Gender and Social Exclusion in Lake Victoria Basin: A Case of Mara and Simiyu Regions, Tanzania

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ABSTRACT

Tanzania has undertaken several deliberate measures to address the social exclusion of traditionally marginalised groups. Yet, it is still felt by some people that good measures, strategies, and plans implemented in health and education are not handled at the household level. The study was conducted in Bunda TC, Bunda DC, and Busega DC to assess gender and social exclusion in the Lake Victoria basin. Specifically, examining disparities in household children's education expectations by gender and investigating gendered differentials in health status and care. This study employed a multistage sampling method, combining random and purposive techniques, to select 447 households. Key informants were purposefully chosen for interviews, and 30 households per village were systematically surveyed. Data were collected through various methods, including documentary review and computer-aided personnel interviews, ensuring comprehensive coverage. Findings revealed that the sex of a child influenced the household expectation of the highest education level of children. Financial expectation determines who should be educated. The girls were on the disadvantageous side. The sex of the household head did not distinguish health status, and the exclusion of health care lies not in differential treatment between males and females but in differing affordability and the availability of health facilities. It is recommended that: the right to education of a girl child should be addressed at the household level; measures to improve health care affordability and availability of health facilities should be ensured; the provision of health insurance for all and free health services for complicated health problems of women should be emphasised.

Key Words: Gender, Lake Victoria Basin, Social Exclusion, Women

I. INTRODUCTION

The Globe desires to attain a sustainable future for all and recognizes that development can only be sustainable if it does not leave anyone behind (United Nations, 2016; United Nations Department of Economic and Social Affairs 2016; United Nations Development Programmes [UNDP], 2022a; United Republic of Tanzania [URT], 2021). However, it has been very undesirable that the benefits of social and economic progress have not been equitably shared among various social groups (UNDP, 2022b; UNDP, 2022c). Discrimination and inequalities continue to play a key role in holding back some groups (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2019; African Union 2018), a situation that threatens the efforts for attaining the global agenda of a sustainable future for all by 2030.

For decades, there has been a clear consensus across countries on the need for education and health care to benefit all people (Bloom, 2005; UNESCO, 2019). However, empirical evidences have revealed that in both developed and developing countries, there are enduring disparities in school enrolment, educational attainment and learning outcomes based on factors beyond a student's inherent capacity to learn (United Nations 2016; Idris, 2018; United Nations Department of Economic and Social Affairs, 2019). Women have historically been suffering from social exclusions more than their male counterparts (African Union, 2009; Semkwiji, 2008; Idris, 2018). Experiences have shown that many of the barriers that lead to their exclusion are grounded not only in the lack of resources and opportunities but rather in discriminative laws, policies and social practices (Wanjala, 2021; Wanjala & Were, 2011; Kaka, 2013).

In Tanzania, deliberate effort by the government has been committed to addressing the issue of gender and women exclusion so as to enable all people including women access to necessary opportunities to benefit from social and economic progress. As such, several policy frameworks, strategies and plans have been formulated and implemented (Lokina, et al., 2017). These includes; establishment of Gender Development Policy in 2000, establishment of the National Strategy for Gender Development (NSGD) in 2005, the Tanzania National Development Vision 2025",

National Local Content and the Local Economic Development framework all of which addresses the issues and women exclusion (UNDP, 2022c).

Moreover, the country ratified several regional and international conventions and protocols that address gender issues. These include: the United Nations Charter on the Human Rights Declaration of 1948; the Southern Africa Development Cooperation (SADC) Declaration on Gender and Development of 1977; the Convention on the Rights of the Child (CRC) of 1989; the Beijing Declaration and Platform for Action of 1995; the SADC Declaration on Gender and Development of 1998; the East African Community (EAC) Treaty of 1998; the African Union (AU) Solemn Declaration on Gender Equality; the Protocol to the African Charter on Human and People's Rights on the Rights of Women of 2003; and the World Summit 2005 Resolution on Gender Equality and the Empowerment of Women (Lokina, et al., 2017; UNDP, 2022c). Such ratifications symbolized Tanzania's willingness to create favorable environment for addressing gender issues.

Despite these efforts and affirmative measures undertaken to address gender issues and women exclusion, successful implementations of these measures have been constrained by the lack of publicly visible will by the governing body, peoples' culture, societal norms and legacy of uncaring behaviour among people (Lokina, et al., 2017). There are still undesirable cases of social exclusion among women in several dimensions including health care and education. It has also been observed that well-structured policies, strategies and plans lack recognition at the lower level and are rarely felt at the local level (Semkwiji, 2009). Along with these bottlenecks, the availability of evidence-based information to monitor the progress towards total inclusion has also been very challenging. This study, therefore, intended to bridge this gap by assessing the gender and social exclusion in Lake Victoria basin. Specifically, the study aims to examine disparities in household children's education expectations by gender; investigating the gendered differentials in health status and health care in the study area.

II. LITERATURE REVIEW

Gender inequality and social exclusion of women in all aspects affecting their lives remain a global concern that not only limits women contribution to their nations' economy but also weakens women capability to contribute for their household and their own wellbeing (United Nations, 2015; UNDP 2022d: Inter-American Development Bank [IDB], 2022). Considering that women constitute a large share of a labour force and are in most cases tied to the household's day to day earning of living, it is obvious that exclusion of this category of the population could undermines their present and future contribution to the household economy and their own well-being (Ritchie & Roser, 2019).

The United Nations Sustainable Development Goal 5 calls for gender equality and adequate inclusion of gender aspect for sustainable development. However, there have been multiple evidences suggesting that women inclusion of the traditionally marginalized group; women, is still a long way to undergo (Ilesanmi, 2018; Hanmer & Klugman, 2016).

The 2017 global estimate have revealed that women share on the global population is about 49.9 percent (Ritchie & Roser, 2019). Alongside with such figure, it has been established that more than 50 percent of countries in the world have more women population than men (Ritchie & Roser, 2019). Considering that women live longer than males, then ignoring women participation implies forsaking nearly a half of the population unutilized.

Gender inequality and Social Exclusion of women is more evident in Sub-Saharan Africa where most poverty-stricken population resides (Ilesanmi, 2018; Chen & Ravallion, 2010). According to Ilesanmi, 2018 Women population in Africa account for approximately half of the population. This category of the population rarely participates in influencing ideas, initiating action that determines their future and the future of the household (Shisana et al. 2009). Such scenario usually subjects them into poverty than their male counter parts. As the literature suggests, this category of the population mostly bears the brunt of poverty across the continent (Ilesanmi, 2018)

There has been undeniable effort by the global in addressing gender inequality and social inclusion women (Shang, 2022; World Economic Forum, 2022). As part of the globe's effort Tanzania is pushing towards addressing gender inequality and social exclusion (Lokina, et al., 2017). A number of deliberate strategies and measures have been put in place which resulted into considerable improvement especially in women's inclusion in political arena (Lokina, et al. 2017; Semkwiji, 2009). However, the gap between expectations and reality is still very huge as women are still a subject of gender inequality and social exclusion.

The literature (UNDP, 2022d; Lokina, et al. 2017; Semkwiji, 2009) observes that, there is still a long way a country has to under to address gender inequality and social exclusion of women despite the notable achievement attained. UNDP, (2022d) performed a review of the development and implementation of gender responsive frameworks in Tanzania. The review came out with an activity report. This report though recognizes effort made by Tanzania

especially in political arena, yet the report observed that; gender equality and women inclusion are far from the planned goals and that most policies have limited gender perspectives. The report recommended among others on increasing the government efforts in addressing gender issues and involvement of both male and female when strategizing measures for addressing gender inequality.

Lokina et al. (2017) and Simkwiji (2009) observed that gender inequality and social exclusion are perpetuated at the household level and that good measures, strategies and plans established at higher level of authority to address gender inequality and social exclusion lack recognition at lower level and unless the matter is addressed at this lower level, the gender inequality and social exclusion will be partially addressed among local communities.

Despite the literature unveiling the lack of recognition of measures to address gender inequality and social exclusion at the lower level, yet availability of evidence-based information to monitor the progress towards gender equality and total inclusion is very challenging in Tanzania especially in rural areas. This study therefore intends to bridge this gap.

III. METHODOLOGY

3.1 Study Area

The study was conducted in Lake Victoria basin in two regions namely; Mara and Simiyu regions. Three councils in the two regions namely, Busega DC and Bunda DC and Bunda TC were involved in the survey (Figure 1). The study involved a total of 15 selected villages in these districts covering a total of 447 households.

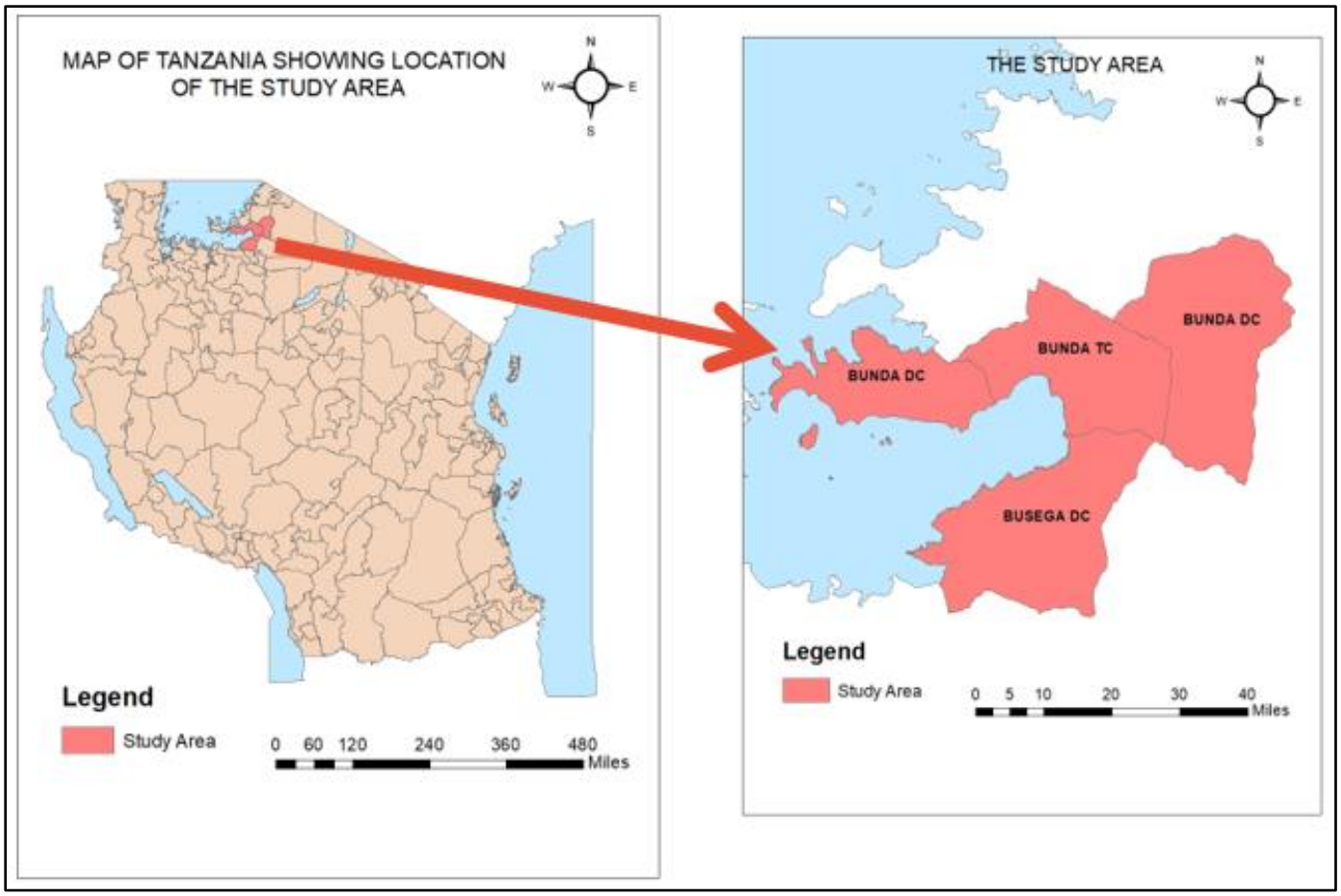

Figure 1
Map of surveyed Local Government Authorities (LGAs)

DC= District Council
TC = Town Council

3.2 Sampling Procedures and Sample Size

This study used a multistage sampling procedure. A combination of random and purposive sampling techniques was used in this study. Simple random sampling was used to select the villages in Bunda TC, Bunda DC and Busega DC to represent other villages along the shores in the Councils. It was also used to select 30 households from each village for the household survey. This sample size was based on the fact that for a researcher to have data that are scientifically justifiable and statistically acceptable in social sciences, a sample of at least 30 is required (Grinnell & Unrau, 2010: IFAD, 2014). Random sampling gave an equal chance to households to be involved in the study and, thus, reduced biases and contributed to increase data reliability. A sample of 447 households was involved in the study, and 30 households from each sampled village were interviewed. Purposive sampling was used to select key informants for the interview.

3.3 Data Types, Methods and Tools of Data Collection

The study used both quantitative and qualitative data. Data collection methods used were documentary review, key informant interviews, household survey and focus group discussion. Information collected from 6 focus groups discussion was analysed to provide answers to this study. The household and village survey questionnaires were administered using tables through the computer-aided personnel interview (CAPI) and Survey Solutions Interviewer Application.

3.4 Data Processing and Analysis

Data collected using computer aided personnel interview (CAPI) were then downloaded from survey solution software in the form of SPSS file for analysis. Collected data were analyzed using descriptive and inferential statistics using SPSS. The descriptive statistics generated included frequencies, percentages and crosstabulation. Furthermore, inferential statistics (Chi-square test) was also performed to test the association among variables. Qualitative data collected through key informant interviews and focus group discussion were analyzed using thematic/Content analysis which emphasizes pinpointing, examining, and recording patterns of themes within data.

IV. FINDINGS & DISCUSSIONS

4.1 Expectation on Education Access by Gender

Household heads in the surveyed households were asked to state the highest level of education that their child in the household will likely complete. Responses were categorized as indicated in table 1. Results from the analysis indicated that, the expectation of household heads on completing the education level lower than the College or University level was higher for girls (58.1 percent) than for their boys' counter parts (54.6 percent). Contrary to this, the household expectation for their children completing the college and university level and other higher levels was higher for boys (45.4) than for girls (42.1). Further investigation on the output (Table 1) revealed that for the levels of education in Tanzania that are not free, like technical or vocational education and above, the households' expectation for their girl children to complete was lower (51.7 percent) relative to that of boys (56.7 percent).

Table 1

Expectations on Levels of Education by Gender

Education level	Expectation on Girls (n=345)	Expectation on Boys (n=344)
Don't know	3.5	3.2
No formal education	0.9	0.0
Primary education	11.6	9.3
Secondary school	32.5	30.8
Technical or vocational school (post Primary or Secondary education)	9.6	11.3
College or university (post-high school)	40.9	44.2
Advanced degree (MBA, PhD etc.)	1.2	1.2

The fact that expectation on boys is higher than girls imply among others that the rights for girls' access to education is denied right from the household. Since the survey was conducted in areas identified as having the highest prevalence of poverty level (World Bank, 2020) it might be that, influenced by lack of financial resources, households

preferred to educate boys at the expense of girls. Several studies (Lugendo et al., 2017; Odero, 2013) in a more similar areas have earlier observed a similar scenario where girls were found to be denied of their rights to education among the fishing folks.

A more similar question was asked in 6 focus groups discussion used in this study. Participants were asked to tell which among boys and girls would the participants prefer to educate in case of limited resources and why. Responses from a focus groups discussion revealed that a large proportion of participants (40.8 percent) preferred boys than girls (28.6 percent). Further investigation of the results indicated that a large proportion of males (61.5 percent) preferred boys while a relatively large proportion of females (47.8 percent) preferred girls (Table 2).

Table 2

Children Education Preference by Gender

Gender	Males (n=26)	Female (n=23)	Total
Girls	3(11.5)	11(47.8)	14(28.6)
Boys	16(61.5)	4(17.4)	20(40.8)
Both	7(26.9)	8(34.8)	15(30.6)
Total	26(100)	23(100)	49(100)

Figures in blankets are percentages

Responding on the why question, respondents were of divided answers. While a substantial proportion of male participants (71 percent) and 17.4 percent of female blamed a girl child for being unreliable, in time of financial need, 19 percent of male and 67.8 percent of female praised a girl child over a boy child for being kind; a claim that correlates to earlier finding by (Birchall, 2016) in Zimbabwe who observed that female are more willing than male to help extended family. There was also 10 percent of male and 14.8 percent of female who claimed that every child deserves equal treatment provided that they belong to the household.

The result from this finding not only subjects a girl child into exclusion but also indicates that the household decision on who should be educated is influenced by the resource expectation attached to the subject who is supposed to be educated. This perhaps supports the argument by (Semkwiji, 2009) who observed that; good policies, strategies and plans established are not felt at the household level. Vertucci (2021) observed a similar scenario among the pastoralist Maasai people of Tanzania where she observed that girls' education is not prized and that girls are in most often married soon after puberty. Taking into account that education determines the future of a girls when she grew up into an adult person (Elizabeth 2011; World Bank 2020), this scenario creates a wake-up call for policy makers in Tanzania for designing and targeting appropriate strategies.

4.2 Heath Status and Access to Health Care by Gender

4.2.1 Household Health Status across Gender of the Household Head

Household health status was assessed across gender of households (Table 3 and Table 4). Household respondents were asked to state how frequent there has been any household member who had ever experienced either less serious illness or serious illness in the past 12 months before the day of this survey. The responses to this question were examined across gender of the household head (Table3 and Table 4). The chi-square results indicated that, there was marginally significant difference between gender of the household head and the household experience of either less serious or serious illness in the past 12 years before the period of the survey (Table 3 and Table 4).

The results indicate the health status measured in terms of frequency of having a household member experiencing a less serious or serious illness was not distinguished by gender. Although earlier study by (Abad-Díez et al., 2014) indicated the existence of significant gender differences in the prevalence and patterns of co-existence of multiple disease between males and females, this study could not find such significant difference among households. This might be attributed by the category of population used in these studies. While (Abad-Díez et al., 2014) used older population, this study did not distinguish the category of the population but instead analysed data for all categories of the population.

Table 3
Frequency of Having a Member with Less Serious Illness in the Past 12 Months

Frequency	Gender of the household head		Total (%)	x^2 −value	p-value
	Male (%) (n=336)	Female (%) (n=111)			
Never	3.6	3.6	3.6	5.915	0.116
Rarely	46.1	34.2	43.2		
Sometimes	21.4	30.6	23.7		
Often/always	28.9	31.5	29.5		

Table 4
Frequency of Having a Member with Serious Illness in the Past 12 Months

Frequency	Gender of the household head		Total (%)	x^2 −value	p-value
	Male (%) (n=336)	Female (%)(n=111)			
Never	39.6	32.4	37.8	2.126	0.547
Rarely	38.4	41.4	39.1		
Sometimes	10.1	10.8	10.3		
Often/always	11.9	15.3	12.8		

4.2.2 Perceived Access to Health Care between Men and Women

The study examined whether access to health care by household in the study area are distinguished by gender. In this case, household respondents were asked to provide their views on health care provision to males and females in the study area. Results in table 5 revealed that a large proportion of respondents (75.8) had an opinion that health care provision is provided equally to both men and women. The findings coherent with the requirement by the Tanzania national guideline for gender and respectful care that requires every health policy, programmes services and delivery models to be responsible to the need of all gender in all diversity (URT, 2019). There was also a substantial proportion (16.8) of household respondents who felt that females are favoured than males in terms of health care provision. This scenario might be attributed by the fact that some women problems require much care and attention (Gupta & Pagan, 2022).

Table 5
Perceived Access to Health Care between Men and Women

Responses	Frequency	Percent
Don't know	20	4.5
Male	13	2.9
Female	75	16.8
About the same	339	75.8
Total	447	100

4.2.3 Affordability of Medical Treatment by Gender

Affordability of medical expenses was assessed in this study. Results (Table 6) revealed that, a large proportion of female headed households (62.2) could not afford the medical treatment at all, relative to 17 percent of male headed households. Further investigation revealed that, about 30.6 percent could either afford with some or much difficulties and none of a woman claimed to afford medical treatment. This might be attributed by the fact that in most cases, women problems require intensive care than men. This perhaps supports the findings by Owens (2008), who observed that, women tend to use significantly more services and spend more health care dollars than men. Not only that but also many women in Tanzania tend to be poor than their male counterparts (World Bank, 2020) and therefore more likely unable to afford medical treatments.

Table 6
Affordability of Medical Treatment by Gender

Responses	**Male Headed** (%) (n=336)	**Female Headed** (%) (n=111)	**Overall** (%) (n=447)
No	17	62.2	28.4
Yes, if money is borrowed	7.7	15.3	9.4
Yes, with much difficult	44.1	15.3	36.9
Yes, with some difficult	24.1	4.5	19.2
Yes, because the employer pays for us	0	2.7	0.7
Yes, households can afford	7.1	0	5.4
Total	100	100	100

The existence of a relatively high proportion of women who could not afford medical treatment implies among others that affordability may act as an agent of social exclusion regardless of the availability of services.

4.2.4 Ability of Health Care Facility to Adequately Treat Women

Respondents were asked to state whether the health facility available are adequately capable of treating women. Responses (Table 7) varied substantially across localities. While the majority of respondents 36.9 felt that health facilities found in their area are often times capable of treating women, with the highest responses (44.4 per cent) in Bunda TC, only 26.5 of responses in Busega DC had an opinion that health facilities are capable of treating women. The results also revealed a substantial proportion (7.8 per cent) of respondents who argued that health facilities available at their area are not capable of treating women.

Table 7
Ability of Health Care Services to Adequately Treat Women

Responses	Bunda DC (n=150)	Bunda TC (n=150)	Busega DC (n=147)	Overall
Don't know	2.0	2.0	5.4	3.1
No health care facility in the village	1.3	0.0	2.7	1.3
No	11.3	2.0	10.2	7.8
Rarely	1.3	2.7	0.7	1.6
Sometimes	26.7	29.3	41.5	32.4
Often	40.0	44.0	26.5	36.9
Always	17.3	20.0	10.9	16.1
Yes, but women prefer not to go	0.0	0.0	2.0	0.7

This scenario not only exposes the challenges of the lack of qualified health professionals with specific skills related to women's problems that are facing many countries in Africa (Nuhu et al., 2020; Oleribe et al., 2019) but also creates a wake-up call to decision-makers to undertake a re-evaluation of various aspects of health care delivery. This comes from the fact that women tend to use significantly more services and spend more health care dollars than men (Owens, 2008; Gupta & Pagan, 2022). The results also imply that the exclusion on health care in the study area does not lie on differential treatment between male and female but rather on differed affordability and availability of capable health facilities to treat women.

V. CONCLUSIONS & RECOMMENDATIONS

5.1 Conclusions

The study aimed at examining disparities in household children's education expectations by gender; investigating the gendered differentials in health status and health care in the study area. Findings from this study revealed that, the household expectation on the highest education level that their children are likely to complete was influenced by gender of a child. Financial expectation determines who should be educated. Girls were on the disadvantageous side. The health status of the household was not distinguished by gender as both males headed and female headed household experienced similar health status. Exclusion on health care lies not on differential treatment

between males and females but rather on differed affordability as well as availability of health facilities capable of treating women.

5.2 Recommendations

Basing on these findings, it is therefore recommended by this study that, the right to education of a girl child should be defended right from the household level. Cultural norms, issues of financial expectations and uncaring behaviour among households should be addressed right from the household level. The study also recommends that, measures to improve healthcare affordability and availability of health facilities capable of treating women should be ensured. The provision of health insurance for all and the provision of free health services to complicated health problems of women should be emphasized. Women should also be afforded with financial resources and technical skills to enable them to undertake minor economic activities to raise their income which could enable them to access health services.

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