Children’s Vulnerability to HIV/AIDS, Poverty and Malnutrition in Buhaya: Advancement through women’s empowerment

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Abstract
Children form a vulnerable segment in society in general, given their dependence on adults for their immediate needs. The impacts of HIV/AIDS result in increasing children’s vulnerability to poverty, malnutrition, HIV/AIDS and related illness. The HIV/AIDS epidemic also causes many children to be orphaned and raised by grandparents and members of their extended family who may already struggle for their own livelihood security. This paper focuses on children’s particular vulnerability to the vicious cycle of poverty, malnutrition and HIV/AIDS in Buhaya in northwestern Tanzania, a region that has been severely impacted by HIV/AIDS for nearly three decades. Buhaya has also experienced a decline in access to fertile land and decreasing agricultural productivity for the past three decades, causing and exacerbating widespread household poverty, food and nutrition insecurity and fueling the HIV/AIDS epidemic and its cycles. In this chapter, I describe some of the very vulnerable situations children in Buhaya are living in, as witnessed during one year of field research in the village of Nsisha. I highlight the plight of children living with single mothers who are often viewed as ‘illegitimate’ and therefore not recognized by patriarchal Bahaya clans. This precarious situation results in the deprivation of children’s rights to land inheritance as well as to basic needs such as food and nutrition security, healthcare, education and a viable future in this predominately semi-subsistence agricultural society. Given that children’s and women’s health, nutrition, and poverty work in synergy and interdependently affect each other, I argue that empowering women and upholding their human rights is crucial to breaking inherited cycles of poverty and its manifestations and to advancing the welfare and future of children in Buhaya.

Background of Research and Methods Used
The material for this paper emanates from broader socio-cultural anthropological research conducted in 2005-06 on the connections of widowhood, food insecurity and HIV/AIDS in the village of Nsisha located approximately twelve kilometers from Bukoba Urban in northwestern Tanzania. At the beginning of this research I conducted a village survey whereby my field assistant and I interviewed the head or other available adult member of each household in the village. We gathered socioeconomic information based on the type of housing inhabitants occupied (such as mud, brick, cement and whether the roof was constructed from thatch or iron sheets), assets owned (such as livestock, number of farms, bicycle, radio), and number of people living in the house and their gender, age and relation to household head. Afterwards, we conducted over 180 structured and unstructured interviews with widows, widowers, (married) couples, single women with children, and an orphan-headed household and obtained information on personal histories, agriculture, gender, widowhood, poverty and HIV/AIDS. During the year of research I had the opportunity to observe the conditions under which children, particularly orphans and (other) children living in the poorest households, live in Nsisha. In addition, through the interview questions and open-ended answers, I gained an understanding of some general and specific challenges that children face and how many of them are entrapped in situations of poverty, malnutrition and illness.
HIV/AIDS: Onset and aftermath

The first case of HIV/AIDS was diagnosed in 1983 (Rugalema, 1999; Iliffe, 2006), a time which coincides with increasing population, increasing land pressures due to a patriarchal system in which bibanja (plural of kibanja) parcels are bequeathed primarily to the eldest and youngest sons (Culwick, 1938; Cory & Hartnoll, 1971), a decline in soil fertility and the aftermath of the Tanzanian-Ugandan War (Kaijage, 1993; Lyons, 2004; Iliffe, 2006). This was a volatile time in Buhaya marked by various forms of socio-culture and economic decline, and widespread household poverty and food insecurity (Rugalema 1999, 2004). The results of the war brought many refugees into the area, which further compounded the ecological challenges as people competed for important livelihood resources (Lyons 2004). The war and the active black market, or magendo, are blamed for instigating the first epicenter of HIV/AIDS (Rugalema 1999, 2004; Lyons 2004), of which Buhaya was part. Rape during war, extra-marital sexual encounters, and high social interaction and prostitution along the border served as major venues for contracting and spreading HIV/AIDS to the hinterlands of Buhaya, creating a region that was truly and shockingly devastated by an HIV/AIDS pandemic (Kaijage 1993; Lyons 2004).

For over three decades Buhaya has experienced the wrath of the HIV/AIDS pandemic. Its coincidence with deteriorating ecological challenges (Tibaijuka 1997) created an upheaval in the traditional Bahaya agricultural and cultural system as they once knew it (Rugalema 1999, 2004). Fewer households are able to own and maintain cattle, which is an offshoot of a 1900’s rinderpest epidemic (Kjekshus 1996; Piters 1999 cited by Mitti and Rweyemamu 2001) compounded by decades of increasing land pressure, decreasing grazing land, and widespread poverty (Rugalema 1999). During the HIV/AIDS crises, cattle serve as disposable assets which provide capital for patients who are suffering from and who eventually die from AIDS (Rugalema 1999, 2004). Often money is eaten up by medical expenses from either traditional or biomedical treatments and funerary expenses (Tibaijuka 1997; Rugalema 1999, 2004). The decline in cattle negatively impacts the kibanja since lack of manure to enrich the poor soils leads to lower banana productivity (Bajjukya 2004). The kibanja also suffers neglect as time is devoted to caring for patients and observing funerary and mourning rituals. As a result, it becomes a bush, and stubborn weeds take over, making it very difficult to preserve (Rugalema 1999), or restore. This neglect of the kibanka attracts insects known as ekiuka which ravage banana trees and farms (Rugalema 1999, 2004). At the onset of HIV/AIDS, ekiuka was already devastating the kibanja, and the two ecological travesties resulted in the Bahaya using one term, ekiuka, to refer to the pathogens which destroy healthy banana plants and the pathogens which lead to AIDS and destroy the Bahaya people (Rugalema 1999, 2004; Githinji 2008).

Since its inception in 1983 a generation of people, primarily parents, have been wiped out by the HIV/AIDS pandemic (Kaijage 1993), leaving a generation of vulnerable children who contract it and die, while others are left destitute, or are orphaned and forced to live with remaining relatives (Urassa et al. 1997; Foster and Williamson 2000; Barnett and Whiteside 2002; de Wagt and M. Connolly 2005; Turnushabe 2005). Some orphans, such as a case mentioned later in this chapter, become the heads of households after the death of both parents.

One of the greatest impacts of the HIV/AIDS pandemic is an increase in widowhood, female-headed households and insecure relationships, since AIDS is both a cause and consequence of distrust, separation, divorce and death. Since men tend to die earlier than women, there are more paternal orphans than maternal orphans (Gillespie et al. 2005). In most cases paternal orphans most often reside with their mother, grandmother or female relative (Rugalema 1999; Foster and Williamson 2000; Barnett and Whiteside 2002; de Wagt and M. Connolly 2005). In situations where a wife dies before the husband, he usually remarries and his children are not always counted as orphans (Gillespie et al. 2005). A child who loses both parents is considered a double orphan and similar to cases of paternal orphans, these children often go to live with a female relative (Urassa et al. 1997; de Wagt and M. Connolly 2005; Gillespie et al. 2005; Iliffe 2006; Beegle et al. 2007).

HIV/AIDS has also resulted in a generation of people born into the HIV/AIDS era who see AIDS like malaria, something that is common, chronic, ubiquitous and inevitable—a normal part of everyday life (Rugalema 1999, 2004). In fact, several informants in their twenties and thirties stated that HIV/AIDS is ‘the disease of the time.’ This normalization leads people to take risks and become numb to the dire consequences that HIV/AIDS has on their life, and that of their dependents, family, and larger community. This embodied normalization of HIV/AIDS is also a coping mechanism since life inevitably has to go on (even) during times of crises (Rugalema, 1999, 2004). However, I argue, becoming numb to or seeing HIV/ AIDS as a normal part of everyday life ultimately results in the intensification and perpetuation of widespread poor health, poverty and food insecurity in Nsisha (de Wagt et al. 2004). However, I argue, becoming numb to or seeing HIV/AIDS as a normal part of everyday life ultimately results in the intensification and perpetuation of widespread poor health, poverty and food insecurity in Nsisha (de Wagt et al. 2004). However, I argue, becoming numb to or seeing HIV/AIDS as a normal part of everyday life ultimately results in the intensification and perpetuation of widespread poor health, poverty and food insecurity in Nsisha (de Wagt et al. 2004).
cycles of poverty, food insecurity, and poor health created and perpetuated by HIV/AIDS (Foster and Williamson, 2000; Gillespie et al. 2005; UNFAO 2005, Beegle et al. 2007; UNICEF, 2007). The remainder of this paper focuses on some vulnerable situations witnessed during fieldwork which confront children in Nsisha. All households in Nsisha have been affected by HIV/AIDS and declining agricultural output, thanks to the pathogens which kill their banana plants and other food crops. Most households, in fact, are (very) poor and (highly) vulnerable to food insecurity, the impacts of HIV/AIDS and related maladies. Given children’s specific vulnerability and dependence on their parents and other adults, they often suffer the most from the devastations of poverty, malnutrition and HIV/AIDS, and this is readily visible in Nsisha.

For the remainder of this section, I will highlight the following situations: grandmothers who are the primary caregivers to their (orphand) grandchildren; the plight of orphans who are integrated into (large, poor) households; orphan-headed households, (“illegitimate”) children of single mothers; children affected by prostitution and gender inequality in education. Finally, the chapter concludes by summarizing the research findings illustrated in this chapter and by stating that women’s empowerment and (ensuring their) human rights is the keystone to a better life for children.

Overwhelmed Grandmothers

As mentioned previously, many informants in Nsisha said that the devastation wrought by HIV/AIDS has taken away a large portion of a generation of parents whose deaths leave behind many orphans. Similar findings have been reported in Iliffe (2006), Rugalema (1999, 2004) and Beegle et al. (2007). Many of these children go to live with the aged grandparents, specifically grandmothers (Urassa et al. 1997; Barnett and Whiteside 2002; Gillespie et al. 2005). In Buhaya as in many parts of Africa, it is not uncommon for grandchildren to live with grandparents and to be fostered by extended family members (de Wagt et al. 2005; Rugalema 1999). In Nsisha, for example, parents often send their children to live with grandparents in order to provide them company during their old age. Also, it is not uncommon to find children living with their aged grandmother so that the parent(s) can engage in wage-earning activities afar, such as working on the islands on Lake Victoria, tea plantations in Buhaya, and in other occupations spread throughout the country. However, the HIV/AIDS pandemic forces many grandmothers to become the primary providers of their grandchildren by default. We also came across grandmothers who were still strong and able to farm and provide for their grandchildren, and they were happy to have their company. Often these grandmothers received sufficient remittances to provide for the needs of the child(ren). However, there are many situations where grandparents are too old to farm and have little or no assistance. Similar to Rugalema’s findings (1999, 2004) and Iliffe (2006) these grandmothers in Nsisha have lost their own social security—their own children to HIV/AIDS. Lacking strength to farm and money to purchase household needs, these grandmothers cannot provide children under their care with basic necessities. Consequently, these children become vulnerable to food and nutrition insecurity and illnesses like malnutrition. They also suffer from lack of health care and have no chance of receiving an education which ultimately subjects them to a dim future (see also de Wagt and Connolly 2005; UNFAO 2005; Gillespie 2005; Hecht et al. 2006; Iliffe 2006). According to many respondents in Nsisha, AIDS imposes a double burden. Not only does HIV/AIDS ‘take away the children making people suffer in old age’ but it also forces them to become parents again to their own grandchildren. Since they are old and frail, they themselves need assistance which they traditionally depend on (Rugalema 1999, 2004; Githinji 2008).

No Sanctuaries for AIDS who are Integrated into (large, poor) Families

The grandparents are not the only people who take care of AIDS orphans. In some cases in Nsisha, AIDS orphans are integrated into the families of their parents’ siblings and other members of their extended families (Rugalema 1999; Foster and Williamson 2000; Barnett and Whiteside 2002; de Wagt et al. 2005; Beegle et al. 2007). It is important to mention, that not all orphans are vulnerable (Gillespie et al. 2005). Children living with their extended families may not experience major problems generally associated with orphanhood since they are well cared for, provided for, nurtured and educated. For example, there was a large, hardworking but generally poor family who happily took in a young orphan and he was treated equally to the other six young biological children in the household. However, it is common to find cases where orphans integrated into already large, poor families may be seen as a burden—another mouth to feed when the livelihood situation is already strained and challenged (Barnett and Whiteside 2002; Gillespie et al. 2005; Iliffe, 2006). Both extremes and variations in-between were observed in Nsisha. In such situations where integrated orphans are seen as a burden and treated poorly, these children may not receive equal care and nourishment to the biological children and may suffer from neglect (Gillespie et al., 2005; UNICEF, 2007). During fieldwork for instance, I came across a case whereby a young woman was left to care for her newborn baby and her husband’s very young half-brothers. One of the half-brothers was five years old and the other was seven years old. These children had lost their mutual father and respective mothers to HIV/AIDS. They were sickly and thin and very well could have been infected with HIV/AIDS. The young mother (their sister-in-law) who resided with was focused on caring for her newborn baby and tending to her home and farm while her husband worked afar on the islands in Lake Victoria. The two orphans were not well cared for and did not receive much attention. In fact the young mother did not seem to even notice them and they were forced to fend for themselves even though they were young.
children and obviously sickly.

It is important to realize that in many situations, the poverty situation is so severe that the aunts and uncles who integrate their orphaned nieces and nephews into their own families may want to provide for the child(ren) well, but are unable to do so because of their own household poverty (Barnett and Whiteside, 2002; Iliffe, 2006; Beegle et al., 2007). This was a common explanation made by many informants in Nsisha. It could be easily mistaken on first look that an orphan is neglected given the fact that the child wore dirty, torn clothes and appeared thin and sickly. However, often times after learning more about the household where the child resides, one can understand that the poverty is often spread evenly among all household members.

In other situations like that mentioned above, orphans are indeed treated unfairly, creating very negative effects for the orphan. The psychosocial and overall health impacts that orphanhood, neglect, and mistreatment for example have on a child are heavy, and can impact the child for the rest of his or her life (See also Foster and Williamson, 2000; Gillespie et al., 2005; Iliffe, 2006; Beegle et al., 2007). The situation is usually more severe for the orphan who is HIV/AIDS positive and deprived of the nurturance, attention, special nutrition and healthcare assistance he or she needs (UNFAO, 2005; UNICEF, 2007). These situations were among the most difficult to observe during research, leaving you to wonder what the fate of the child will be. Sometimes we learned of their death, other times we would witness their progressive decline and neglect.

**Stolen childhood: Orphan as heads of households**

Sometimes in Nsisha, when older children orphaned by AIDS are viewed to be mature enough, they inherit their parent’s kibanja and household and become the parents/guardians to their younger siblings (Rugalema, 1999; Barnett and Whiteside, 2002; Iliffe, 2006). Hence, the older siblings are forced to become parents at a very young age, bearing the responsibilities of adults and sacrificing their youth, education and chance to a better future (Foster and Williamson, 2000; Barnett and Whiteside, 2002; Iliffe, 2006). As informants mentioned, these children are also particularly predisposed to vulnerable situations since they are too young to understand the cultural norms and legal intricacies involved in land inheritance. This renders them vulnerable to greedy relatives or other people who try to steal their land, household items, and control food from the farm (Barnett and Whiteside, 2002; Iliffe, 2006). As witnessed during research most often these orphans, similar to the poorest children, are not able to go to school (Barnett and Whiteside, 2002; de Wagt and Connolly, 2005; Iliffe, 2006) because they cannot afford and do not have the means to obtain the money needed to pay for school fees, uniforms and supplies. The excerpt below provides a good illustration of relatives’ exploitation and dispossession of three teenage orphans, Anna, Rita and Lucas who live in the outskirts of Bukoba Urban and had lost both parents to HIV/AIDS;

> After the death of their parents, their paternal aunt and her boyfriend came to occupy their home — the house and land of their deceased father. The children were verbally and physically abused by both the aunt and her boyfriend. The youngest child was noticeably ill and had symptoms of tuberculosis and/or HIV/AIDS. Their aunt allotted them approximately 200 shillings (approximately $0.20 per day for food), which is not adequate enough to feed three teenagers. The eldest girl, who took on the motherly role for her younger siblings, said that her aunt’s aim was to control the kibanja and house and prevent the children from becoming the lawful heirs. She ridiculed the children and abused them, depriving them of their basic needs including access to their home and adequate food. Being double-orphans to HIV/AIDS, the children were stigmatized and chastised by some community members, and the eldest girl mentioned that she often felt vulnerable and was lured and exploited by older men. The children were truly in one of the most vulnerable situations possible, and did not have support from other family members and neighbors.

Such sad cases were not observed in the village of Nsisha during the time of this research. In fact, I only came across one case of an orphan-headed household. Though in that case the eldest brother who was the head of the household was in his twenties, they had been orphaned for several years. Fortunately, the three children were able attend primary school with the help of their married, eldest sister and a local NGO who assisted them with school uniforms and supplies. However, their kibanja was in very poor condition and was generally unproductive. They did not have the time and labor power needed to maintain the farm and were busy seeking paid labor opportunities. They also leased parcels of their kibanja in order to obtain needed household money.

We also witnessed cases of neighbors generously taking care of orphans. One such case involved a double HIV/AIDS orphan who was fostered and educated by his parents’ neighbors. The neighbors even built the boy a home. They felt that since he was nearing adulthood he would need a home and farm of his own to sustain a future wife and family. His ‘foster mother’ stated that even though she could never replace his parents, she treated him as if he was her own son and felt that ‘that is just the way it should be.’ In this positive and hopeful case, generosity was easily displayed and afforded because aside from their warmth and compassion, the foster parents were relatively wealthy.

**Widowhood, Single Mothers and ‘Illegitimate’ Children**

As mentioned previously, one of the greatest impacts of HIV/AIDS is the increase in widowhood and female-headed households. Children living in these situations (whether biological or orphans), tend to suffer greatly since women in general are limited in their capacity to obtain money used to meet children’s required needs, including food and nutrition security, clothes, school fees and healthcare (UNICEF 2007). According to many informants, having both parents was better than having only one because even if the parents did not get along well, there was often more household food.
and nutrition security and money for children, compared
to situations where children live with a widowed or single
mother. In essence, two contributors to a household income
yield more than one. As Rugalema (1999, 2004) reports and
as this research confirms, when women were asked how
their household changed after widowhood, separation or
decease of their partner, they stated that their household
income and food and nutrition security declined (See also
Joseph 2005). Decrease in the amount and lack of quality,
nutritious food, primarily protein-rich foods such as milk,
eggs, fish and meat, increases children’s vulnerability to
malnourishment and susceptibility to illness (UNFAO 2005).

In addition, the patriarchal and patrilineal structure of
Bahaya society means that women in general do not own
or control the means of production and land necessary for
 ensuring household economic, food and nutrition, and health
security. With little income and means of making money,
a single mother often cannot afford to send her children
to school (Rugalema 1999, 2004; Beegle et al. 2007). As
witnessed during this research, these children remain home
tending to the household tasks of cleaning, gathering and
preparing food and tending to younger children. One HIV/
AIDS widow for example, could not send her six year-old
daughter to kindergarten because she could not afford the
$.50 monthly fee. There is also an asymmetric treatment
of paternal orphans according to gender. A widow without
sons can be forced off her husband’s kibanja (Culwick 1938;
Cory & Hartnoll 1971; Tibaijuka 1997; Rugalema 1999;
Muchunguzi 2003) rendering her unable to fend for herself
and her female children. This type of female marginalization
in Bahaya society fuels cycles of (female) poverty, hunger
and related disease specifically because women cannot
fulfill their roles as primary farmers and providers of
food and nutrition security and care (Githinji 2009).

The notion ‘illegitimate’ children in Bahaya, refers to a child
who is not recognized by the father and the patri-clan (Cory
and Hartnoll 1971). This means that the child is in essence,
considered fatherless, and is prohibited from inheriting land
and receiving assistance throughout life. In the patriarchal
and patrilineal agricultural Bahaya society, the only way to
inherit land under customary Bahaya law is through the
father and his clan (Cory and Hartnoll 1971; Muchunguzi
2003). His land symbolizes and provides a child with cultural
and social protection and recognition, and an essential and
practical asset in an environment comprised predominately
of small-scale farmers (Rugalema 1999, 2004). The so-called
‘illegitimate’ children may suffer scorn and isolation given
that they are unprotected in society, considered fatherless
and do not belong to a clan. As informants stated, children
like these ‘have no head and no tail.’ Not only can this cause
psychological problems for the child, but it can also condemn
the child to a life of extreme poverty if the mother is not able
to provide overall household security and education, and
does not receive assistance from her own kin or external
agencies. These are the children in Nsisha who (often) tend to
look the most malnourished and unhealthy, and often suffer
for long before receiving medical assistance, if they do at all,
for common, treatable maladies such as worms, amoebas,
malaria and malnutrition.

**Prostitution as a cause and effect of children’s vulnerability**

Poverty-induced prostitution as a common practice in
Nsisha, especially for single women with children, but also for
widowed and married women (Rugalema 1999, 2004) was
witnessed in this research. Transactional-sex becomes more
widespread and common as poverty and food and nutrition
insecurity situations increase, collectively helping to fuel
the HIV/AIDS pandemic and its deleterious effects (UNFAO
2005). Although changing slowly, Bahaya patriarchal society
continues to prohibit women from equal access to resources
as men, including, land, education, and salaried employment
(Swantz 1985; Rugalema 1999, 2004; Muchunguzi 2003); which
are some of the main resources needed to raise women’s and
children’s empowerment and ensure their human rights (see
Nagengast 2004; Grown 2005; Lopez-Claros and Zahidi 2005;
UNICEF 2006; Kalipeni et al 2007; ADFVI 2008). It is documented
that Bahaya women have practiced prostitution since the
1930s and 1940s (Swantz 1985; White 1990; Weis 1993, 1996;
Kajjage 1993). Scholars claim that Bahaya women were tired
of the constraints and limitations imposed by their patriarchal
society and hence fled to East African urban centers to engage
in prostitution (Swantz 1985; White 1990; Weis 1993, 1996,
2003; Stevens 1995). Often, these women returned home
with enough money to purchase a kibanja and build a house
for themselves, which they could dispose of and bequeath to
whoever they chose (Swantz 1985; Weis 1993, 1996). Due
to their independence and subversion of cultural and gender
prescriptions and norms, these women were often resented by
society. Given the risky nature of their work and susceptibility to
contracting and dying from AIDS, these women came to be seen
as ‘buying their own grave’ (Weiss 1993, 1996; Stevens 1995).

Children brought up in situations where their mother is
engaged in prostitution are exposed to a risky environment,
behavior and lifestyle. Children are directly put at risk since
they depend on their mother who may contract a sexually
transmitted disease, including HIV/AIDS, which may result
in increased poverty, as she becomes sick and unproductive.
Some children are born with HIV/AIDS and suffer a short
life. One such case was witnessed early on in this research,
whereby Leticia, a twenty-eight year old mother and former
prostitute died of HIV/AIDS, and was immediately followed by
her youngest child only three weeks later. When the mother
dies of AIDS, children die as in this case or become orphaned
and vulnerable. Girl children are especially vulnerable as they
can be abused by sugar-daddies who offer them small gifts
This was a common worry of parents and guardians of young
girls, especially since there were rumors of a few male primary
teachers and older men in the village who were known to
taunt and lure young and often, poor girls. There are also cases
of girls being raped, abused and forced into early marriages
or prostitution (Joseph 2005; UNICEF 2007). In Nsisha, older
female prostitutes who work on the islands in Lake Victoria
recruit vulnerable young girls who are enticed by promises of
making money and gaining material possessions such as fancy shoes, clothes, make-up and the means to straighten their hair and lighten their skin. This is the current generation of women who are ‘buying their graves’ (Weiss, 1993, 1996; Stevens, 1995), often leaving children orphaned, infected with HIV, and socially insecure (illegitimate). Normally, these children become the responsibility of elderly grandmothers and already poor and large families, as mentioned earlier, and with a bleak and myopic view of the future.

Malnutrition and Lack of Access to Health Care

The environmental challenges in Buhaya combine with emanations of socio-economic decline and result in lower banana yields (Bajukya 2004), forcing this banana-culture to increasingly depend on roots and tubers (Tibaijuka 1997; Rugalema 1999; Iliffe 2006). Access to milk, meat, eggs and fish are important protein sources which are out of reach for most people. Poverty has pushed healthcare beyond reach for many people in the village. Whether it is traditional medicine or biomedical care, both require capital (Tibaijuka 1997). In addition, clinics and hospitals are far away, and require money for transportation to and fro. Inaccessibility to healthcare often causes children to suffer from undiagnosed and treatable common and chronic childhood maladies mentioned previously: worms, colds, amoebic infections, malaria and malnutrition (UNFAO 2005; UNICEF 2007). Sometimes, when children are diagnosed with malnutrition for example, being told to eat a more protein-rich diet is not realistic since these foods are the most expensive and the most out of reach (Beegle et al. 2007). Continued exposure to chronic and long-term malnutrition may lead to a lifetime of cognitive problems, health issues (such as wasting and stunting) and livelihood limitations (UNFAO 2005; Beegle et al. 2007). In addition, untreated childhood maladies can also lead to death, and they often do (UNFAO 2005; UNICEF 2007). On several occasion during the course of this research, villagers’ lamentations announcing the death of (another) child commenced the day. It was normal for the villagers to assume the cause of death was ‘malaria’, while in truth it was usually common maladies mentioned above.

Gender Asymmetry in Education Provision

Education helps break the vicious cycle of poverty, malnutrition and poor health (Nagengast 2004; Grown 2005; Lopez-Claros and Zahidi 2005; UNFAO 2005; UNICEF 2006; Kalipeni et al. 2007; UNICEF 2007, ADF VI 2008). According to the International Convention on the Rights of the Child, education is a basic need that all children should have access to (Barnett and Whiteside 2002, 211; UNICEF 2007). However, poverty (often) begets poverty, and children who grow up in poor households often do not have the opportunity to attain education (UNFAO 2005; Iliffe 2006). Although primary education is ‘free’ there are costs including uniforms, shoes, pencils and paper. All categories of orphans; those who become heads of households, those who are integrated into large, poor households, and those who are isolated, neglected, and labeled ‘illegitimate’ (Cory and Hartnoll 1971) have little to no chance of attaining formal education (Rugalema 1999 2004; Iliffe 2006; Beegle et al. 2007). The same applies to non-orphaned children living in poor households. The girl child is even more vulnerable compared to the boy child, in general (Rugalema 1999, 2004; UNICEF 2009). The boy child is seen as the one who is the most worthy of investment in the patriarchal, patrilineal, and virilocal Bahaya society (Swantz 1985). He is seen as the breadwinner who will bring pride to the family and perpetuate the clan and Bahaya culture (Swantz 1985). Girls on the other hand are viewed as people who leave the clan and go to live with, expand and perpetuate their husband’s clan (Swantz 1985; Rugalema 1999, 2004). Girl children are also assigned the duties of tending to younger children, cooking, cleaning, and feeding animals (Swantz 1985). Few female children reach beyond primary education (Rugalema 1999, 2004) or work in salaried and professional positions; most girls in Nsisha marry and become pregnant at a young age, and the vicious cycle of patriarchy and women’s marginalization repeats (Githinji 2009).

Conclusion: Addressing Children’s Vulnerability as a Women’s and Human Rights Issue

This paper describes some of the vulnerable situations children in Buhaya are living in. Due to the fact that children are dependent on adults for their basic needs, they are at their parents’ and caretakers’ mercy. Buhaya has experienced the wrath of HIV/AIDS and its manifestations for approximately three decades, and in the process, children are the most affected and vulnerable segment of society. Furthermore, they are the most susceptible to the cycles of poverty, food insecurity, malnutrition and related illnesses that drive and result from the HIV/AIDS pandemic. Due to the high impact of HIV/AIDS in the past three decades, a large portion of a generation has died, leaving orphans who are either cared for by their remaining parent or by a female relative. Often these children are integrated into already poor and large families where they can be seen as a burden; another mouth to feed in an already food insecure household. Many times, caregivers want to care for orphans well, but cannot since household impoverishment is common and widespread in Buhaya. Sometimes orphans are mistreated which compounds their vulnerability and susceptibility to abuse, poor mental and physical health and a grim future. Similar to the poorest children, (HIV/AIDS) orphans are often deprived of an education and consequently a chance at a hopeful and stable future.

Since children are most often cared for by women, and increasingly single women, they are highly affected by the constraints women endure under patriarchal and patrilineal Bahaya customs. Women in general are deprived of the very resources they need to fulfill their social role as primary farmers and providers of food, nutrition and care. This situation renders women and mothers, and specifically single women with dependents very vulnerable to poverty and resultant emanations of food and nutrition insecurity and related illnesses which they then bequeath to their children and future generations (Githinji 2009).
The future lies in the hands of our children. How well they are nourished, cared for, treated by family, kin and society, and how well they are formally educated makes a difference. The cycles of poverty, malnutrition, and HIV/AIDS in Buhaya have condemned many children to a lifetime of hopelessness. This needs to be viewed as a human rights concern and a violation of the Rights of a Child (Barnett and Whiteside 2002; UNICEF 2007). All children are entitled to basic needs such as a nurturance, a safe environment to live in, attention, food and nutrition security, healthcare, education and a hopeful future in order to grow into healthy and productive adults (Barnett and Whiteside 2002, 211; UNICEF 2007). However, many children in Buhaya do not have these basic human rights, especially HIV/AIDS orphans and children living in the poorest households (Rugalema 1999, 2004; Beegle et al. 2007). There is therefore need for children to be recognized as a vulnerable segment of society who are dependent on their parents, adults, and often times, single (foster) mom (Swantz 1985; Baylies and Bujra 2000; Sweetman 2001; Morgan 2002).

As HIV/AIDS increases children’s vulnerability to poverty, malnutrition and HIV/AIDS, it also increases the pressures on single women, the primary caretakers of children and orphans (Iliffe 2006; UNICEF 2007) who are already constrained by patriarchal Bahaya norms. As found in most cultures in the world, raising children is predominantly the primary responsibility of women. Consequently, the institutionalized discrimination and marginalization of women predisposes children and future generations to insecurity (Githinji 2009). Improving the lives of children is contingent on women’s empowerment and upholding women’s and children’s human rights (see Nagengast 2004; Grown 2005; Lopez-Claros and Zahidi 2005; UNICEF 2006; Kalipeni et al. 2007; UNICEF 2007; ADF VI 2008).

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