.

At the family level, the girl child is more vulnerable to child labour than the boy. Traditionally, girls are supposed to help their mothers with household work, denying the girl child enough time for recreation and schoolwork. In severely adverse conditions, as when the parents cannot afford to pay school fees, the girl child is normally the first to be denied access to family school funds. In situations where parents become incapacitated, the girl child assumes the responsibility of taking care of the sick parent(s) and her siblings. In this case, the children become breadwinners themselves, coping with the economic burden of handling the family and thus falling prey to the WFCL such as sexual exploitation, mining and quarrying. Exploitative work situations, moreover, often leave them vulnerable to HIV/AIDS. To compound the problem, a common myth in sub-Saharan Africa suggests that young girls pose less danger of infection from HIV/AIDS, thereby increasing demand for their sexual services.

All these factors contribute to the creation of a group of children especially vulnerable to being affected by or living with HIV/AIDS.

Literature review

HIV/AIDS in the United Republic of Tanzania

The first cases of HIV/AIDS in the United Republic of Tanzania were reported in 1983.[3] The pandemic has since evolved from a rare disease to a common household problem, one which now affects most Tanzanian families.[4] The progression of the HIV/AIDS pandemic has had a clear impact on all development sectors, not only through pressure on HIV/AIDS case management and resources, but also through debilitation and depletion of the economically active population, especially young women and men.

Situation analysis. The HIV/AIDS pandemic, since the first three AIDS cases in the United Republic of Tanzania were reported in 1983, has progressed differently in various population groups. Early in the pandemic, urban populations and communities located along highways were most affected. A situation analysis of HIV/AIDS was conducted in 1997 and showed the situation worsening, with the pandemic spreading rapidly into rural areas. What had been a low rural incidence increased in some areas to more than 10 per cent. As more and more infected women became pregnant, mother-to-child transmission also appeared to be on the increase.

In the calendar year 2000, from the 20 regions of mainland Tanzania, a total of 11,673 HIV/AIDS new cases were reported to the National AIDS Control Programme (NACP). This indicated that the number of cases had risen, in total, from three in 1983 to 130,386 in 2000 (NACP, 2000).

Simulation models estimate, however, that only one in five AIDS cases are reported. The NACP therefore estimates that 44,250 cases appeared in 1999 and 600,000 cumulative AIDS cases have arisen between 1983 and 1999.[5] Distribution of HIV/AIDS cases by age and sex during the period January to December 2000 indicates that most cases, for both sexes, fall within the group aged 20-49 years. This report and a previous one indicated that the peak age for female infection was 25-29 years, while that for males was 30-34 years.

Generally, females were infected with HIV at an earlier age than were males,[6] assuming a similar incubation period for both sexes. Specific case rates in 1999 indicate that males have a higher case rate (28.2 per 100,000 population) compared to females (26.5 per 100,000 population). The 2000 NACP report confirmed this trend.

Reaction. Over the past 18 years, the United Republic of Tanzania has applied different approaches to controlling the spread of HIV infection and minimizing its impact on individuals, families and society in general. Since the first HIV/AIDS cases were reported in this country, the National AIDS Control Programme, Ministry of Health, has

[3] For sub-Saharan Africa as a whole, the problem began to surface in the late 1970s.

[4] See www.tanzania.go.tz/healthf.html .

[5] See www.tanzania.go.tz/healthf.html .

[6] Biologically, girls mature earlier and socially they face more temptation to engage in sexual relationships earlier than do boys.

led the national response. The programme began with the “short-term plan”, a two-year phase (1985-86), followed by medium-term plans (MTPs) each extending for five-year periods. The third and current MTP began in 1998.

The programme has identified appropriate national responses, the most effective being those touching on the major determinants of the pandemic and on factors that make people vulnerable to HIV infection.

In recent years, multisectoral efforts have been launched against the pandemic. The Cabinet of Ministers issued a government circular in November 2000 calling for a multisectoral approach against HIV/AIDS which focused, in part, on the impact of HIV/AIDS in workplaces (Mukoyogo, 2001). The establishment of the Tanzania Commission for AIDS (TACAIDS), within the Prime Minister’s Office, was another step towards realizing a multisectoral needs approach. The Commission has assumed the responsibilities for guiding and coordination formerly undertaken by the NACP under the Ministry of Health.

Prevalence. AIDS is a late consequence of HIV infection. Its long incubation period (between five and ten years), and the absence of significant symptoms in the early stages of infection, makes it impossible to calculate the exact number of HIV infections in the country. The only reliable data available is derived from blood donor data and a few sero-prevalence studies undertaken in selected regions. As of 1996, 6.8 per cent of adult male donors and 8.2 per cent of females were HIV positive. Extrapolation from these figures, given an estimated population of 15.5 million adults in mainland Tanzania, suggests at least 1.35 million HIV positives – 8.7 per cent of the adult population. At least 5 per cent of these infections could develop into full-blown AIDS, producing about 68,000 new AIDS cases per year.[7]

The HIV/AIDS/STIs Surveillance Report for calendar year 2000 documented a doubling in HIV incidence among female blood donors from 1991 to 2000 (from 7.2 per cent to 13.3 per cent), compared to an increase among males of from 5.8 per cent to 9.2 per cent during the same period. The incidence of HIV among first-time attendees at antenatal clinics among pregnant women ranged from 4.2 per cent to 32.1 per cent, respectively, in different sites in Mwanza and Iringa. The report also says that 13.3 per cent of 800,000 women who delivered in health-care facilities were HIV positive. HIV prevalence among antenatal clinic attendees is highest among those aged 14-24 and 25-34 years. HIV prevalence among adults among those aged 15-49 years was estimated at about 12 per cent, while 60 per cent of new HIV infections occurred among those aged 15-24 years (UNDAF, undated). It was estimated that about 70,000 to 80,000 babies were being infected annually through HIV-positive mothers (UNDAF, undated). This has reversed both the under-five and infant mortality trend and life expectancy. UNDAF estimates the number of orphans, most of them from parental AIDS deaths, at close to 2 million.

In general, the incidence of HIV infection among both men and women has steadily increased over the past ten years. Rates of HIV infection among blood donors show specific differences according to age and sex. In 2000, as in previous years, a higher incidence of HIV infection was seen among females than among males of the same age group. Incidence across age groups for males ranged from 6 per cent to 10.9 per cent, while among females it ranged from 8.2 per cent to 15.2 per cent for the same age groups (15-19 and 35-39 years, respectively). The most affected age group among females was 25-29 years (16.8 per cent HIV positive) compared to 10.9 per cent HIV positive among the most affected group of males, which was 35-39 years (NACP, 2000).

[7] See www.tanzania.go.tz/healthf.html .

Although the prevalence of HIV infection among adult blood donors in 2000 was an estimated 9.9 per cent, the range varied from 3.8 per cent to 19.5 per cent, respectively, in Kigoma and Kagera regions. The regions most affected were Kagera, Mbeya, Morogoro and Iringa, with incidences ranging from 14.6 per cent to 19.5 per cent; Arusha, Coast, Rukwa and Ruvuma ranged from 10.2 per cent to 13.8 per cent; while Shinyanga, Mara, Tanga, Dar es Salaam, Mtwara, Singida, Mwanza, Tabora, Kilimanjaro, Lindi, Dodoma and Kigoma ranged from 3.8 per cent to 9.4 per cent (NACP, 2000).

Mother-to-child vertical transmission of HIV, also prevalent, is on the increase. The number of hospitalized HIV-infected children at the Muhimbili National Hospital is said to be 19.2 per cent (TACAIDS, 2002). The problem appears to be on the rise as more infected women become pregnant. Data from sentinel surveys in antenatal clinics show sero-prevalence rates of 5.5 per cent to 23 per cent and, assuming a 30 per cent prenatal transmission rate, the proportion of infected newborns could reach 7 per cent (NACP, 2000).

Increasingly, HIV/AIDS is the major underlying reason for hospital admissions and deaths. Due to HIV/AIDS, many diseases seemingly under control ten years ago have returned to previous levels. For example, 52 per cent among 128 newly detected tuberculosis (TB) patients in Mbeya were HIV infected in 1995, as were 57.4 per cent in Bukoba hospital in 1992. In 2000, TB accounted for 1.7 million deaths out of the 2.4 million people worldwide who died of HIV/AIDS (UNAIDS, 2000; 2001). HIV/AIDS has erased gains made during the 1980s in TB control. TB case rates had been declining steadily up to 1982 but since then there has been a sharp increase in the number of reported TB cases and, in most urban areas, these have more than doubled (Palangyo, 2000). Studies conducted in Dar es Salaam, Hai and Morogoro showed that HIV/AIDS was the leading cause of adult mortality, especially among women (NACP, 2000).

Those affected. The above observations indicate that four categories are most affected: children, women, the poor and mobile populations.

- *Children*. Single or double orphans are compelled by economic hardship or family instability to enter the labour market. These children find themselves exposed both to the WFCL and HIV/AIDS infection. Young boys and girls having sex with older women or men, and unable to make informed decisions about sexual matters, are also affected.

- *Women*. Early marriages and early initiation into sex among women, including young girls engaging in sex with older men, put females under high risk of HIV/AIDS infection. In addition, the failure of women to protect themselves from HIV infections due to economic hardship, repressive customary laws, dangerous folk beliefs and polygamy may all exacerbate the situation.

- *The poor*. In most cases illiterate and unemployed, the poor are especially encouraged by circumstance to engage in sex as a means of earning a living.

- *Mobile populations*. Those who work away from home for varying periods during the year include children engaged in prostitution, petty traders, migrant workers, military personnel and long-distance truck drivers. The inability of children engaged in prostitution to negotiate safer sex with clients puts them at particularly high risk. Health workers are another group at high risk, with the danger of contact with infected material on the job. They often lack the necessary protective gear and education to protect themselves.

Of all these four categories, girl children suffer most and, of this group, orphans are especially vulnerable.

A study commissioned by the ILO and executed by the Kiota Women's Health and Development Organization (KIWOHEDE) identified 14 types of physical and emotional abuse and violence against girl children. These included: rape by individuals or groups of boys who were typically older and had engaged in promiscuous and unprotected sex; refusal by customers to use condoms; exposure, consequently, to STDs including HIV infection; and assault and battery (being robbed of money as well as facing sexual abuse and harassment). Other problems which girl children most often faced included: harassment from police and local guards; early pregnancy; refusal by clients to pay them; unwonted sexual overtures; pressure to use alcohol or other drugs; lack of accommodation; violent abuse; bondage; premature sex; and living in destitution (ILO, 2001[f]).

Determinants. Individually or in combination, a variety of societal, behavioural and biological factors put people at risk of HIV infection.

- Commercial sex workers (CSW), including children engaged in prostitution, potentially increase the sexual transmission rate of HIV. Studies conducted among major towns and truck stops show that, as a group, people involved in prostitution have an incidence of HIV infection as high as 60 per cent. A study conducted in the Moshi Municipality indicated that bar workers suffered HIV infection rates of 32 per cent, while research in Dar es Salaam showed that 50 per cent of the bar workers were HIV positive (MUTAN, 1990). Many children are employed in these places, thus making them more vulnerable to HIV/AIDS-related diseases.

- An important social determinant of vulnerability is the fact that a large proportion of the population earn very low and/or irregular incomes. More than 50 per cent of Tanzanians live below the poverty line and the situation among females is worse than it is among males, since females are less advantaged in terms of education, employment opportunities and income, and health protection (PRSP, 2001). In addition, low or irregular income encourages labour migration (Bagachwa, 1988). Women in such situations may easily be tempted to exchange sex for money, putting themselves and their spouses at risk of HIV infection. People with low income, moreover, have less access to medical care, including that for STDs and HIV/AIDS.

- Socio-economic patterns, cultural norms, and beliefs and practices that subjugate or subordinate women are important determinants for HIV/AIDS infection. Males use their socio-economic superiority to dominate sexual relationships, employing social status, power and wealth to gain sexual advantage over females, and many girl children fall victim to this pattern (Rau, 2002). Cultural practices such as wife inheritance, polygamy and female circumcision are common among many tribes in the United Republic of Tanzania. Obligatory sex in marital situations is condoned even by religion and, in some faiths, women cannot divorce their spouses. In some cultures, furthermore, multiple sex partners for men are tolerated, even encouraged.

- Young people leave home and school environments to become independent without a source of income. In the United Republic of Tanzania every year, about 300,000 pupils leave primary education at the age of 13-17 years, and a significant proportion of these migrate to large towns like Dar es Salaam in search of employment (Madihi, 2000). These youths, especially girls, become very vulnerable because they take work that is poorly paid and have to supplement their meagre incomes through unsafe sexual practices. Although attempts have been made to introduce sex education in schools, they have not adequately prepared those leaving school to cope with the sexual realities.

- Illiteracy and lack of formal education is on the rise in the United Republic of Tanzania. The fact that many young people are not being enrolled in school is partly to blame. In the 1980s, the national literacy level was about 80 per cent. Today, it has

declined to less than 60 per cent (Mwangosi, 1991). This is unfortunate because it has been shown that the prevalence of HIV infection among educated women, for example, is lower than it is among uneducated women. It also makes written educational campaigns such as those aimed at increasing awareness of HIV/AIDS-related issues less effective.

- Social isolation for long periods and peer pressures for high-risk behaviour [8] among military personnel constitutes another determinant for HIV/AIDS infection. When one is enrolled in the army, in the United Republic of Tanzania, one is confined to a camp and barred from marriage for six years. This makes one vulnerable to high-risk sexual behaviour, and hence to HIV infection, especially when the army conducts no proper HIV/AIDS prevention programmes.

Impact. Information collected from several parts of the country indicates that HIV-infected persons die about four to 12 months, on average, after falling ill. [9] During this period, a member of the family often has to stay with the patient at home or in the hospital to provide care, especially during the terminal stages of the disease.

The medical, emotional and social costs to patients and families are very high. More socio-economic difficulties arise when the patient is the primary breadwinner in the family (KIWOHEDE, 2001). When death finally comes, the traditional family structures – already stressed by poor health, the increased burden of care and poverty – are often at the point of breakdown.

Available data from severely affected communities show that AIDS often leads to social and economic disruption among affected individuals, families and communities. The poorest households are least able to cope with the impact of adult deaths due to AIDS. They are frequently unable to provide for even the most basic needs in the short term. Child nutrition, education, health and living standards among the survivors may be severely affected (Rwegoshora et al., 1997).

Data indicate that as many as 50 per cent of all hospital beds in the country are occupied by patients with HIV/AIDS-related illnesses (Palangyo, 2000). In the United Republic of Tanzania, the average lifetime costs, including nursing care, for an HIV/AIDS victim is an estimated $US290 for adults and $US195 for children. Consequently, the demand for care and hospital supplies is enormous and government health facilities and other resources are strained beyond capacity.

The health sector in particular is experiencing increased demand for services, as AIDS patients occupy an ever-increasing number of beds in hospitals. Given that AIDS patients typically suffer multiple episodes of illness, furthermore, public expenditure on AIDS treatment is especially high. In the education sector, we find children withdrawn from school either due to lack of money or because help is needed at home. The social welfare sector is having to cope with a large increase in the number of AIDS orphans.

Industries are losing skilled workers and incurring high recruitment and training costs for new personnel. Omolo (1989) argues that, as labour in agriculture declines, agricultural production and productivity declines. Since agriculture is the backbone of the Tanzanian economy, and most agricultural workers are aged 15-45 years, the same age group most

[8] Military men and women in camps are usually isolated from normal life and sexual practices. In such situations, they may be forced by peer pressure to engage in unnatural sexual practices, e.g. rape or sodomy, which are high-risk types of behaviour in respect of HIV infection.

[9] See www.tanzania.go.tz/healthf.html .

affected by the pandemic, the impact of HIV/AIDS is becoming more pronounced as the pandemic spreads to rural communities. Production of food and cash crops is bound to suffer as more of the labour force gets sick and dies from AIDS.

Due to the HIV/AIDS pandemic, the estimated life expectancy by 2010 will revert to 47 years instead of the 56 years projected in the absence of AIDS (URT-MoLYD, 1997). Between 1992 and 2010, moreover, the mean age of the working population (labour force) is predicted to decline from 31.5 to 29 years. Thus, the overall younger workforce will have less education, less training and less experience. In addition, the number of HIV/AIDS orphans, it was predicted, would increase from between 260,000 and 360,000 in 1995 to between 490,000 and 680,000 by the year 2000. Families, communities and the Government will have to generate resources to cater for the needs of these children.

Consequently, HIV/AIDS will reduce average real GDP growth rate in the period 1985-2010 from 3.9 per cent without AIDS to between 2.8 and 3.3 per cent with AIDS. These factors will certainly have a negative impact on the overall national economic performance and on the average real socio-economic welfare of the population.

Nature of child labour

The advent of a plantation and cash economy in the late nineteenth century, together with industrialization and urbanization, led to the proliferation of paid jobs (KIWOHEDE, 1998). Commercial activities took advantage of increased opportunities to employ child labour, which was both cheap and pliable. The potential for exploitation of children, and recognition of their vulnerability, was finally reflected in labour laws introduced by the colonial administrators, for example a 1940 ordinance covering employment of women, children and young persons (URT/Planning Commission, 1998).

Child workers are a traditional feature of Tanzanian society. But, since most of this employment has largely been hidden within the context of unpaid family work and in the informal sector, reliable official statistics regarding the extent of this force are unavailable (Panga, 2000). The ILO has recently sponsored a pilot study of persons in employment which uses 10 years of age as its baseline, thus recognizing the existence of working children in an age group far below that which is legally permitted. The conclusion and publication of this study is expected to provide important information regarding child labour in the country.

In any case, households have been under increased pressure from a variety of factors:

- a declining economy during the 1980s;
- the removal of state subsidies on food, education, health care and other social welfare measures; and
- retrenchment of workers from employment following globalization of trade and social policies.

Extended survival strategies were therefore needed, among them allowing children to work and thereby contributing to the household economy (Rwegoshora et al., 1997).

The outbreak of HIV/AIDS, which coincided with the socio-economic problems of the 1980s, worsened the child labour situation. The HIV/AIDS crisis increased the number of orphans to the point extended families and communities were unable to cope. Bereaved children and those who had to nurse ailing parents had to seek alternative means of support for themselves and other family members. Among the consequences: many children were forced to drop out of school; and child-headed households became more common.

Heightened risk of injury and illness. Most jobs demand physical exertion, mental maturity, experience and social support. Children are normally physically immature and labour exposes them to the following risks:

- They are more likely to suffer injury because tools are normally designed for adults rather than for children. At the same time, children tend to be less skilled and less experienced, again rendering them more likely to suffer from industrial accidents.
- Children who carry heavy loads at work during their early years may develop abnormally shortened statures.
- Children have thinner skin than adults, which means they are more likely to be affected by hazardous chemicals and, when they are, to suffer more acute symptoms than would adults exposed to the same environment.
- Children's internal organs are still developing and are vulnerable to environmental hazards, especially chemicals, that in normal circumstances would not harm an adult.
- Children who start working at an early age often suffer prolonged exposure to toxic materials while they are still growing and developing, which can have deleterious effects (Madihi, 2000). Children in employment are often exposed to acute poisoning from chemicals (especially pesticides in agricultural applications), use of contaminated containers and accidental ingestion when food or water is contaminated with pesticides. Their exposure to physical, chemical and biological agents may cause acute or chronic diseases, or may result in chronic disablement, e.g. by byssinosis (from cotton dust), silicosis (from rock dust), asthma, blood diseases and cancers. Any of these may prove fatal.

Heightened risk of fatalities. Young children, because they tend to be weaker and less experienced than adults, also suffer more fatal accidents from machinery, vehicles, electrocutions, falls, asphyxia and crush injuries. Work in quarries and mines is especially hazardous in this regard.

Overwork, fatigue, inappropriate work design and content. Employment opportunities for children tend strongly to require only minimal skills, with exertion the most important performance factor. Overexertion taxes the body and in children this may result in null development (dwarfism) and mental maladjustment. Perpetual fatigue for children arising from long working hours without rest creates depression and a sense of perpetual illness. Poor work design and work content often makes child labour grossly inefficient and intrinsically unsatisfying.

Impaired growth and development. Home and school environments are essential for a child's development. Children in employment are deprived totally or partially of these environments and therefore have little chance to develop their potential capacities.

Child slavery, prostitution and physical abuse. Children in employment often work under deplorable conditions. They are forced to work like slaves in homes or on farms. Often, children are forced to work against their will, in what amounts to forced labour. Child prostitution, for example, can be a form of forced labour and it is identified in ILO Convention No. 182 as one of the worst forms of child labour. In the United Republic of Tanzania, forced labour of children is found mainly on farms employing seasonal labourers. The latter tend to be young unmarried men, who often subject the younger child labourers to sexual abuse.

Psychosocial ills. Child labourers are robbed of their childhood. Psychological and intellectual disadvantages include deprivation of education. In the long run, this often leads

to uninformed health attitudes and practices such as alcoholism and drug abuse, and failure to join trade unions, [10] which would otherwise fight for their rights as workers.

Children affected by HIV/AIDS

According to Baylies and Bujra (2000), a combination of physical, psychological and social factors expose children to risk of HIV/AIDS. Youths lack the social skills, services and information required to avoid the risks associated with such activities as unprotected sex.

On another level, living environment affects exposure to HIV/AIDS. Kamuzora and Gwalema (1998) conclude that children who live in marginalized circumstances – e.g. orphans, street children, children engaged in prostitution and those who grow up in urban slums – are especially vulnerable to the disease. A high percentage of these children have limited access to formal education, health information, health services or assurance of even a subsistence livelihood.

KIWOHEDE (2001) suggests that many orphans have to find alternative life paths to survive. The economic hardships suffered by many such children can force them into prostitution, sodomy and related practices. These factors, together with adult rape of children, make them extremely vulnerable to HIV/AIDS infection.

Girls who turn to prostitution put their lives at high risk. Most of these girls come from families living in poverty. The new environment and their lack of experience in handling urban dwellers can jeopardize their lives. Ignorance can lead these girls to practices that they would not otherwise consider. Even where they are aware of the risks, it is often difficult for them to convince clients that they should uses condoms and these girls typically cannot afford to lose clients.

Problems facing orphans. A study by Mnenge (1991) revealed compound problems facing school-going orphans, including lack of school fees, lack of care and guidance from guardians, limited food supply and health problems.

The current rapid assessment reveals similar findings for HIV/AIDS orphans. Some of these children attended irregularly, while others dropped out of school completely, required to seek means of support for themselves or their families or guardians.

Orphans work in hazardous environments and may be subject to slavery. A study by J. Lutimba and J. Mwabuki (1997) and documented by J. Bujra and S. Mokake (2000) reported:

> During the night, people at Hyena Ground [in Manzese] … drink to the extent of doing and shouting. … Sexuality and sex are displayed openly, especially by the prostitutes who are there renting rooms and waiting for customers. … After returning from school, children from poor families come here to sell cooked food brought from their homes to earn money for their families. Mostly young girls between the ages of 10 and 12, they arrive at around 6 p.m. and work to 10.00 p.m. … We saw many young and old men trying to seduce them by offering money which would cover the total sales of food … and give the chance to have sex with the girls. One man was overheard to say, "I am giving you this money to give mama so that we can make love before you have to get off home." (Bujra and Mokake, 2000).

[10] Failure to have the rights of remuneration and security.

Such observations have also been documented by the Tanzania AIDS Project (TAP, 1994), where young girls are sent out by their guardians or even parents to sell cooked food at the drinking grounds (local pubs), where often drunken men pay them to engage in sex. Some of these girls are orphans whose parents have died from AIDS, and now these girls themselves are subjected to unprotected sex that exposes them to HIV/AIDS.

Another study by KIWOHEDE (2001) presented similar observations. Some girls had to abandon school to assume responsibility for their families. Interviews with girls who had resorted to prostitution revealed that the girls were forced to drop out of school, since no support was offered to them from members of their extended families. In extreme cases, the children were even robbed of personal belongings by their guardians.

HIV/AIDS and child labour

The 1990-91 Labour Force Survey estimated that 2,369,380 people, including 53,748 children under the age of 15, worked in the informal sector. Preliminary data from the 2000-01 Child Labour Survey suggest that 4.1 million out of an estimated 10.2 million children aged between 5 and 14 years were not attending school and were working (President Mkapa's speech to the ILO, 2001).

Poverty and HIV/AIDS were cited as important factors behind the increase in child labour, where the traditional extended family, already experiencing widespread household poverty, could not cope with caring for more than 1 million HIV/AIDS orphans (Mkapa, 2001; UNDAF, undated).

Several studies on child labour in the United Republic of Tanzania commissioned by the ILO have suggested correlations between increased child labour and both household poverty and orphanhood. HIV/AIDS attacks young parents, the most energetic and productive part of the labour force in the households and in the national economy. Family resources are often exhausted in nursing the sick parents. After they die, household poverty becomes even more severely entrenched, especially for the children left behind. These orphans are forced to find alternative means of survival.

Most of these children wind up working in the informal sector. Most of them, especially those in forced labour, are socio-economically insecure and exposed to health hazards including HIV/AIDS and illegal, immoral and inhumane working conditions.

Self-employment. Children work in small-scale operations such as pottery-making, cooking-oil extraction, brewing and selling local drinks, making mats and baskets, small retail shops and related trade activities, flour milling, automobile garages, carpentry, building works, brick-making, poultry farming, fisheries or vegetables, fruit and flower farming (ILO, 2002; Kadonya et al.:3).

Children engaged in domestic service. Others perform a variety of tasks in the household, including areas similar to those mentioned in the first category: small retail shops and related activities; poultry, farming; and brewing and selling local drinks. Children working in this sector are subjected to long working hours as well as physical and sexual abuse.

Children engaged in prostitution. These children are most vulnerable to HIV/AIDS infection and other STDs.

Quarrying. Working conditions for children in this occupation are even worse than those for adults. Children collect, crush, carry and load stones for construction. In some cases, children participate in actual mining activities, falling victim to frequent accidents (ILO, 2002; Kadonya et al., 2002; Mwami et al.).

3. Findings

Respondent profiles

This study has drawn on a sample of 191 children, 44 parents/guardians, 42 local leaders and several other informants. The sample included respondents from two districts in Dar es Salaam Region (Ilala and Temeke) and two others in Arusha Region (Arumeru and Arusha). Table 1 presents the number of respondents in the districts studied.

Table 1. Number of respondents, by district

Region	District	Children				Parents				Local leaders[1]	
		Respondents			% of total	Respondents			% of total	Respondents	%
		M*	F*	T*		M*	F*	T*			
Dar es Salaam	Ilala	15	34	49	25.7	2	8	10	22.7	10	23.8
	Temeke	25	27	52	27.2	8	7	15	34.1	11	26.2
Arusha	Arumeru	25	25	50	26.2	5	5	10	22.7	10	23.8
	Arusha	16	24	40	20.9	6	3	9	20.5	11	26.2
Total		81	110	191	100.0	21	23	44	100.0	42	100.0

* M = male; F = female; T = total.
[1] Identification by sex was not done.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

The sample comprised children with both parents surviving, single orphans and double orphans (table 2). Respondents included 110 girls (57.6 per cent) and 81 boys (42.4 per cent) aged between 10 and 18 years. Female parents/guardians numbered 23 (52.3 per cent) and males numbered 21 (47.7 per cent), with the total parent/guardian sample aged from 24 to 72 years (table 3). Of the parents/guardians, 52.3 per cent were married, 22.7 per cent were single, 13.6 per cent were widows and 11.4 per cent were divorced. Both mortality and divorce rates were high and had devastating effects on child development.

Table 2. Status of children's parents

Parenthood status	Number of respondents			Percentages of total
	Male	Female	Total	
Both parents alive[1]	33	41	74	38.7
Double orphans[2]	17	33	50	26.2
Single orphans (female parent alive)	22	25	47	24.6
Single orphans (male parent alive)	9	11	20	10.5
Total	81	110	191	100.0

[1] Because they were too young at the time of death, some children could not understand that their biological parents had had HIV/AIDS. This information was disclosed by informants and some parents interviewed. Thus, they understood their guardians to be their real parents. [2] "Double orphans" are here construed as those children who have lost both parents.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

About 51.3 per cent of the children interviewed were from the area where the interviews were conducted, while 48.7 per cent had migrated from other parts of the country. (The migrant children represented virtually all regions in the country.) Table 4 presents reasons for migration.

The majority indicated that they had migrated mainly in search of alternative income. But the focus group discussions uncovered a wider range of reasons. Some had migrated because of family problems at home, including inadequate food and clothing. Those engaged in farming, in particular, were working long hours, often on empty stomachs, starting as early as 6 a.m. and finishing at 5:30 p.m. In such cases, they had to drop out of school or were not enrolled at all because their parents or guardians failed to pay school fees and related expenses.

Still others claimed that they had escaped brutal treatment from parents, especially step-parents or “guardians”. As one of the respondents remarked: “Whenever my father came back home, I experienced beatings like hell. I was just his punching bag!”

Others suffered such abuses as rape and sodomy.

Table 3. Distribution by age (both children and parents/guardians)

Children				
Age group	Number of respondents			Percentages of total
	Male	Female	Total	
Children (10-12 years)	10	12	22	11.5
Middle childhood (13-15 years)	33	26	59	30.9
Late childhood (16-17 years)	38	72	110	57.6
Total	81	110	191	100.0
Parents				
Age Group	Number of respondents			Percentages of total
	Male	Female	Total	
24-30 years	4	7	11	25.0
31-35 years	4	5	9	20.5
36-45 years	4	8	12	27.3
47-55 years	5	2	7	15.9
56-72 years	4	1	5	11.3
Total	21	23	44	100.0

Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Household socio-economic status

The households surveyed were located in urban, peri-urban and rural communities. The majority of occupants lived in simple houses constructed of concrete blocks and roofed with sheets of corrugated iron. The majority of households were tenants renting a maximum of two rooms. One house could accommodate four to six families sharing one toilet and a bathroom. The same bedroom was often used as sitting room and kitchen. A single room rented for about 5,000-10,000 Tanzanian shillings ($US5.5-11) per month.

Table 4. Reasons for rural-urban migration

Reasons for child migration	Number of children			Percentage of total
	Male	Female	Total	
Seeking employment	32	41	73	78.5
Taken by relatives/guardians	5	4	9	9.6
Following parents	2	3	5	5.4
Matrimonial conflicts	3	–	3	3.2
Attending school	1	1	2	2.2
Seeking treatment	–	1	1	1.1
Total	43	50	93	100.0

Source. HIV/AIDS and child labour research data from rapid assessment, 2002.

Parental responsibility

Most parents/guardians interviewed were living with at least one child. With five of these respondents (11.4 per cent), however, all their children were living elsewhere. Over half (56.4 per cent) of the parents/guardians were living with between one and four children, while 41.1 per cent accommodated five to ten children. In one case, the household included 20 children. This was a case where grandparents were taking care of grandchildren from daughters who worked elsewhere. The fathers of these children were unknown or had abandoned the households.

Table 5 provides a comparison of responses from children and parents regarding household numbers of people[1] and numbers of children,[2] respectively. It is shocking to note that 18 (9.4 per cent) of the children were living on their own, while nine (4.7 per cent) were sharing accommodation and food with friends.[3]

Adults and children reported slightly different household numbers, but an average of three to six people per household appeared about right. The children's responses revealed that a substantial number (9-15 per cent) came from households having more than nine people. Both groups reported similar numbers at the extremes of 19-20 adults and children in a household. The larger the household, the more miserable living conditions for children become. For one thing, they become overburdened with household chores.

Most of the parents/guardians had to take care of both their own children and other dependants. The number of own-children parents/guardians ranged from one to seven. Again, most households had dependent children ranging from one to five. Table 6 presents numbers of both own and other dependent children. More than one-fifth of the respondents had at least one own child, about 40 per cent had at least one dependant and more than 25 per cent had four own children. The majority of parents/guardians tended to take care of one dependant in addition to their own children.

[1] Children were asked how many people there were in households in which they were staying.

[2] Parents/guardians were asked how many children were staying in their households.

[3] This means no one depended on the other. Each had to contribute for house rent and meals.

Table 5. Household numbers of adults and children as per children and parents/guardians' responses

Number of people and children	Number of people M	F	T	Percentages of total	Number of children M	F	T	Percentages of total
1	10	8	18	9.4	3	1	4	10.3
2	5	4	9	4.7	4	3	7	17.9
3-5	27	40	67	35.1	5	12	17	43.6
6-8	30	38	68	35.5	4	3	7	17.9
9-11	7	12	19	9.9	1	2	3	7.7
12-15	2	6	2	4.1	–	–	–	
19-20[1]	–	2	2	1.0	1	–	1	2.6
Total	81	110	191	100.0	18	21	39	100.0

[1] Under the "children" column, only one parent/guardian respondent reported 20 children in the household.
Source. HIV/AIDS and child labour research data from rapid assessment, 2002.

Table 6. Household numbers of own and other dependent children

Own children: Number of children	Number of respondents M	F	T	Percentage of total	Dependent children: Number of children	Number of respondents M	F	T	Percentage of total
1	3	4	7	21.2	1	5	5	10	40
2	2	4	6	18.2	2	3	6	9	36
3	2	4	6	18.2	3	3	1	4	16
4	3	6	9	27.3	4	1	–	1	4
5	2	1	3	9.1	5	1	–	1	4
7	1	1	2	6.0					
Total	13	20	33	100.0	Total	13	12	25	100

Source. HIV/AIDS and child labour research data from rapid assessment, 2002.

Dependent children included nieces/nephews (26.9 per cent), grandsons/daughters (26.9 per cent), cousins (23.1 per cent), young brothers/sisters (19.2 per cent) and others such as children of friends (3.8 per cent). Where nieces/nephews or grandsons/daughters were being taken care of, in most cases, they were orphans. Where cousins and young brothers/sisters were being taken care of, it was a matter simply of extending support to one's parents/guardians and/or unpaid work in household chores or where children were working in small family businesses.

Death of parents (60 per cent) was the major reason given for living as a dependant in a household other than one's own by birth. Other reasons given were: "attending school" (9.1 per cent); economic hardship of the parents (6.8 per cent); and sick parents, working or being married each accounted for 2.3 per cent. Other reasons, such as seeking employment or training opportunities, represented 2.3 per cent of the total.

Thirteen respondents (31.7 per cent) confirmed that they had children under 18 years who were living outside the households; seven of these respondents had males, eight had girls and one respondent had children of both sexes in this category. These respondents gave such reasons for their children's living outside the household as attending school (35.3 per cent), economic hardship (29.4 per cent), death of parents (17.6 per cent) or dropping out of school (5.9 per cent). Other reasons, such as sick parents or seeking

employment or training opportunities accounted for 11.8 per cent. Local leaders and other adult informants confirmed those factors as contributing to child labour.

About 25 per cent of the parents/guardians (ten respondents) indicated that they had taken in non-related children because the children's parents had died. Of these, 50 per cent said they wanted to employ the orphans as domestic workers; 41.7 per cent reported taking them in because of family disharmony; and 8.3 per cent because of family poverty. The researchers are convinced that even children ostensibly taken in only on the basis of coming from "poor families" were used as domestic workers with little pay and no contract.

Those parents/guardians interviewed considered persons in their households aged from 5 to 26 years to be "children". Criteria of adulthood included more than age – only when persons established a self-sustaining life outside the household or became married were they recognized as adults. When asked at what age children should be allowed to engage in wage employment, over half (54.5 per cent) indicated after completion of school at each level.[4] Again, over half (55 per cent) responded that children should not begin work before 18 years of age, at least so far as the worst forms of child labour were concerned. Twenty per cent recommended 20 years, while 15 per cent suggested 16 years as the minimum age. Others (5 per cent for each) recommended 19 and 21 years, respectively.

Parents' economic status

Sixty per cent of the children reported being single or double orphans (see table 2). This data was supported by parent/guardian responses regarding their reasons for taking in dependent children. About 57.6 per cent responded that those children had deceased parents. The children with living parents (66 or 54.5 per cent) said that their mothers worked as artisans, farmers (21.2 per cent), food vendors (15.2 per cent) and petty traders (3 per cent). The proportions who worked as government employees or labourers stood at 1.5 per cent each. Another 55 (45.5 per cent) reported their mothers to be jobless. Sixty children (63.8 per cent) had fathers who were working. Occupations reported included farmers (15 per cent), petty traders and artisans (5 per cent each) and labourers (3.4 per cent). The proportion working as government employees or food vendors stood at 1.7 per cent each. Again, 34 (36.2 per cent) reported that their fathers were not working. Yet 68.2 per cent of those who reported that their fathers were working failed to mention what their fathers were doing. This suggests that many parents were not involved in any genuine income-generating activity, at least to the knowledge of their children.

Cause of parental death

Asked whether their parents' death was preceded by long illness, 51 children (72.9 per cent) said that had been the case with their mothers and 75 (77.3 per cent) reported the same for their fathers. Only 15 (27.1 per cent) and 22 (22.7 per cent) of respondents, respectively, reported sudden and unexpected deaths of mothers and fathers. The deceased parents had suffered, among other things, from chronic malaria and TB, which is often HIV/AIDS related. During the period 1988 to 2000, they died at the age of 20-60 years, among mothers, while from 1990 to 2000 fathers died aged 30-78. Unrepresentative as it was, the selected sample thus indicated that women were more afflicted with health problems than were men, who appeared to live longer.

[4] This suggests that, when a child completes primary education at 14 years old or so, or completes secondary or other training skills, the child is obliged to secure alternative means of support.

Life experience in orphanages

When asked about the relative quality of their lives after being orphaned, 88 children (75 per cent) could not say because they had been too young at the time their parents died. Among those able to report, 19 (65.5 per cent) responded that life was miserable; four (13.8 per cent) experienced a largely unchanged standard of living, compared to life prior to orphanhood; four others (13.8 per cent) claimed that life was relatively better than it was prior to the parents' death; and two (6.9 per cent) said that they had no experience because their parents were not living together. These data suggest that the majority of orphaned children face difficult life experiences.

Responsibility for household chores

Of the children interviewed, 46.1 per cent indicated that responsibility for household chores was shared among household members. A substantial percentage (16.2 per cent) instead indicated that female members were disproportionately burdened with household chores. Of the female members, including the respondents, most of whom were female, 22 per cent reported participating in household chores. This was also supported by parent/guardian responses. Among male family members, only 3.7 per cent of brothers, 0.5 per cent of fathers and the respondents themselves engaged in household chores. We may conclude that females and children – especially female children – are relatively overwhelmed with household chores.

House cleaning was cited as the commonest household chore among children, followed by cooking, shopping, taking care of the children, house repairs, keeping cattle and caring for the sick and old. These activities occupied much of the children's time and attention, with 75.4 per cent of them working more than eight hours a day.

Educational status of the children

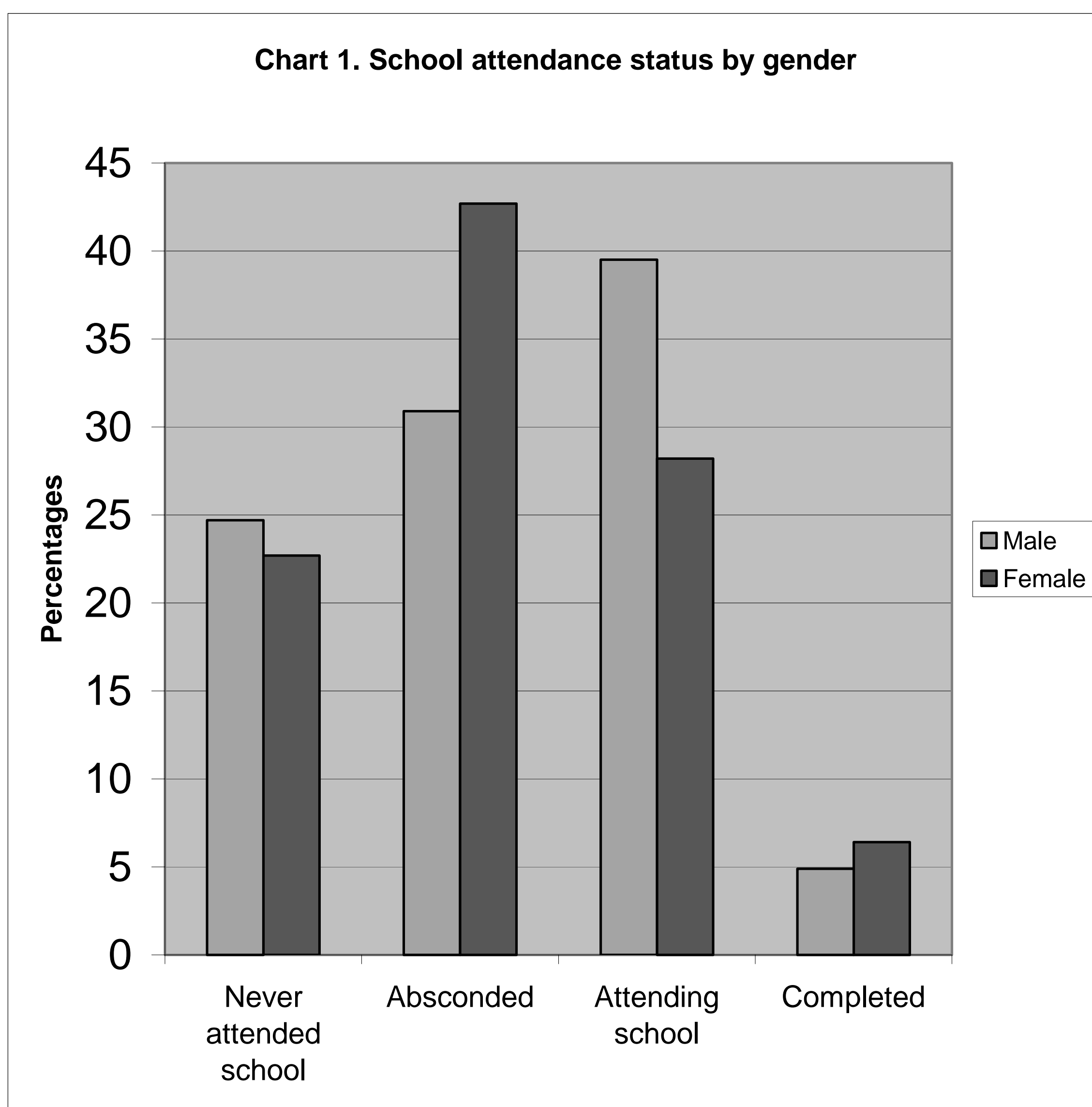
From 1993 to 2001, 72 children (37.7 per cent) dropped out of school because, inter alia, of failure to pay school fees, pregnancy, parental divorce and death of parents leading to the subsequent need for children to work to support their families. Implementation of structural adjustment programmes also had a grave impact on the poor, who were unable to pay for goods and services in the market, including merit goods such as education and health. There were also 45 children (23.6 per cent) who had never attended a single class. This suggests that about 60 per cent of children of school-going age were outside classrooms.

Data indicate that more boys than girls were attending school. More girls had also dropped out of school. Chart 1 presents school attendance by gender.

The chart indicates that about 25 per cent of the boys (20 respondents) never attended school, compared to about 23 per cent of the girls (25 respondents). In contrast, about 31 per cent (25 respondents) of the boys dropped out of school (absconded), compared to about 43 per cent of the girls (47 respondents). Only about 28 per cent (31 respondents) of girls were attending school, compared to about 40 per cent (32 respondents) of boys. These figures support the claim that more girls than boys drop out of school and thus more boys benefit from educational opportunities than their female counterparts.

Among those attending school, 71.1 per cent of the boys attended regularly, compared to only 59.4 per cent of their female counterparts. Similarly, 15.8 per cent of the boys responded, compared to 34.4 per cent of the female children, that their school attendance depended on factors including taking care of children and sick where the parents were too sick to do so and inability to pay school fees and/or related expenses. This suggests that

girls shouldered heavier household burdens than their male counterparts and were hence forced to drop out of school or not enrol at all.



Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

By comparison, parent/guardian respondents indicated that, from 1995 to 2001, 25 per cent of children dropped out, while 75 per cent of children in their households were attending school. Among those children attending school, six were studying at the pre-primary, 25 at the primary, two at the secondary and one at the tertiary levels. Parent/guardian respondents reported reasons for children dropping out of school that included inability to pay school fees (six respondents), reluctance on the part of the children (three respondents) and the necessity for children to work (two respondents).

The majority of those in school (43 children or 68.3 per cent) attended regularly. Only one or two children responded that they were attending school three and four times a week, respectively, while 17 respondents reported that their attendance depended on a number of factors. Among parent/guardian respondents, only one respondent reported that his/her child was attending school four times a week, while ten respondents said their children were going to school depending on factors including: having to take care of children or the sick and old, or being unable to pay school fees or other related expenses.

Of the children who had dropped out of school, 42 said they would like to return but 30 responded categorically that they were not ready to go back to classes. Among other reasons, they reported the inability to pay for school expenses, poor health (disabilities), the need to earn a living or supporting sick people in the family. In contrast, almost all the parents would have liked those dropouts to return to school except for those few who despaired, having become convinced that their children did not like schooling any more.

Research indicates that double orphans were the leading category among unenrolled children of school-going age. Orphans also represented the smallest percentage of those currently attending school. Double orphans ranked second to single orphans in male parent-headed households among school dropouts (see table 7). About half of the single orphans who came from households headed by single male parents dropped out of school. This suggests that men often failed to attend to children adequately in the absence of the mothers. Even in cases where single fathers decided to replace outgoing or deceased mothers, reportedly, many stepmothers abused their husbands' children. Children complained, for example, of inadequate meals and gross overwork.

Table 7. School attendance by parenthood status

Status	Both parents	Double orphans	Single female parent	Single male parent	Row total (percentages)
Never attended school	15 (20.3)*	17 (34.0)	9 (19.1)	4 (20.0)	45 (23.6)
Absconded[1]	28 (37.8)	20 (40.0)	14 (29.8)	10 (50.0)	72 (37.7)
Attending school[2]	28 (37.8)	11 (22.0)	19 (40.4)	5 (25.0)	63 (33.0)
Completed	3 (4.1)	2 (4.0)	5 (10.6)	1 (5.0)	11 (5.8)
Column total (percentages)	74 (38.7)	50 (26.2)	47 (24.6)	20 (10.5)	191 (100.0)

* Figures in parentheses represent percentages. [1] This is referred to in the text as "dropped out of school". [2] A substantial number of children who claimed they were attending school were doing so through the Complementary Basic Education (Programme) in Tanzania (COBET). This programme enrols children who have passed the standard enrolment age.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Parents and guardians were responsible for meeting school expenses for the children in their care. Assistance with meeting school expenses was sometimes also available from voluntary charitable organizations (NGOs) or the children themselves. Almost half of the parents/guardians said that other relatives (e.g. brothers, sisters, uncles or aunts) were responsible for paying the school fees in their households. This is unsurprising, since the number of children staying with guardians was too large for the guardians to handle on their own. In some households, taking care of orphans was a shared responsibility throughout the family, with family members submitting remittances to assist orphans, especially when these children were staying with grandparents.

Parents who paid school expenses for their children represented 23.3 per cent of the total. Another 20 per cent said that education was offered free and 10 per cent were receiving assistance from NGOs or other sources.

Some parents complained of bureaucratic appropriation and mismanagement by school administrators of NGO financial assistance for orphaned children, which sometimes failed to reach its intended targets. Government support through local authorities was criticized as being too bureaucratic and insufficiently transparent. Moreover, most of those

deserving educational support were either ignorant of the system or too occupied in earning a daily subsistence income to pursue such assistance.

Most of the children who dropped out or never attended school had experience of close family members' relatives who similarly either absconded or never attended school. In extreme cases, children came from families where no one had attended school.

Parents/guardians recommended several intervention strategies to reduce school dropouts:

- 41.7 per cent proposed free education;
- 25 per cent recommended cost-sharing programmes to reduce burdens on the family;
- 12.5 per cent suggested closer cooperation between teachers and parents; and
- 8.3 per cent recommended free education for orphans.

Table 8 summarizes parent/guardian responses on strategies to mitigate the problem of school dropouts.

Table 8. Recommended strategies to reduce school dropouts [5]

Strategy	Number of responses[1]			Percentages of total
	Male	Female	Total	
Provide absolutely free education	4	6	10	35.7
Reduced cost sharing	3	3	6	21.4
Closer teacher/parent cooperation	3	1	4	14.3
Community sensitization	1	2	3	10.7
Free education for orphans	1	1	2	7.2
Community support	1	1	2	7.2
Enhanced quality	1	–	1	3.5
Total	14	14	28	100.0

[1] Twenty respondents had no comments, claiming that, since the Government had already embarked on a free education programme, the problem was already taken care of.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Local leaders and other informants also commented on strategies to curb the problem of school dropouts. They recommended that, among children with parents, the parents should be held responsible if their children dropped out of school. Some recommended that school dropouts should be taken back into the classroom or put under a special education programme. Still others advocated community mobilization and legal support to ensure that children are confined to the school learning environment before they are allowed to engage in any income-earning activity.

[5] More than one response was allowed.

Child labour and working conditions

This study looked at four sectors of child labour in relation to HIV/AIDS: domestic service; self-employment; mines and quarry; and commercial sex. The available data confirm the existence of child labour in the four selected categories. It also indicated that the problem was pervasive in other sectors, especially family labour. Table 9 summarizes the related responses of both children and parents/guardians. Local leaders and other informants also confirmed the participation of child labour in food and cloth vending, petty trade, mines and quarries and other occupations.

Table 9. Categories of child labour, as reported by children and parents/guardians

Child respondents					Parent/guardian respondents			
Job category	Number of respondents			Percentages of total	Number of respondents			Percentages of total
	M	F	T		M	F	T	
Household work	7	38	45	46.4	4	6	10	50.0
Self-employment	29	12	41	42.3	2	6	8	40.0
Commercial sex	–	9	9	9.3	1	1	2	10.0
Quarrying	2	–	2	2.0	–	–		
Total	38	59	97	100.0	7	13	20	100.0
Others								
Family work	8	14	22	100.0				
Hairdressing/cut salon	–	–	–		1	1	2	66.7
Labourer					1	–	1	33.3
Total	8	14	22	100.0	2	1	3	100.0

Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Factors behind child labour

Effective policy interventions require an understanding of the factors contributing to child labour. Local leaders and other informants identified five main factors: [6]

- death of parents;
- poverty in families;
- children who want to adopt an adult way of life before maturity;
- parents falling ill and leaving no one in the family to take care of the children; and
- children dropping out of school.

Parents recognized these factors. They also suggested that children were compelled to start working early because of the need to help support the family or to achieve economic independence.

[6] These factors have been documented in other studies commissioned by the ILO.

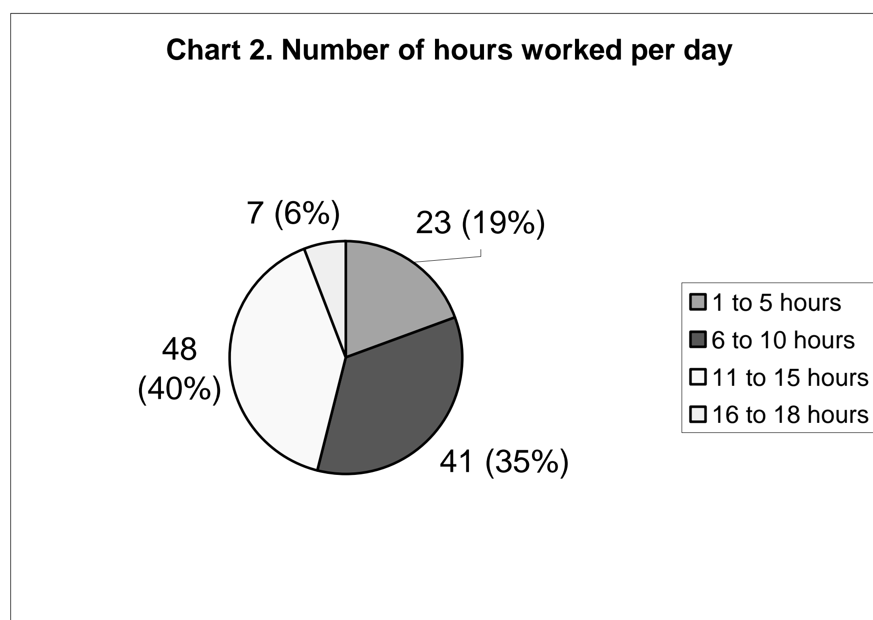
The children themselves stated that they started working early in order to supplement family incomes, gain economic independence, gain experience or acquire capital to establish their own businesses or support household enterprises. Others pointed to the need to pay school fees or help pay family debts. Patterns of expenditure among the children studied confirmed these reasons. Much of the children's income was given to parents/guardians. (Some gave all of their income to their parents/guardians.) Other income was spent on medical care, food, school fees and leisure.

Parents/guardians confirmed that children contributed to household income, with 14 respondents attesting to such contributions – one said that all the child's earnings went to the parent/guardian, while nine reported that half of the children's income was given to the parents/guardians. Four respondents said no such contributions were made.

Working conditions

Most of the children covered in this study were employed in domestic work; others were engaged in small businesses.

Working hours were too long (see chart 2). About 40 per cent worked between 11 and 15 hours per day. Even if one were to grant that working one to five hours might be considered normal household socialization, over 75 per cent worked more than six hours per day. This disrupts a child's social and psychological development. It also deprives children of opportunities to attend school regularly and concentrate on studies.



Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Some children found it difficult to attach values to household chores and could not estimate hours worked. Surprisingly, 37.7 per cent of the children said they were not working, although the researchers nevertheless observed them engaged in petty trading, selling such goods as cookies, fried fish, cooked maize and bananas. Among those who said they were working, 75 (63 per cent) reported that they went unpaid. Only 34.6 per cent were paid wages ranging from 3,000 to 20,000 Tanzanian shillings ($US3.05-20.3), and 2.4 per cent (three respondents) were paid over 20,000 Tanzanian shillings per month. Table 10 summarizes trends in child labour wages, with the majority of child workers (43.2 per cent) being paid 3,000-5,000 Tanzanian shillings ($US0.5-5) per month.

Those who were employed, but did not get wages, instead received payment in kind. For example, 81.3 per cent were provided with basic necessities such as food, clothing and shelter. But few (1.3 per cent) were given shelter and clothing and only 17.4 per cent were assisted in paying school fees.

The sample children started working anywhere between the ages of 6 and 17 years. Focus group discussions revealed, however, that most started working earlier than claimed in their interviews. Chart 3 compares the responses of children and their parents/guardians regarding the age at which the children started work. While the children said they started work at ages as young as 6 years, parents/guardians claimed that children in their households started working no younger than 12 years. Yet 15 per cent of parents/guardians recommended the minimum age to start working should be 16 years. The rest recommended 18 years and older.

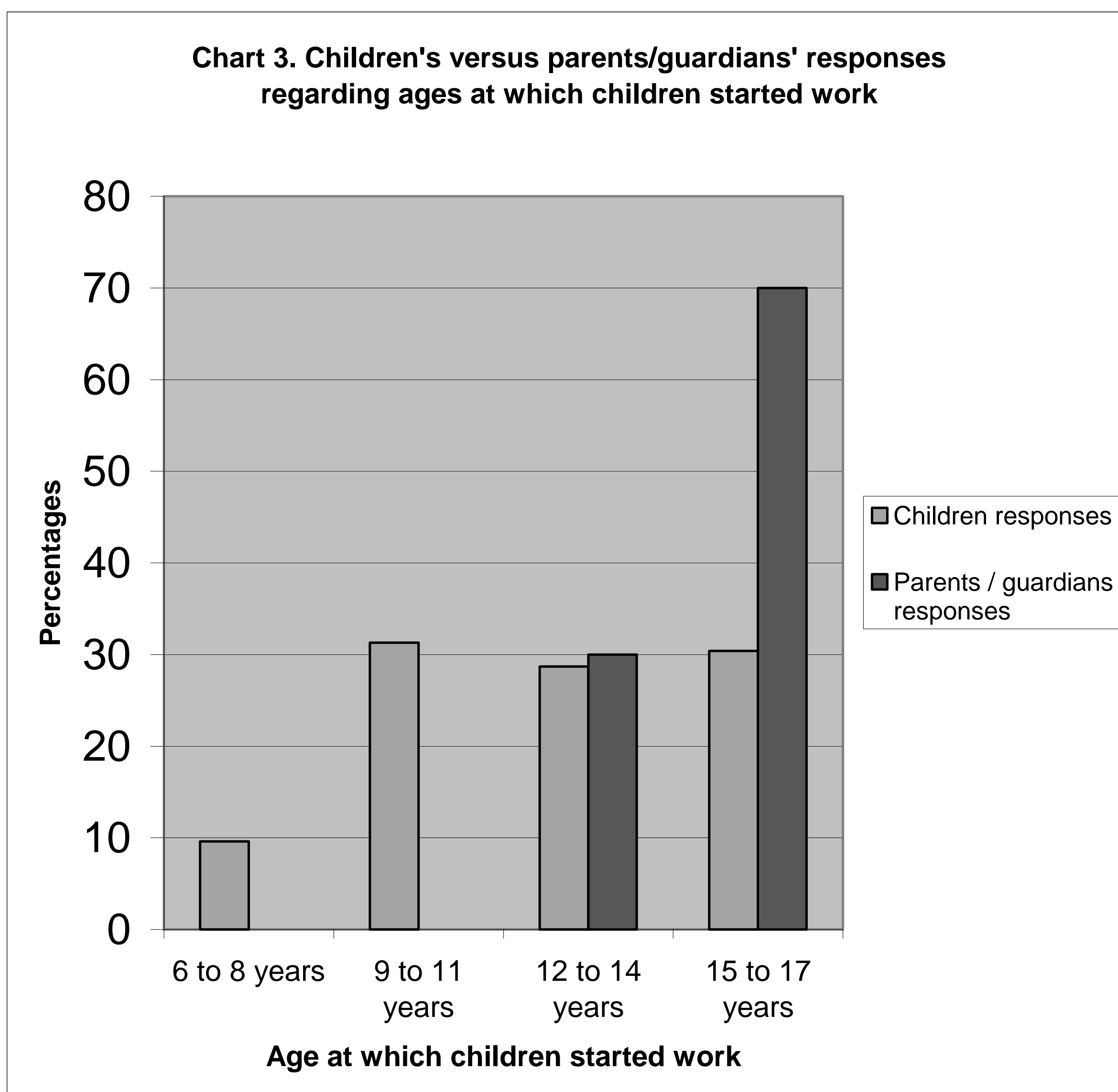
Table 10. Monthly wages among working children

Amount paid (in Tanzanian shillings*)	Number of respondents	Percentages
3 000-5 000	19	43.2
5 500-7 000	4	9.0
8 000-10 000	9	20.5
15 000 and 20 000	9	20.5
30 000, 35 000 and 50 000	3	6.8
Total	44	100.0

* $US1 is equivalent to 910 Tanzanian shillings.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

About 10 per cent of the children (11 respondents) indicated that they started work between 6 and 8 years, and about 31 per cent claimed they started at ages ranging from 9 to 11 years (36 respondents). About 29 per cent claimed they began at between 12 and 14 years of age (33 respondents). Only about 30 per cent of children reported beginning work between the ages of 15 and 17 years (35 respondents), however, while parents/guardians (seven respondents) claimed that about 70 per cent of the children had done so.

Focus group discussions suggested that almost all the children were working with no contract, whether oral or written, specifying terms of employment. Some respondents (37.6 per cent) had lost hope of alternative employment, however, and viewed their jobs as permanent. This was true even for four parents/guardians, while seven responded that their children were working at seasonal or temporary jobs. Other children (40 per cent) responded that they were working on a short-term basis; others (9.6 per cent) on a daily or weekly basis; and 3.2 per cent each reported seasonal work or working for different employers. Only 1.6 per cent indicated that they were involved in family work, which had no contract, while 4.8 per cent responded that they had no contracts, contrary to what was suggested in the focus group discussions.



Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Sectors involving child labour

As mentioned above, child labour manifests itself in a number of sectors. This study, however, limited its focus to domestic work, self-employment, commercial sex and quarrying.

Double orphans (about 45.5 per cent) were the majority of those who reported performing unpaid family labour in the households of their extended families or other families who gave them shelter. These children received payment in kind – meals, clothes and shelter. About 68.3 per cent of those who were self-employed were single or double orphans, about 55.6 per cent were engaged in prostitution and about 50 per cent worked in quarries (see table 11).

Domestic work

Child workers, both orphans and children who had both parents, were commonly found in domestic service. About 40 per cent of children with both parents living engaged in domestic work. Poverty, in many cases exacerbated by the burden of caring for orphans

(most of whom were victims of the HIV/AIDS pandemic), led some parents/guardians to offer their children for domestic work even without pay. Those families could not otherwise afford the basic necessities for all their members.

Usually children were offered to close relatives or friends for domestic work. This was one means by which poor families could dispose of unproductive labour.

Some children, then, had to suffer poverty as well as coercive and exploitative family structures in their own households, while shouldering most of the domestic work. Many of them decided, therefore, that it would be better if they left home and sought to earn compensation for their labour outside the family context.

Table 11. Child labour and parental status

Child labour sectors	Both parents alive	Double orphans	Single orphans, female parents	Single orphans, male parent	Row total (percentages)
Domestic work	18 (41.9)*	9 (31.0)	12 (34.3)	6 (50.0)	45 (37.8)
Self-employment	13 (30.2)	7 (24.1)	16 (45.7)	5 (41.7)	41 (34.5)
Commercial sex	4 (9.3)	3 (10.3)	2 (5.7)		9 (7.6)
Quarrying	1 (2.3)		1 (2.9)		2 (1.7)
Family work	7 (16.3)	10 (34.5)	4 (11.4)	1 (8.3)	22 (18.5)
Total	7 (16.3)	10 (34.5)	4 (11.4)	1 (8.3)	119 (100.0)

* Figures in parentheses represent percentages.
Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Over 60 per cent (28 respondents) of the children involved in domestic work had either dropped out of school or never attended school. Only about 7 per cent (three respondents) had completed school, and 31 per cent (14 respondents) said they attended school. Over 70 per cent (32 respondents) under this category were aged between 16 and 17 years; 24.4 per cent were aged between 13 and 15 years; and 4.4 per cent were aged between 10 and 12 years.

Domestic work and self-employment jobs entailed long hours. The children worked from as early as 5.30 a.m. to as late as midnight and, in extreme cases, even beyond. Children working as domestic workers shouldered a wide range of activities including washing and ironing household clothes, cooking, infant care, attending to the sick, animal husbandry, shopping for the household food and fetching water. Yet, the children were paid just 3,000-5,000 shillings ($US3.3-5.5) per month or paid in kind with meals and shelter. They typically received inadequate compensation (reported 34 times) and were overworked (reported 17 times). They also faced humiliation ranging from physical harm (reported one time)[7] to sexual abuse by sons and daughters of the employer (reported 27 times), by the employer or spouse or by other family members (reported nine times).

[7] Respondents were allowed to provide more than one answer, where applicable.

Self-employment

Most children in this category were conducting their own small businesses or were employed in others. Activities included: operating kiosks; selling chips, milk, fruits or cigarettes; working as porters; assisting with crafts; and working in beauty salons. Porters, for example, hired their carts on a daily basis. Rates ranged from 500-5,000 shillings (about $US0.5-5) per day, varying from one place to another and according to the size of the cart.

Operators of kiosks and street vendors worked into the night. Normally, they conducted their businesses in the vicinity of bars and hotels which closed late. Their compensation was typically discriminatory and exploitative.

About 70 per cent (28) of children working in this category were single or double orphans. Of the single orphans, 39 per cent (16) and 12.2 per cent (five), respectively, lived in female- and male-headed households, while 17.1 per cent (seven) were double orphans. The majority of children working in the self-employed sector (63.4 per cent or 26 respondents) were older than 15 years; 31.7 per cent (13) were aged 13-15 years; and 4.9 per cent (two) were younger than 13 years. Most had dropped out of school or had never attended (65.9 per cent or 27 respondents), while 22 per cent (nine) were attending school and 12.1 per cent (five) had completed their primary-school education.

Children engaged in prostitution

It is predominantly children who are socially isolated and trapped in poverty who engage in this category of work. Some experience sexual abuse from guardians or other members of the community before getting dragged into prostitution.

In this rapid assessment sample, five of the children engaged in prostitution were orphans (55.6 per cent), among whom three (33.4 per cent) had lost both parents and two (22.2 per cent) were living in female-headed households. There was one child in this category aged between 10 and 12 years; three children aged 13-15 years; and five children aged 16-17 years.

Among the children involved in prostitution, seven (77.8 per cent) had either dropped out of school or had never attended; one child (11.1 per cent) was still at school (attending occasionally) and one child had completed primary school. Four of the children engaged in prostitution (44.5 per cent) started working when they were older than 15 years; 33.3 per cent (three) started at 12-14 years; and one each (11.1 per cent) started working at the ages of 6-8 and 9-11 years.

A greater proportion of girls than boys engage in this occupation. Following the death of both parents, girl children in particular are often left extremely vulnerable to male demands for prostitution.

These children engaged in two types of commercial sex. Some made this their main source of income, waiting in special places for customers; others engaged in other types of business while remaining receptive to potential customers for sexual services. The first type, witnessed at Vingunguti and Kijenge in Dar es Salaam and Arusha Regions respectively, was open. Payment depended on negotiation and the status of the customer, but ranged from as little as 200 Tanzanian shillings (about $US0.2) to as much as 5,000-10,000 Tanzanian shillings (about $US5-10) per act. The second type of activity was usually camouflaged, with the girls working as bar attendants and beauty salon staff and/or customers. They usually sat at bars waiting for men who would buy them drinks before negotiating services.

The children in prostitution, as did other sex workers, faced problems with law enforcement officials. Police often held them in custody on charges of loitering or vagabondage. Others were refused payment after providing services. (Customer reluctance to pay was also common in sectors such as domestic work, mining and small businesses.) All children involved in prostitution reported having suffered from STDs and HIV infection (one child suspected that she was HIV positive).

Quarrying

As with commercial sex, quarrying invited the participation of such especially vulnerable children as orphans. In most cases, orphans do not have people who can act as referees in the domestic and self-employment sectors. They have no alternative other than entering into heavy and dangerous types of work such as mining and quarrying. Even girl children are thus employed, especially in quarrying or in providing such services for miners as food vending, brewing and selling local drinks. In quarrying operations, girl children collect sand and clay and break up rocks for customers in the building sector.

Two boys said they worked in quarrying. (No girls from the sample reported such work.) One child was part of the 13-15-year age group, and the other the 16-18 year group. One had started working when he was 6-8 years old, while the other had started at the age of 9-11 years. It was surprising, however, to discover that both children were attending school. Clearly, this was due to the Complementary Basic Education (Programme) in Tanzania (COBET). They reported working on weekends and during vacations. One child was staying with both parents, while the other was staying with his mother only. Working conditions in this sector were miserable. Children were working under a sunshade with heavy tools and often suffered health problems, including accidental injuries, severe headaches and body pains. Surprisingly, again, one of the two respondents claimed to suffer no work-related problems.

Problems associated with child labour

Child labour presents many health hazards and problems related to social and economic conditions. Many children reported inadequate pay, overwork, harassment from sons and daughters of employers, including sexual harassment from sons and the bosses themselves. Others reported customers refusing to pay, lack of proper care/guidance and dangerous work. They also suffered, among other things, from burns, cuts or other wounds, coughs, TB, STIs, fungus infections, skin diseases, chemical poisoning and eye infections.

The four work categories referred to above all had negative impacts on the children. Problems included the physical and psychological stresses of working at an early age for long hours while deprived of sufficient sleep. Although most children in the study were older than 13 years, they looked as though they were 6-10 years old, suggesting retarded physical development.

The majority (57.7 per cent) reported job-related harm, while 42.3 per cent reported no harm. (Parents/guardians responded similarly, with 58.3 per cent reporting significant job-related harm to the children and 41.7 per cent reporting none.) Those who responded affirmatively had suffered burns, cuts or other wounds (reported 22 times); coughing, TB and other respiratory problems (reported 12 times); STDs (reported six times); fungus infections (reported six times); skin diseases (reported three times); chemical poisoning, especially in hairdressing salon work (reported three times); eye infections, especially in carpentry (reported twice); beatings (reported once). Most respondents (63.6 per cent) suffered these problems frequently; fewer reported them twice (18.2 per cent), once (12.7 per cent) or three times (5.5 per cent).

Local leaders reported that child labour was related to such problems as:

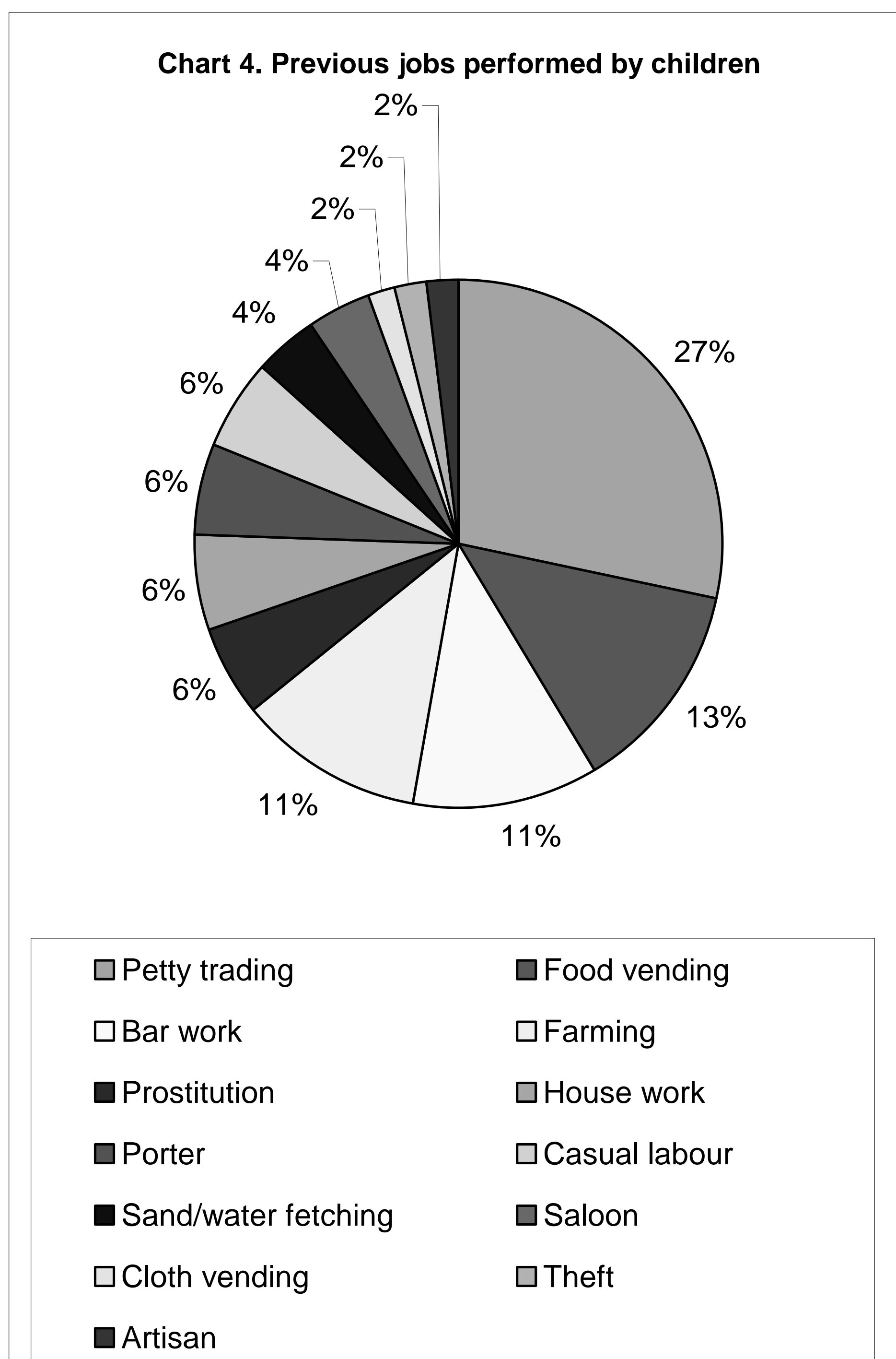
- frequent accidents;
- retarded child growth;
- exposure to infection by HIV/AIDS and venereal diseases;
- deprivation of educational opportunities, ultimately leading to poor socialization and poverty; and
- a tendency to become involved in theft, drug abuse, prostitution and robbery, an observation supported by the parent/guardian and child respondents.

Job mobility was high among child workers within the informal sector. About 43.8 per cent of the children said they had performed other types of jobs before their current ones. Most of the jobs qualified as worst forms of child labour. The most common jobs undertaken included petty trade (15 respondents), food vending (seven respondents), bar work and farming (six respondents each). Others were involved in prostitution, housework, portering and casual labour (three respondents each); sand/water fetching and hairdressing salon work (two respondents each); and cloth vending theft, and handicrafts (one respondent each) (see chart 4).

Children engaged in prostitution faced even greater hazards. Where prostitution was combined with closely associated jobs such as working in bars and beauty salons or in housework, where child sexual abuse is high, more than 25 per cent of those children engaged in other types of activities were at high risk of HIV/AIDS infection.

Mobility among those who worked in prostitution and related job categories, moreover, may spread HIV/AIDS to other categories of employment – especially since the culture of testing for HIV/AIDS status is little developed in the United Republic of Tanzania. The danger of the situation is all the greater, given a tendency for people seeking sexual intimacies to be attracted to newcomers.

Most respondents said they decided to change jobs because of inadequate pay and harsh working conditions. Other reasons cited included: the simple need for change; being salvaged by relatives from the work; falling ill; and being advised to leave jobs because of the risks entailed.



Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Existing measures to curb child labour

Little effort has been made to curb child labour and most of this has been in the formal sector, where some legal safeguards do exist.

Some parent/guardian respondents expressed pessimism about strategies to combat child labour that did not also address the issue of poverty. They argued that neither legislation nor political rhetoric were effective measures in themselves. Curbing child labour, they believed, required the concerted effort of all stakeholders in fighting poverty and ignorance.

For example, the Government has introduced special classes (COBET) for older children who had had no opportunity to attend school at a conventional age. This measure does provide children with an opportunity to learn reading and arithmetic, but it does not assist them in solving the immediate socio-economic problems that compel them to enter the labour market. This rapid assessment indicates that more stakeholders need to be involved in identifying the problems and designing the relevant programmes and projects, inculcating a sense of ownership and encouraging a sustainable response.

Local leaders proposed a number of strategies for the elimination of child labour, including:

- community mobilization;
- counselling of parents, children, teachers and employers with the object of creating an ethos that militates against child labour;
- applying sanctions against employers whenever they do employ children;
- providing a law-and-enforcement framework that can apply sanctions against those involved in recruiting and employing children; and
- designing and implementing a special education programme.

HIV/AIDS awareness

All parents and guardians were aware of the HIV/AIDS pandemic, while 93.2 per cent of the children interviewed indicated that they were aware of the issue. Both groups of respondents said that information about HIV/AIDS was disseminated through media, friends, schools and workplaces, and parents or other relatives. Some respondents were acquainted with cases of HIV/AIDS within their own families and neighbourhoods; others suspected that they themselves were HIV-positive. Responses indicated that HIV/AIDS programmes were conducted in schools or workplaces in the form of discussions/education, counselling, information dissemination, provision of condoms, voluntary services and care/support services.

The rapid assessment tested the respondents' awareness of HIV/AIDS-related issues:

- about 74.3 per cent of the children interviewed said they were aware of protective measures. Another 20.9 per cent indicated that they did not know of any, while 4.7 per cent responded that they were not aware;
- more than a half (58.6 per cent) indicated that mosquitoes could not infect a healthy person with the HIV virus, while 10.5 per cent said that this was a means of transmission and 30.9 per cent said they did not know;
- the majority also indicated that it was possible for a healthy-looking person to be infected with HIV (69.1 per cent), while only 8.9 per cent were ignorant of the fact that a healthy looking person might be a HIV/AIDS victim;
- again, 68.6 per cent believed that HIV/AIDS could be transmitted from mother to child, while 5.8 per cent did not realize this; 22 per cent did not know that a healthy-looking person could be a victim, while 25.7 per cent did not know about transmission of viruses from mother to child.

Table 12 summarizes HIV/AIDS awareness among both children and parents/guardians. The data suggest that both parents and children are widely aware of

HIV/AIDS. Some respondents, however, were unaware of how HIV/AIDS was actually transmitted. Beliefs regarding vectors of transmission varied and included the ideas that HIV could be spread through mosquito bites. More than 30 per cent of the parents and guardians indicated that HIV/AIDS could be transmitted by witchcraft and claimed to know individuals in their home localities who were responsible for such practices.

Respondents also reported knowing people who clearly suffered from HIV, but said that many people were not prepared to acknowledge this publicly because of the attached stigma.

Table 12. HIV/AIDS awareness among children and parents/guardians

Among children					Among parents/guardians			
Issue	Number of respondents			% of total	Number of respondents			% of total
	M	F	T		M	F	T	
Have you heard about HIV/AIDS (Yes)	76	102	178	93.2	21	23	44	100.0
HIV/AIDS programme at school/workplaces (Yes)	51	72	123	64.4	16	19	35	89.7
Existence of any means of protection against HIV/AIDS (Yes)	58	84	142	74.3	19	21	40	90.9
Infection of HIV/AIDS through mosquitoes (No)	49	63	112	58.6	16	20	36	81.8
Possibility of healthy-looking person can be HIV positive (Yes)	60	72	132	69.1	19	20	39	88.6
Transmission of HIV/AIDS from mother to child (Yes)	60	71	131	68.6	20	20	40	90.9
Knowledge of a place which can test for HIV (Yes)	46	65	111	58.1	17	18	35	79.5
Proper usage of condom can protect against HIV/AIDS (Yes)	41	66	107	56.0	12	14	26	59.1
Transmission of HIV/AIDS through witchcraft (No)					15	14	29	69.0
Protection through one uninfected partner (Yes)					17	19	36	81.8

Source: HIV/AIDS and child labour research data from rapid assessment, 2002.

Many of the children interviewed knew the HIV/AIDS pandemic existed and, to some extent, knew of ways the infection could be transmitted. Yet few children (18.3 per cent) had volunteered for HIV/AIDS tests. In contrast, a substantial portion of parents/guardians (40.9 per cent) had been tested.[8] Reasons given among those who had not gone for testing included fear, negligence, cost, lack of personal confidence, age barriers and the logistics of getting to a testing centre. Among the 32 children and 18 parents/guardians who had gone for HIV/AIDS tests, three and one, respectively, remained unaware of the test results – it appeared that they were afraid to collect them, suspecting that they were indeed positive.

Most of the children interviewed (78 per cent) thought that parents, ideally, should tell their children ways to avoid infection, while 22 per cent did not recommend such a strategy. Among the parents/guardians, on the other hand, 90.9 per cent were in favour of educating their children in this regard. Those who opposed this practice claimed that the

[8] Even among those who claimed they had been tested for HIV infection, it had in many cases been involuntary, where medical staff had taken blood for testing when the respondents had fallen ill. The latter were neither informed nor given evidence that the HIV test had been administered.

subject was shameful, frightening for children and children were too young for such information.

Measures proposed to avoid infection included:

- abstinence from sex;
- use of condoms;
- avoidance of shared shaving equipment;
- caution with blood transfusions; and
- voluntary HIV/AIDS testing.

In many areas, the war against HIV/AIDS has been hindered by social and cultural attitudes. This study, for example, revealed that both Muslim and Christian clerics and other community leaders were strongly predisposed to believe that HIV/AIDS victims had violated religious and social norms, and that the infection was punishment for such sins as adultery. These religious leaders resisted promotion of condoms as one means to fight the pandemic, claiming that this policy would only encourage more adultery. The argument tended to be that, unless people avoided promiscuity, HIV/AIDS was there to stay. The only real solution, according to this viewpoint, was to observe religious norms and guidelines.

Women, on the other hand, especially housewives, tended to blame spouses or other sexual partners for infidelity, and held promiscuity responsible for the pandemic. At the same time, those women had neither the power to abstain from sexual relations with their spouses, nor could they demand the use of condoms. Most remained locked into relationships where they believed that HIV/AIDS infection was likely. Some managed instead to end the relationships.

Increasing alcohol abuse is also blamed. The proliferation of bars in the vicinity of residential neighbourhoods encourages many people, including children, to hang around drinking or engaging in petty trade. Drunken people are more likely to infect children with sexually transmitted diseases, including HIV/AIDS. Unfortunately children, especially girls, lack the experience, social skills, information and services to avoid such risks. Some respondents recommended that the Government legislate special zones for selling and drinking alcohol.

Child labour and HIV/AIDS

A correlation exists, by way of HIV/AIDS orphans, between the pandemic and an increasing incidence of child labour. And HIV/AIDS is more than simply one among other direct causes of child labour – it also aggravates a number of these other problems, threatening a geometrical rise in the incidence of child labour.

One important way of combating child labour, therefore, is to contain the spread of HIV/AIDS. As it stands, HIV/AIDS is the leading cause of death among young parents, thereby producing an ever-increasing number of orphans.

The presence of parents is the best way to ensure proper childcare, guidance and protection, and to limit the number of children engaged in child labour. The death of their parents pushes children into an exploitative labour market. This situation is exacerbated by increasing poverty due to dwindling family income and other resources through meeting medical costs of sick parents, etc., before death from AIDS. The extended family, the

traditional means of support for orphans, too often does not have the resources these days to provide for these children.

In the absence of social support systems outside the extended family, and where basic social services are inadequate, orphans run greater risks of malnourishment and stunted growth than do children with parents. They are often the first to be deprived of education when extended families cannot afford to educate all children in the household. These orphans are then forced by socio-economic circumstances rather than by their economic choices to enter the labour market early.

A bad situation is then exacerbated by the fact that many of these children wind up in the worst forms of child labour. Most working orphans complained of a whole complex of problems, among them going without food, forced initiation to commercial sex work and failure to receive wages.

Another contributing factor is the social stigma so often attached to children infected with or affected by HIV/AIDS. [9] Guardians or foster parents have to be especially sensitive in caring for HIV/AIDS orphans. The attached social stigma can lead the children to believe themselves to be in some way abnormal. Some become severely depressed, avoiding social contact and losing hope of a happy life. Feeling that their peers do not accept them at school or at play, some children run away from community prejudice, migrating from rural to urban areas or from one city to another to seek support for alternative lives.

Children who have both parents in good health have a greater chance of staying alive, [10] excelling at school and becoming responsible citizens. Working children tend to be exposed to HIV/AIDS infection, to work under hazardous conditions, to lose their rights to enjoy a proper childhood and to lose the opportunity to develop their capacities and thereby live a more fulfilled life while contributing more to society. Rather than surviving and realizing their potential as persons, they face the prospect of a relentless struggle for survival, for basic education, for love and affection and for protection against exploitation, abuse and discrimination.

Meeting the needs of these children represents a new major challenge for local communities, governments, and international organizations. The lack of parental upbringing, nurturing, guidance, sense of identity, status and, above all, education jeopardizes the contribution they can make to national development.

[9] Prejudice against HIV/AIDS victims does exist, although people tend to hide it. One HIV/AIDS sensitization workshop, for example, revealed that about 85 per cent of health staff, especially in the village health centres, were worried about HIV infection through contact with infected patients (*Uhuru*, 14 March, 2002). Similar observations were made in Keko and Mbagala Wards in Temeke District; Mvuti Ward, on the outskirts of Ilala District; Moshono, Singisi and Moivo Wards in Arumeru District; and Themi and Sekei wards in Arusha Municipality, where this study was conducted.

[10] HIV/AIDS claims the lives of parents as well as those of children through mother-to-child transmission and early unsafe sexual practices.

4. Conclusions and recommendations

Surprisingly little effort has been made to relate HIV/AIDS and the increasing incidence of child labour in developing countries. In general, the impact of the HIV/AIDS pandemic on Tanzania's population structure and socio-economic development has not been well established, particularly in its effects on the labour market and child labour. This rapid assessment tested the proposition that HIV/AIDS is one of the main factors linking orphanhood and child labour in the United Republic of Tanzania and this report proposes intervention strategies.

Methodology

Data collection applied two main methods: questionnaires and focus group discussions (FGD). Respondents were of three types:

- 191 working children engaged in four types of labour taken as representative of other types of child labour commonly found in the United Republic of Tanzania: the self-employed; those engaged in commercial sex; domestic workers; and those involved in quarrying;
- 44 parents/guardians; and
- 42 local leaders and key informants, as well as several other informants such as employers, taxi drivers and religious leaders.

Main findings

The study produced a number of significant findings. The main ones are outlined below.

Orphaned children and child labour

The rapid assessment concluded that orphaned children were compelled to enter the labour market to survive and/or to help support other family members.

The study revealed that more than 60 per cent of children working in the informal sector were either single or double orphans. (Most of the dead parents had died from HIV/AIDS-related complications.) About 70 per cent of the children involved in the self-employed sector, 60 per cent of those in domestic work and 55 per cent of those in prostitution were either single or double orphans.

Most of these children had dropped out of school or never attended school. More than 65 per cent of the children involved in self-employment, 60 per cent of those in domestic service and 77 per cent of those in prostitution had dropped out of school.

Among those engaged in prostitution, close to 60 per cent of children were aged 15 years or younger. In domestic service this was true of about 30 per cent and of about 40 per cent in self-employment.

Family structure and responsibilities

About 60 per cent of parents/guardians said they were supporting at least one dependent child. Death of the children's parents was given as the main reason. Again, most of the parents had reportedly died from HIV/AIDS-related causes.

Children from poor households were more vulnerable to child labour than those from relatively affluent households. The majority of the families surveyed were too poor to meet the demands, including schooling, of supporting the extra children. They themselves worked in the informal sector and they introduced the children, especially orphans, to income-generating activities to supplement family labour resources and income.

Once accustomed to working, these children often went on to seek independent employment outside the family boundaries. In this way children became exposed to worst forms of employment and HIV/AIDS infection.

Gender dimensions

Most of the girls worked as domestics or in prostitution. In self-employed activities, girls were found in hairdressing salons, kiosks, shops and food stalls. In mining, they were engaged in crushing stones and carrying gravel and clay. Otherwise, the majority of child workers in mining and most self-employment activities were male.

Female children were also required to shoulder heavy household chores and thus were most vulnerable to dropping out of school to take care of the family whenever parents fell sick or died.

Girl children, furthermore, tended to experience the most hazardous work environments, since they were often exposed to forced sex by employers and others and, eventually, to HIV/AIDS infection.

We may conclude that girls in the United Republic of Tanzania are more vulnerable than are boys to both child labour and to HIV/AIDS.

Educational dimensions

About 67 per cent of the single- or double-orphan respondents never attended school and about 62 per cent had dropped out of school. The majority of dropouts said that they had left school before engaging in child labour. The major reason cited was lack of money to meet the cost of necessities for themselves and their families. The death of one or both parents due to HIV/AIDS or other causes was another major factor behind dropping out.

Many of the dropouts showed interest in returning to school if educational costs could be met. These data suggested that orphans were most vulnerable to lack of educational opportunities and, when enrolled, were more likely to drop out of school and go to work.

Nature of jobs

The children worked without clear contracts stipulating terms and conditions of employment. Consequently, they worked more than eight hours a day. At the same time, they received little payment or were merely provided with meals and accommodation plus other basic human requirements such as clothes and medicine when they fell sick. In many instances, their employers or customers refused to pay them as (orally) agreed. Some were forced into sexual relationships with their employers or other members of the family. Their working environments exposed the children to health hazards including physical stunting

and social-psychological problems that impaired or obviated their development into responsible adults.

HIV/AIDS awareness

Over 90 per cent of the respondents indicated awareness of HIV/AIDS. They said that mass media, friends and workplace communications were the main means of promoting HIV/AIDS awareness. The safest means of preventing HIV/AIDS infection, it was widely assumed, was abstinence from sex. The majority of respondents also recognized condom use as another means. Girls engaged in prostitution, however, sometimes found it difficult to insist on the use of condoms with customers who said it interfered with their pleasure.

A substantial proportion of respondents (30 per cent) believed that supernatural power was one means of HIV/AIDS transmission, while others considered mosquitoes to be a vector. Community mobilization is evidently needed to ensure people are fully aware of HIV/AIDS modes of transmission and their consequences.

Although the majority of children in the study knew the location of HIV testing centres, they did not take advantage of such services. The main reason cited was fear. They said that many people died soon after becoming aware that they were affected, so it was better to live without having the test. Other reasons included the costs or, since the children were too busy earning an income, the logistics of getting to the centre.

It was suggested that parents or guardians needed to discuss the HIV/AIDS pandemic with their children, sharing knowledge regarding modes of transmission and means of avoiding infection.

HIV/AIDS-related social stigma did not devolve directly on parents who were victims. Family members, it appeared, cared for them sympathetically. People outside the family, however, imposed moral judgements on HIV/AIDS victims, blaming their problem on involvement in prostitution, for example. For the affected children, who were often ostracized, it was even worse.

Main policy implications and recommendations

The United Republic of Tanzania has formulated a national policy on HIV/AIDS and the Tanzania Commission for AIDS (TACAIDS) has been established to regulate the roles of the various actors in containing the HIV/AIDS pandemic. Nevertheless, other issues require the attention of the Government and the society in general.

Orphanages and HIV/AIDS

- The society and the Government need to develop clear plans to help and support those affected by the scourge, especially orphans and children living with the disease.
- Existing centres should be improved, and more established, to provide as many orphans as possible with access to basic education and other skills training. The available centres have inadequate facilities and are overcrowded.
- More effective community sensitization programmes are needed to ensure that HIV/AIDS orphans and other people living with the scourge, especially children, live in harmony in society, free from discrimination or stigmatization.

- Action-oriented social and economic programmes should be designed to involve communities in working against the spread of HIV/AIDS and in dealing with HIV/AIDS orphans and those infected.
- More informed and more effective participation of religious organizations and other social groups should be sought in community mobilization campaigns against the spread of HIV/AIDS.
- A national campaign should aim at educating communities about the effects of HIV/AIDS, not only on individuals but also on the society and nation at large.

Child labour and its effects

- Practicable child labour laws addressing the real issues need to be passed and enforced.
- The general public needs to be empowered regarding the social, economic, political and legal dimensions of the issue, if they are to support measures against child labour.
- Basic education should be provided free of charge at all levels to children who cannot afford to meet the costs of education.
- If the Government and NGOs provided more and better facilities to deal with the growing number of orphans, the number of child labourers would be reduced.
- Training programmes should be designed and established for HIV/AIDS orphans and children who have completed their basic education before the age of 18 years.

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Appendix 1

Children's questionnaire [1]

Personal particulars

1. Name of region
   - Dar es Salaam
   - Arusha
2. Name of district
   - Ilala
   - Temeke
   - Arumeru
   - Arusha
3. Name of the ward ....
4. Sex
   - Male
   - Female
5. Age ....
6. Place of birth ....
7. In which district have you lived before?...
8. Why have you moved? ....
9. How many people live in your household? ....
10. Do you stay with your father?
    - Yes
    - No
11. Do you stay with your mother?
    - Yes
    - No
12. Do you stay with your sisters?
    - Yes
    - No
13. Do you stay with your brothers?
    - Yes
    - No
14. Do you stay with your younger brothers/sisters?
    - Yes
    - No

[1] Also available in Swahili.

15. Do you stay with your employer?

    Yes

    No

16. Do you stay with your guardian?

    Yes

    No

Educational information

17. Are you attending school at the moment?

    I never went to school

    Absconded

    Attending school

    Completed std. vii

18. How often do you attend school?

    Not applicable

    Every day

    Three times a week

    Four times a week

    It depends on the situation

19. Who pays for your school requirements (fees)?

    Not applicable

    Myself

    Parents

    Guardians

    Voluntary organization

20. If absconded from school, what were the reasons for absconding?

    Not applicable

    School is far away

    Unable to pay school requirements

    Parents died

    Family does not allow me to go to school

    I do not like school

    I was sick

    So as to support my family

    To earn a living/income

    Pregnancy

    Divorce of parents

21. When did you abandon school? *(mention year)*

22. Would you like to go back to school?

    Yes

    No

23. If not give reasons for not returning to school.

    Not applicable

    School is far away

    Unable to pay school requirements

    Family does not allow

    I am sick

    So as to support my family

    So as to support the sick parent(s)

    To earn a living/income

24. Was there any other person in your family who did not attend school?

    Mother

    Father

    Sister

    Brother

    None

    Nobody attended school

Parental information

25. Is your mother alive?

    Yes

    No

26. If alive, is she working?

    Yes

    No

27. If yes, what is she doing?

    Food vendor

    Petty trade (kiosk)

    Artisan

    Farmer

    Government employee

28. If she is dead, had she previously been ill for a long time?

    Yes

    No

29. What was her age at the time of her death?...................................

30. What were the causes of her death?

    TB

    Accident

    Chronic malaria

    Fever (headache, etc.)

    Child-birth related

    Abdominal related

Heart problems

Killed/witchcraft

HIV/AIDS

Others

Do not know

31. Do you remember the year when she died?

    Yes

    No

32. If yes, which year?...

33. Is your father alive?

    Yes

    No

34. If alive, is he working?

    Yes

    No

35. If yes, what is he doing?

    Food vendor

    Petty trade (kiosk)

    Artisan

    Farmer

    Government employee

    Labourer

36. If he is dead, had he previously been ill for a long time?

    Yes

    No

37. What was his age at the time of his death? ....

38. What were causes of his death?

    TB

    Accident

    Chronic malaria

    Fever (headache, etc.)

    Abdominal related

    Heart problems

    Organ failure

    Killed/witchcraft

    HIV/AIDS

    Others

    Do not know

39. Do you remember the year when he died?

    Yes

    No

40. If yes, which year?..

41. What was the quality of your life like before the death of your parents?

Similar experiences

Still young

Life was miserable

Life is miserable

Parents separated

Work-related information

42. In which sector are you working?

Domestic work

Mines and quarries

Self-employment

Prostitution/commercial sex

43. Who is responsible for household chores?

Mother

Sister

House girl

Myself

Mother/sisters

Mother/sisters/myself

Brothers

All

Father and myself

44. Which household chores do you perform?

Cooking

House cleaning

House repairs

Purchases market/shopping

Care for the children

Looking after cattle

Nothing

All of the above

45. How many hours do you work per day?.............................

46. How much are you paid per month? ....

47. If not paid, what other support do you get?

Basic necessities support (such as)

Shelter/clothes

School fees

Any other................................

48. At what age did you start working? …………………… years.

49. What problems do you face as a result of this job?

    Little pay
    Harassment from sons
    Sexual harassment from customers
    Sexual harassment from police
    Little food
    Overworked/tired
    Lack of proper care
    Risky work/danger
    No employment
    Customers resist paying
    No payment (salary)
    No problems

50. Do you remember when you started working?

    Yes
    No

51. Which year did you start working? ....

52. What were the reasons you started working?

    Gain experience
    Supplement family income
    Help pay family debt
    Earn money to establish my business
    No school nearby
    Pay school fees
    Be economically independent
    Others

53. What are terms and conditions of employment?

    Permanent
    Short term/casual
    Seasonal/school vacation
    Worked for different
    On daily/weekly basis
    No contract
    Family work

54. Have you suffered any harm from your work?

    Yes
    No

55. If yes, mention the harm you have suffered.

    Skin disease
    Coughing/TB
    Burns/cuts/wounds

Beatings

Chemical poison

Venereal disease

Fungus

Others

56. How often have you suffered such injury?

Once

Twice

Three times

Often

57. How do you spend your income/salary?

Give it all to parents/guardians

Give part of it to parents/guardians

Pay for my school requirements (fees)

Buy food

Leisure

Medical care

Save

Others

58. Have you ever performed any other work before?

Yes

No

59. If yes, describe the work.

Housework

Cloth vending

Farming

Food vending

Petty trade

Pottery

Casual labour/employ

Bar work

Artisan

Hairdressing salon

Theft

Prostitution

Sand/water selling

60. Why did you abandon that work?

Does not pay

Tough work

Advised to leave it

Falling sick

Need for change

Salvaged from the work (by NGOs or Government)

Motivated by friends

HIV/AIDS information

61. Have you heard about HIV/AIDS?

    Yes

    No

62. Where did you get this information?

    From parents

    From friends

    From relatives

    Through media (TV, radio, newspapers)

    School/work/office

    Various sources

    Suspecting yourself to be HIV positive

    Encountering other HIV/AIDS cases

    Any other

63. Are there HIV/AIDS programmes at schools?

    Yes

    No

64. How are those programmes conducted?

    Information dissemination (fliers, brochures, etc.)

    Discussion/education (skilled educators)

    Availability of condoms

    Voluntary testing

    Counselling

    Others (mention)

65. Are there any means by which an individual can protect herself/himself from HIV infection?

    Yes

    No

    I do not know

66. Can HIV/AIDS be transmitted through mosquito bites?

    Yes

    No

    I do not know

67. Is it possible that a healthy-looking person is HIV/AIDS positive?

    Yes

    No

    I do not know

68. Can the HIV infection be transmitted from mother to child?

Yes

No

I do not know

69. Have you been tested for HIV/AIDS?

Yes

No

70. If not, what reasons have prevented you from being tested?

Fear

Not important

Time not yet conducive

Logistics

Lack of personal confidence

Age barrier

Others

71. If yes, were you informed of the results?

Yes

No

72. Do you know of a place where you can get an HIV/AIDS test?

Yes

No

73. Can proper usage of condoms prevent HIV/AIDS infection?

Yes

No

I do not know

74. Is it appropriate for parents to discuss HIV/AIDS and related information with their children?

Yes

No

I do not know

75. If not, why not?

Shameful

Children may be frightened

Young children should not be exposed to this information

76. If yes, what should be the content of the discussion?

Avoid sharing shaving equipment

Take care with blood transfusions

Voluntary HIV testing

Proper use of condoms

77. Have you suffered humiliation because you are an HIV/AIDS victim? (stigma, humiliation, etc.)

    Yes

    No

78. How were you humiliated?

    Neglected/isolated

    Teased

    Not allowed to go to school

79. Who was behind this humiliation?

    Other children

    The community in general

    Parents

    Guardians

    Step parents

    Sisters/brothers

Children engaged in prostitution

80. Did anybody inform you of the terms and conditions of the work?

    Yes

    No

81. Were you informed clearly of your duties and conditions of employment?

    Duties of the job

    Remuneration systems and other benefits

    Payments for each sex act

    Working area

82. Who explained to you your duties and responsibilities?

    Employer/group leader

    Customers

    Co-workers

    Any other (specify)

83. Are there clearly stipulated relations between you and your clients?

    Yes: clearly stated and stipulated

    Not stated, but expected

    Not stated, but have to be negotiated with the clients

84. What services and support do you get?

    Clothing/uniforms

    Accommodation

    Meals

    Legal support

    Credit support

    Free medical treatment

85. Have you been informed of health hazards, including work-related diseases

Yes

No

86. If yes, who informed you?

Group leader

Medical staff

NGOs/volunteers

Media

Social welfare worker

Co-workers

87. Do you have adequate preventive and precautionary information regarding HIV/AIDS?

Adequate

Not adequate

Never given any information

88. Do you take precautionary and preventive measures against HIV and related diseases?

Yes

No

89. If not, what are the obstacles?

Clients resist usage/demand

Negligence

Non-availability

Others

90. How often do you have medical check-ups?

Few occasions

Frequently

Never check

91. Who organizes your medical check-ups?

Employer/manager

Myself

NGOs

92. Have you ever been infected with any disease as a result of this work?

Yes

No

93. If yes, what diseases did you suffer?

Venereal disease

HIV/AIDS

Skin diseases

Other

94. Who paid for your medical expenses?

Group leader/employers

Myself

Counselling centre

Free service/Government

95. Are you supplied with condoms in your club/workplace?

    Establishment provides

    Establishment does not buy for us

    Others

96. How many customers have you used condoms with, among the last five encounters?

97. If you do not use condoms, why not?

    Customers pay more if you do not use

    Customers refuse to use

    No condom available

    Did not know/care to

98. If condoms are not used, what are the reactions from customers?

    Customers refuse to

    No condom available

    Others

99. Would you encourage your sister/brother to work in this area?

    Yes

    No

100. If yes, what are the reasons?

    It is profitable

    Needed to earn a living

101. If not, what are the disadvantages?

    Danger of HIV/AIDS

    Not socially respected

    Others

102. Do you stay with other people in your household? *(specify)*

    Uncle

    Aunt

    Cousin

    Niece/nephew

    Concubine

    Family friend

    NGO

    Grandparents

    Son/daughter

Appendix 2

Questionnaire for parents and guardians

Personal particulars

1. Name of the region
   - Dar es Salaam
   - Arusha
2. Name of the district
   - Ilala
   - Temeke
   - Arumeru
   - Arusha
3. Name of the ward ....
4. What is your sex?
   - Male
   - Female
5. What is your age? …………………………………….
6. Marital status
   - Single
   - Married
   - Divorced
   - Widowed
7. How many children do you have in your household? ....
8. How many boys? ....
9. How many girls? ....
10. How many are your own children?..
11. How many are just dependants? ....
12. What kind of relationship do you have with them?
    - Niece/nephew
    - Young brother/sister
    - Cousin
    - Grandson/granddaughter
    - Other relationship ....
13. Why do you live with these children?
    - Their parents are sick
    - Parents dead
    - Economic hardship
    - Working
    - Married

Attending school

Others

14. Do you have a child under 18 years living outside?

    Yes

    No

15. If yes, is it a male or a female?

    Male

    Female

16. Why is he/she staying there?

    Parents died

    Economic hardship

    Absconded from school

    Attending school

    Others

17. Do you live with any non-biologically related child?

    Yes

    No

18. If yes, why do you live with such child?

    Parents died

    Poor family

    House girl/boy

Educational information

19. Are children in your household attending school?

    Yes

    No

20. If they attend school, how often?

    Every day

    Four times a week

    It depends

21. What level of education have they attained? ....

22. Who pays school fees and other requirements for the children?

    Free education

    Parents

    Other relatives

23. If they do not attend school, why not?

    Absconded school

    Failed to pay school

    Completed school

    Sick/disabled

    Others

24. If he/she has abandoned school, give reasons.

    Unable to pay

    Child does not like

    Petty business/labourer

    Others

25. When did he/she abscond? ....

26. Would you like your child to go back to school?

    Yes

    No

27. If not, what reasons are there for not going back to school?

    Child does not like

    Lack of funds for school fees

    The child helps the family to earn income

28. What steps should be taken to ensure children go to school?

    Provide absolutely free education

    Teacher/parent should be close

    Community support for orphans

    Others

Child labour

29. Do you have any children under 18 years who are working?

    Yes

    No

30. If yes, at what age did he/she start working?...

31. Are there any compelling reasons for starting work?

    Need for training/experience

    Contribute to family income

    To get working capital

    Economic independence

    Support family project

32. What types of work are the children doing?

    Prostitution

    Hairdressing salon

    Household services

    Household chores

    Small business

    Mining and quarrying

33. What are the terms and condition of the work?

    Permanent

    Seasonal/temporary

34. What are the forms and type of remuneration?

Money/salary

Commodities/things in kind

Nothing

35. Does the child contribute to the household income?

    Yes

    No

36. How does he/she use his/her income?

    Gives it all to parents

    Gives parents part of the income and saves the balance

37. Has he/she suffered any harm/injury from working?

    Yes

    No

38. If yes, mention the harm suffered.

    TB/coughing

    Venereal diseases

    Burns/skin diseases

    Others

39. Do you think the work involved is dangerous/Are there risks involved?

    Yes

    No

40. Who is responsible for household chores?

    Mother

    Sister

    Mother and sister

41. At what age may a child be allowed to work? ....

HIV/AIDS-related information

42. Have you heard about HIV/AIDS?

    Yes

    No

43. Where did you get this information?

    Parents

    Friends

    Relatives

    Media

    School

    Religious centres

    Hospital/dispensary

    Office/workplace

44. Are there HIV/AIDS programmes in the workplace?

Yes

No

45. How are those programmes conducted?

Information

Discussion/education

Provision of condoms

Counselling

Voluntary testing

Care and protective services

Others

46. Are people able to protect themselves from HIV/AIDS?

Yes

No

47. Can HIV/AIDS be transmitted through witchcraft?

Yes

No

48. Is it possible that a healthy-looking person can have HIV/AIDS?

Yes

No

I do not know

49. Can one be protected by remaining constant with one partner?

Yes

No

I do not know

50. Can HIV/AIDS be transmitted through mosquito bites?

Yes

No

I do not know

51. Can HIV/AIDS be transmitted from mother to child?

Yes

No

I do not know

52. Have you been tested for HIV/AIDS?

Yes

No

53. If not, why not?

Fear

Not important

54. If yes, were you informed of the results?

    Yes

    No

55. Do you know a place where you can have a check-up?

    Yes

    No

56. Can proper use of condoms prevent HIV infection?

    Yes

    No

    I do not know

57. Is it proper for parents to discuss HIV/AIDS with their children?

    Yes

    No

    I do not know

58. If not, why not?

    It is shameful

    Worrying children

    Others

59. If yes, what should parents discuss with their children?

    Use of condoms

    Abstaining from sex

    Avoid sharing of razors

    Care in blood transfusions

    HIV testing

    Others

HIV/AIDS-affected parents/guardians

60. Has your child's school attendance been affected as a result of your health problems?

    Yes

    No

    I do not know

61. If yes, what are the reasons?

    Poor economic condition

    Unable to pay for school fees

    No proper care

62. Have you ever received any support after falling sick?

    Yes

    No

63. If yes, what types of support have you received?

    Food

    Shelter

Money

Others

64. Has the support been enough for all school requirements?

Yes

No

65. If not, why not? ....

66. Who supports you when sick?

Husband/wife

Children

Sister

Brother

Friends

Others

67. What type of support do you receive?

Taking care of children

Household chores

Cooking

Others

68. Are your children aware of your HIV-positive status?

Yes

No

I do not know

69. Have you talked with them about your HIV status?

Yes

No

70. Why have you not informed them?

Children still too young

Disappointed

Difficult to talk to

It is shameful

The news of infection has been too recent

71. Do you think that HIV parents should inform their children of their status?

Yes

No

I am not sure

72. If yes, why?

Psychological preparation

Taking precautions

Knowing the truth

Preparing for future

Other

73. If not, why not?

    Demoralizing

    Does not help

    Difficult to discuss

74. Is there anybody who will take care of the children?

    Yes

    No

75. If yes, what is your relationship with him/her?

    Husband/wife

    Sister

    Friends

76. How often does he/she visit you?

    We live together

    Once per week

    Rarely

77. How do you evaluate his/her support?

    Very high

    Average

    Is not known

78. What other steps should be taken to support him/her?

    Parent’s openness to children

    Government support to orphans

    Medical support

    Moral and religious

    Economic empowerment

    Others

Appendix 3

Questionnaire for key informants

Personal particulars

1. Name of the region

    Dar es Salaam

    Arusha

2. Name of the district

    Ilala

    Temeke

    Arumeru

    Arusha mjini

3. Name of the ward ....

4. Which work are you doing?

    Ward executive officer

    Local officer

    Petty trader

    Businessman/woman

    Artisan

    Farmer

    Religious leader

    Businessman/woman

5. Do you have any information about child labour?

    Yes

    No

6. If yes, in which employment sector do children in your area work?

    Food vendor

    Cloth vendor

    Petty trade

    Clay/stone pottery/quarries

    Others

7. Which factors do contribute to child labour?

    Death of parents

    Economic hardship

    Parents' illness

    Ambitious children

    Death of parents

    Absconding from school

8. What problems can result from child labour?

    Accidents

    Retarded growth

    HIV/AIDS and other venereal diseases

    Lack of education

    Theft

    Life hardship

    Poor socialization

9. What steps are taken to curb children abandoning school?

    Parents taken to task

    Children are taken back to school

    Special education programmes

    Mobilization of community

    No strategies to curb child labour

    Legal support

    Counselling to return to school

10. Is there any relationship between HIV/AIDS and child labour?

    Yes

    No

11. If yes, what is the relationship?

    Lack of education

    Worse working environment

    Luxurious spending

    Health problems

    Economic problems

    Forced sex by employer

    Lack of parental care

    Desire for money

12. Are there any steps being taken to curb child labour?

    Yes

    No

13. Mention strategies taken, if any.

    Children are taken back to school

    Special education programmes

    Counselled to go back to school

    Mobilization of community awareness

    Employers taken to task

    Legal support

14. Are there any steps taken to curb the impact of HIV/AIDS on children?

    Yes

    No

15. Can you give us your opinion, if any, on child labour?

    Use of condom

    Abstaining from sex

    Counselling

    Community mobilization

    Education and training

    Legal support

16. Do you wish to make any other comments about child labour and HIV/AIDS?

    Provide children with free education

    Improve parents' income

    Legal support

    Community mobilization

    Abstaining from sex

    Economic empowerment

    Loans for small groups

    Any other