Socio-Economic Impact of HIV/AIDS on Children Affected by HIV/AIDS in Southwest Nigeria[1]

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This paper aims to determine how the needs of the children affected by HIV/AIDS could be appropriately met. The study was based on a survey of persons in HIV/AIDS affected households, which included 135 adults and 206 of their children. At least 44% are orphans. 2% of all the children are HIV positive. A fair number of the children engage in economic activity. Major needs of the children included school uniform, books and bags and financial assistance. One-fifth of children linked parents' inability to do more of what they desired to their ill health.

In conclusion, the specific impact of HIV/AIDS on children need be responded to now more than ever. The well being of children affected will depend on the community and public policy interventions introduced to moderate the impact of the disease on children and families.

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SOCIO-ECONOMIC IMPACT OF HIV/AIDS ON CHILDREN AFFECTED BY HIV/AIDS IN SOUTHWEST NIGERIA[3]

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INTRODUCTION/BACKGROUND TO THE STUDY

The HIV/AIDS pandemic is a serious challenge threatening the minimal developmental achievements of Nigeria and that of the entire African continent in general. This is because the African population is not only the most vulnerable but least capable of confronting the attendant consequences of the disease. Ever since it was first noticed in 1984 in Nigeria, its prevalence has been consistently on the increase. Nigeria currently has an estimated adult prevalence of 5.0%.

The HIV/AIDS pandemic will transform the situation of children in the developing world through direct and indirect increases in child mortality, rising rates of adolescent HIV, widespread orphaning, and the deterioration of societal and community conditions due to adult mortality. There are more than 13 million children currently under age 15 who have lost one or both parents to AIDS, most of them in sub-Saharan Africa. By 2010 this number is expected to jump to more than 25 million (UNAIDS, 2002). The number of orphans will continue to soar, regardless of the success of current HIV prevention efforts, as tens of millions of people living with HIV/AIDS today fall ill and die over the next decade.

Attention has been drawn to the plight of children orphaned by AIDS not only because of the scale of the problem in some areas but because the children are at risk long before either parent dies. HIV/AIDS clinical disease reduces an individual's capacity to work and uses up household resources in providing care. The resultant economic deprivation affects all members of the household. Not only are there fewer resources available for school fees and other expenses, the quality of care for children may diminish as many young children have to take on responsibility for caring for sick parents. It further creates child labourers, abandoned and street children. The fast growing problem of street children is an indicator that the extended family, the traditional social services provider, is breaking down (Drew, Makufa & Foster, 1998). Also, available evidence indicate that governments, families, organizations and other institutions are failing to help these children (Rwechungura, 1992)

Children make up a significant proportion of the Nigerian population of over a hundred million. The high proportion, at least 55 percent of children relative to the entire population, is as a result of a persistent high fertility along side mortality decline over the years and a culture of high value of children (NPC, 1998). Children contend with poor chances of survival at birth, with infant and under-five mortality at 70 and 133 per 1000, respectively (NPC, 2000). Also access to clean water, food and health are limited, thereby ensuring that their nutritional condition is poor. In summary majority of children in Nigeria may be exposed to dangerous conditions, along-side high violation and progressive erosion of their rights.

The effect of the epidemic on children is expected to be similar across developing countries. In other words, it is not expected that the experiences of children affected or inflicted with AIDS will differ significantly across developing countries, but will vary depending on the level of the epidemic. The experience from other countries like Zambia, Kenya and Uganda (Foster *et al*, 1997) where the effect of the epidemic is more advanced relative to Nigeria, points to the vulnerable conditions of these children. Given the different stages of the epidemic in various countries. Presently, such empirical data as it relates to Nigeria is limited, if at all available.

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While the challenge posed by HIV/AIDS to health has now been universally recognised, the specific impact of HIV/AIDS on children remains poorly documented, analysed, understood and responded to. Indeed, most of the recent debate on the impact of HIV/AIDS has focused on adult prevalence and death rates, on ways to control the spread of the disease over the short term, and on the measurement of its economic impact. While understandable, this approach may have diverted the attention of the national authorities and international agencies from the recent deterioration in infant and child mortality, enrolment rates, malnutrition and emotional development that has taken place in several countries, from the new pernicious ways through which HIV/AIDS affects child well-being, and from the urgent need to strengthen traditional interventions and to introduce new ones to address the multifaceted impact of HIV/AIDS on children's lives. If anything, the examination of the impact of HIV/AIDS on infants and young children has been comparatively neglected right in a period during which AIDS made the achievement of the Millennium Goals became increasingly more elusive.

The purpose of this paper is to determine how the needs of CABA could be appropriately met, with a view to making appropriate recommendations.

In order to effectively accomplish this, the following research questions need to be answered:

1. What is the situation of children affected by HIV/AIDS?
2. What are the needs of these children?

LITERATURE REVIEW

The human immunodeficiency virus (HIV) has reached an epidemic point in Nigeria as in many countries in African continent. The virus is one of the greatest threats to global health. About 70% of the infected people in the world are in sub-Saharan Africa. A significant proportion is currently living with acquired immune deficiency syndrome (AIDS). The Southern African countries have explosive epidemics with highest seroprevalence rates of 20-45%, the rates are between 7-25% in East African countries, and the lowest rates of 2-10% are in West African countries. Slightly more than one-half of those infected are women, and also about one-half are young adults (UNAIDS, 2001).

The prevalence level in the country has now reached an epidemic mark, with seroprevalence rates of 5.8 per cent in 2001, and 5.0 per cent in 2003. Though it appears that there was a slight drop in the prevalence rate but the truth is that due to the population growth rate, the actual number of people with the virus is on the increase. The rates vary by geographical locations. The HIV prevalence of 2.3 per cent was obtained in the South West zone. Approximately 3.5 million people are estimated to be infected with the virus in 2002, leading to 1.4 million deaths, and causing 847 thousand children to become orphans. Surveillance indicates that 70% of HIV infections in the country occur among women and men through heterosexual relationships, other modes of transmissions are blood transfusion, and mother-to-child (FMOH, 2002).

Social science studies on HIV/AIDS in Nigeria are increasing, although at present, most are concentrated along sexual practice, knowledge, attitude and behaviour. Studies by Haastrup (1999), Dada et al (1998); and Olayinka and Osho (1997), reveal high awareness of HIV/AIDS, particularly among youths with a poor understanding of the aetiology. Such knowledge, therefore, is yet to lead to the expected change in behaviour as measured by risk taking attitude**.** This observation is, however, not peculiar to Nigeria.

The HIV/AIDS epidemic impacts not only on families and communities, but also on entire nations. It will reduce life expectancy, bring about economic loss, increase burden on health care, and increase the population of orphaned children. As regard orphaned children, child fostering by extended families is the communal strategy of coping that is common in cultures of Nigeria. On the basis of communal responsibility, children even outside situations of distress, for reasons that bother on improved probability of care or discipline, permit children to live with extended families.

Data on the size of orphaned children in Nigeria is not available. Estimates based on the 1991 census figure, however, reveal that approximately 12 per cent of children aged 15 years and below live in households where both parents are not present (NPC, 1998). The proportion of these children is expected to increase with increased adult mortality resulting from AIDS. The ability of family support to cope with the expected increase in the number of orphans will depend on the actual magnitude of orphans, the physical and emotional distance from extended families, especially with regard to affected families from urban settings.

In addition, where prime-age adult mortality is high, parents may be less willing to invest in their children's schooling, either because they fear that the children will not live long enough to realize the higher earnings schooling promises, or because the parents themselves do not expect to live long enough to benefit from their children's future earnings. Similarly, relatives who take in an orphan may be less willing than the parents would have been to invest in the child's schooling. For all these reasons, children who have lost one or both parents are likely to have lower enrollment rates than those whose parents are alive.

The needs of orphans, which may not be adequately met, include health, education, empowerment and nutrition. Muller and Abbas (1990) in a study in Uganda report a higher risk of prematurely leaving school among children in households with orphans compared to those without orphans. Given the importance of education to the future of children in developing countries, the researchers argue for a means of reaching these orphans. Issues of maltreatment, resort to work rather than school, and neglect of orphans are not uncommon (Foster *et al*, 1997)

The strain of meeting the needs of AIDS orphans has been reported to lead to the collapse of the extended family network in places like Uganda and Zimbabwe, where orphan rates are close to 25 per cent in some areas (Stein, 1997). Also, not all orphaned children will have access to an extended family network. It therefore stands to reason that other special programmes may be required for such children and households. In the absence of such programmes, older children among orphans who assume some of the care-giving responsibilities for younger siblings begin to miss school. They may also be required to search for work that will bring some financial benefit to assist the family. Growing household poverty and the increase in 'demand' for uninfected younger sexual partners has also increased the numbers of children who are sexually abused and paid as sex workers. This inevitably puts children, especially girls, at extreme risk of contracting HIV. Inadequate training and limited opportunities for children, is associated with an increased risk of HIV infection, as orphans may work as prostitutes to earn money to feed or educate children in their care (Foster, 1999). Teenage prostitution, not among orphans, for financial reasons already obtains in Nigeria (Adedoyin & Adegoke, 1995). Fletcher (2000) opines that sex work is the refuge of desperate women with no education, and often with a cultural imperative to help their families. It is therefore not surprising that Orubuloye (1997) in a study in Nigeria found that the AIDS epidemic has not affected the flow of women into prostitution, despite the risks involved.

In Burundi, children in AIDS affected households begin work for income at younger ages compared to unaffected households, becoming involved in petty trading and running errands at the ages of six or seven (Roudy et al. 2001). Some children end up working in highly hazardous conditions, for example, in the informal mining industry where they risk severe injury. A UNICEF study on HIV/AIDS and child labour concluded that AIDS was responsible for pushing a significant percentage of the millions of working children onto the labour market. (UNICEF – ESARO 2001). The epidemic, therefore, can only serve to reinforce the existing situation by enhancing poverty.

Conceptual Framework

The harm of HIV/AIDS to children is accomplished both directly and indirectly. The direct effect is observed in the number of children who are afflicted with the HIV virus and the AIDS disease

The indirect effect obtains when children who are not afflicted have parents who are afflicted. These children who are affected indirectly suffer from the pandemic as much as children who are directly afflicted. The suffering of affected children commences when one or both parents become ill and continues after the death of parents. They pass through emotional stress of caring and watching their parents pass on, contend with financial difficulties of providing for basic social needs, face social isolation due to the stigma associated with the parents' illness, and general insecurity.

The needs of both HIV/AIDS afflicted and affected children are similar in many respects. These needs relate to basic social services such as health care, education, nutrition and shelter. Other needs include parental care and psychosocial needs. The intensity of the needs of these children will depend on several factors related to: the stage of the disease, the background characteristics of the afflicted parents – age, sex, gender, etc-; the strength of existing kinship relationship, support available to the household from various sources, number of children in household, number of employed adults in household, and characteristics of the children, that is whether afflicted or affected and several other factors.

Culturally in Nigeria as in most parts of Africa, the kinship system, made up of the extended family networks – aunts, uncles, cousins and grandparents – provide a social safety net in times of distress for members of the network. This system, which has remained resilient over-time has been weakened by the existing poverty and increasing individualistic tendency due to modernisation. In the face of no other support system, the strain of the HIV/AIDS pandemic constitutes a further threat to the traditional social support system. The system has been observed to crumble in countries worse hit by the disease (Rwechungura, 1992; Drew, Makufa & Foster, 1998). Beyond the traditional social support system, therefore, a combination of efforts involving national governments, NGOs, CBOs, and international orgarnisations, is advocated for effective and lasting impact on the AIDS crisis (UNAIDS, 2000). Figure 1 shows the relationship of interest for this study, which is the effect of HIV/AIDS on children from the affliction of parents.

METHODOLOGY

This study, which is cross sectional and mainly descriptive in nature, was carried out in two selected states of the southwest zone of Nigeria. A non-probability sampling technique was used in the identification of the study populations. The states were selected based on the prevalence rates as in the 1999 HIV/Syphilis Sentinel Surveillance (FMOH, 1999) as criteria, the two states with high HIV prevalence rates in the zone were chosen; these are Lagos and Oyo states with HIV prevalence of 6.7 and 3.5 per cents, respectively. In each state, the two sentinel sites - a major city and an outside major city – chosen by the FMOH for the 1999 HIV/Syphilis Sentinel Surveillance were used. A city was considered an outside major city when it was not the state capital. Following this format, the major cities are Ibadan and Ikeja (the state capitals for Oyo and Lagos states, respectively) and the out of major city locations are Ogbomosho and Epe for Oyo and Lagos states, respectively. These are locations that have known organised bodies working on HIV/AIDS and persons living with HIV/AIDS (PLWA) that are expected to enhance the identification of the study population.

Sample Design and Size

The study population for the situation analysis of children consist of a survey of individuals within identified households. The sample size of 400 children was estimated as the upper limit based on the assumption of 50% school drop out rate for primary school at a 95 % confidence interval. The study aimed to interview a maximum of 2 children in each household, a tenth of the total calculated sample size was added due to the expected difficulty in getting households with at least a father/mother living with HIV/AIDS. In all a total of 250 households were finally planned for survey with an expectation of 500 children if 2 children are identified in each of the households. The sample size was to be divided equally among the four study sites. During the research, only 135 households and 206 children were surveyed due to time constraint.

With respect to the households, either the head of household or the spouse and children was interviewed. Where only one of the couple is available, for any reason, the one available was interviewed and when the couple is available, an alternative choice between genders was made from household to household. As regards the choice of children to be interviewed in the household, a male and a female child within the ages of 6 and 15 years was interviewed. The lower age limit is to ensure some amount of reasoning by the children, while the upper limit is in consonance with the UNAID definition of a child. In situations where the eligible children exceed the desired number in a household, a simple ballot was done to determine which of the children was interviewed.

Families with people affected by AIDS (PABA) in the community were identified for interview purposively through the identified NGOs working with PLWA, Network of PLWA, and hospitals - public and private. It was necessary and important to go through these routes due to the difficulty of identifying such persons given the stigma attached to the AIDS disease. Representatives of the relevant organisations introduced eligible families to the research team only after the study had been introduced and the consent of the affected persons obtained. The individual then had the choice of either making contact with the researchers or the organisation introducing the researchers to the individual at a location convenient to the respondent. In order words, the identity of eligible families unwilling to participate in the study was not revealed to the researchers to safeguard their privacy.

The information provided by the household head or the spouse determined if eligible children to be interviewed exist in the household. If children aged 6 to15 years are in the household, a random selection from the list of children is carried out. The parents whose consent for the interview of the children had been obtained then communicated to the selected child/children. The parent explained the essence of the interview process and the voluntary nature of the exercise to the child who then decided whether to participate or not. If the child consents to the interview, an arrangement for the interview was made as regards the time and place of the interview. Before, the interview, the representative of the research team again obtained the consent of the child for the interview after explaining the essence of the interview to the child. This process ensured that the privacy of the child is also respected.

The instruments for data collection included an adult and a child questionnaire. The adult questionnaire is directed at the head of household or the spouse. Both instruments consist of closed-ended questions that were pre-coded, and some open-ended questions.

Data Collection Procedures

Interviewers recruited for the administration of questionnaires had at least a first tertiary education degree and were able to dialogue in the local language of the respondents. Employed interviewers were also required to sign an employment contract which would limit their ability to pass on the information gained from the research process in such a manner that identifies the research participants. In addition to the educational qualification requirement, recruited interviewers had a three-day training session on the instruments used.

In administering the structured questionnaires, the gender of the respondent was matched with that of the interviewer. During the fieldwork, interviewers worked in pairs at the household level. The researchers daily edited completed questionnaires and carried out supervision of the interviewers to ensure the quality of the fieldwork activities.

Consent And Confidentiality

Consent was obtained from all respondents of the study population. Both the consent of the parents of the children in addition to that of the children was obtained before a child could be interviewed. Where a parent refused to give consent for his/her child to be interviewed, the consent of the child was not sought for an interview. The interview sessions for the study populations were not overheard by a third party and responses of the children were not discussed with the parents and vice versa. It is important to note that

children were not in the knowledge that they were selected to participate in the study because of the HIV status of either of their parents.

RESULTS

The survey collected information from 135 households affected by HIV/AIDS, consisting of 135 adult respondents and 206 children aged between 6 and 15 years.

HOUSEHOLD CHARACTERISTICS

Household characteristics are useful as determinants of the health status of household members, particularly children, as well as indicators of the socio-economic status of households. Most of the household characteristics as presented in Table 1 indicate that the majority of the respondents are from the lower socio-economic strata. Almost 7 in ten and one in five households use one or two rooms, respectively for sleeping, while approximately 11 percent make use of three rooms and above. More than nine in ten have concrete flooring and iron/metal sheets as roofing material. Close to half of the respondents rely on public tap and borehole with pumps for water supply, while another one-fifth rely on protected well. Almost a tenth report rainwater as main source of drinking water. Approximately 6 percent of households do not have access to a sanitary facility, while another two in five make use of either the traditional pit toilet or an open pit. Consumption of meat among the households occurs either a few times in a month or a few days in a week with a little more than one quarter for each group. Households that consume meat everyday with a little more than one-fifth and once a week with 16 percent, in that order, follow. The responses to household assets reveal that the radio is the most common asset with more than eight in ten households, followed by the television with a little more than a quarter households and fridges by almost 45 percent of the households. The bicycle is the least reported by less than 5 percent, with at least 10 percent reporting ownership of cars.

Background Characteristics of Respondents (Adults)

As shown in Table 2, the majority of the respondents live in urban locations and within medium to high-density areas. Approximately eight in ten respondents are females. A little more than half of the respondents were head of their households while a little more than two-fifth were wives to the head of households. The majority of the respondents (70%) are aged between 30 and 44 years and the majority are currently employed, with more than half (54%) in trading activities and another 23 percent as artisans. About 6 percent are professionals and lower white-collar workers, respectively. A little above nine in ten of the respondents were HIV positive while the balance either did not know their sero status (7.4%) or reported negative (2.2%) sero status. Almost nine in ten respondents' sero status was diagnosed between the years 2001 and 2004.

Background Characteristics of Respondents (Children 6-15 years old)

Table 3 shows some background characteristics of the children interviewed in the households visited. About 49.5 per cent are males and 50.5 per cent are females. The mean age is 10.9 years. The results show that about 43 per cent of the children are orphans. A good majority of the respondents are living with their mothers. Panel 4 of the table shows that at least 90 per cent of the respondents are currently schooling. Majority of those in school are attending public schools. . The results show that the proportion of males who have been absent from school at least once in the last month of the school term is higher than the proportion of females. The most pronounced reason for absenteeism of the children is the child being sick (57 per cent) this is followed by lack of money (17.7 per cent), family needs child's help caring for sick family member (7.6 per cent).

Table 1: Percent Distribution by Household Characteristics

Respondents characteristics	Percentage
No of rooms used for sleeping	
1	69.4
2	19.8
3	6.6
4+	4.2
Flooring material	
Concrete	91.9
Mud	5.2
Tiles	2.9
Dirt	0.7
Roofing material	
Iron/metal sheets	91.9
Wood	4.4
Others	3.7
Main source of drinking water	
Piped into dwelling	3.0
Piped into yard	4.5
Public tap	31.3
Borehole with pump	16.4
Rainwater collection	9.7
Bottled water	0.7
Unprotected dug well	3.0
Protected dug well	20.1
Tanker/truck vendor	7.5
Other	3.6
Household toilet facility	
Flush to sewage	30.4
Pour flush latrine	17.0
Improved pit latrine	6.7
Traditional pit latrine	22.2
Open pit	17.8
No facility	5.9
Consumption of meat by household	
Everyday	22.4
Once a week	16.4
A few days a week	26.1
A few times a month	26.9
Never	2.2
Household does not eat meat	3.0
Don't know	3.0
Assets ownership	
Car	10.4
Bicycle	3.7
Radio	80.7
Television	76.3
Fridge	44.4
Others	14.8

Source: Field Survey, 2003/2004 (Adult-centred questionnaire)

Table 2: Percent distribution of Adult Respondents

CHARACTERISTICS OF RESPONDENTS	PERCENTAGE
SECTOR	
Urban	85.2
Rural	14.8
RESIDENTIAL DENSITY	
Low	10.4
Medium	36.3
High	53.3
SEX	
Male	21.5
Female	78.5
RELATIONSHIP TO HEAD OF HOUSEHOLD	
Head of Household	51.4
Wife	42.5
Son	0.7
Daughter	3.7
Other relatives	1.5
AGE GROUP	
20 – 24	0.7
25 – 29	11.8
30 – 34	25.9
35 – 39	22.1
40 – 44	22.2
45 – 49	11.0
50 – 54	2.9
55 +	2.9
WORK STATUS	
Working	77.8
Not working	22.2
TYPES OF OCCUPATION	
Trading	54.1
Professional	5.9
Artisan	23.0
Lower White Collar	5.9
Farming	1.5
HIV/AIDS Counselor	3.0
Unemployed	6.7
HIV STATUS	
Positive	90.4
Negative	2.2
Don't know	7.4

Source: Field Survey, 2003/2004 (Adult-centred questionnaire)

Panel 8 shows activities engaged in after school hours by those currently schooling. A good majority of those currently schooling are engaged in housework 65.4 per cent (62.1 per cent of males and 68.8 per cent of females), and playing with other children (63.9 percent; 63.2 per cent of males and 64.6 per cent of females). The data shows that while 9.5 and 12.5 per cent of males and female children respectively work for wages after school hours, it is only the females that reported caring for sick household member after school hours. For those out-of-school the two most pronounced reasons for being out of school are lack of money for school expenses and need to help the family to care for sick family member.

Table 3: Background characteristics of Children interviewed

CHARACTERISTICS				ALL
		M(102)	F(104)	
Age	6-10yrs	53.9	47.1	50.5
	11-15yrs	46.1	52.9	49.5
	Mean age	*10.8*	*11.0*	10.9
Proportion of orphans		40.2	45.2	42.7
Person lived with	Both parents	37.3	35.6	36.4
	Mother only	45.1	50.0	47.6
	Father only	7.8	3.8	5.8
	Guardian	9.8	10.6	10.2
Currently schooling		93.1	92.3	92.7
Type of school[5]	Public	69.5	67.7	68.6
	Private	30.5	31.3	30.9
	Mission	-	1.0	0.5
Absenteeism from school[6]		45.3	36.2	40.7
Reason for absenteeism[1]	No money	18.6	16.7	17.7
	Child refuses school	-	2.8	1.3
	Family needs child for chores	2.3	5.6	3.8
	Family needs child's help caring for siblings	-	5.6	2.5
	Child is sickly	60.5	52.8	57.0
	Family needs child's help caring for sick family member	11.6	2.8	7.6
	Other	18.6	16.7	17.7
Activities engaged in after school[1]	Housework	62.1	68.8	65.4
	Playing alone	14.7	16.7	15.7
	Playing with other children	63.2	64.6	63.9
	Looking after other children	5.3	8.3	6.8
	Working for wages	9.5	12.5	11.0
	Working in another Household	1.1	1.0	1.0
	Caring for sick household member	-	5.2	2.6
Reason for being out of school[7]	No money for school expenses	57.1	100.0	80.0
	Child refuses to go to school	-	12.5	6.7
	Family needs child's help caring for siblings	-	12.5	6.7
	Child does not get along with other children	14.3	-	6.7
	Child's performance in school was too poor	14.3	12.5	13.3
	Child works for wages	14.3	12.5	13.3
	Family needs help to care for sick family member	14.3	37.5	26.7
	Others	28.6	-	13.3

Source: Field Survey, 2003/2004 (Child-centred questionnaire)

SITUATION OF CHILDREN

Economic Activities

Data revealed that 23.3 percent of the children were engaged in an income generating activity. Table 4 shows that, across the two states, 22.5 per cent of male and 24 per cent of female children interviewed were engaged in an economic activity. Trading is the activity in which majority of the children were engaged in (60.9 per cent of males and 80 per cent of females). The three most pronounced things which income from the economic activities are spent on include shared household needs [food, soap, etc] (52.2 per cent of males and 36 per cent of females), child's own shoes, clothes etc. (34.8 per cent of males and 48 per cent of females) and child's own school fees, books, uniforms (21.7 per cent of females and 28 per

[5] For those schooling

[6] Shows the proportion who have been absent from school at least once in the last month of the school term, among those schooling

[7] For those not currently in school

cent of females). Other things on which such incomes are spent include school fees for siblings, medicine and care for sick household member and child's own recreation.

Table 4: Percentage distribution of Children's Involvement with economic Activities

ACTIVITIES		M(102)	F(104)	ALL
Engaged in economic activity		22.5	24.0	23.3
Type of economic activity engaged in	Auto repair	8.7	-	4.2
	Trading	60.9	80.0	70.8
	Tailoring	-	4.0	2.1
	Others	34.8	16.0	25.0
Main thing income is spent on	Shared household needs, food, soap, etc	52.2	36.0	43.8
	Medicine, care for sick HH member	4.3	8.0	6.3
	Child's own school fees, books, uniform	21.7	28.0	25.0
	Sibling's school fees	4.3	16.0	10.4
	Child's own recreation	4.3	12.0	8.3
	Child's own shoes, clothes, etc.	34.8	48.0	41.7
	Others	8.7	24.0	16.7

Source: Field Survey, 2003/2004 (Child-centred questionnaire)

Exposure To Skill Acquisition

Data revealed that only 8.3 percent had been exposed to training programme for skill acquisition, while only 23.5 per cent of them had been involved in skill acquisition organised by NGOs (Table 5) The data shows that the more males have participated in any training program compared to the female children. Tailoring and Auto mechanics are the two main skills the children are involved in. A higher proportion of females are engaged in tailoring than the proportion of males engaged in same skill.

Table 5: Percentage distribution of Children's Exposure to skill acquisition

EXPOSURE TO SKILL ACQUISITION		M(102)	F(104)	ALL
Participated in any training program for skill acquisition		8.8	7.7	8.3
Participated in any skill acquisition training program organized by NGOs		33.3	12.5	23.5
Type of skill acquisition involved in[4]	Tailoring	22.2	87.5	52.9
	Auto mechanics	11.1	-	5.9
	Others	55.6	-	29.4

Source: Field Survey, 2003/2004 (Child-centred questionnaire)

Use Of Leisure

Table 6 shows activities the children engage in at their leisure time. The results show that 39 per cent of males and 49.5 per cent of females read during their leisure time. The implication is that their leisure time is the only time that they could do some reading especially those who are currently schooling. About 37 per cent of the males and 22.8 per cent of the females reported being engaged in sports/physical activity. Some of the other activities children are engaged in during their leisure period include non-physical games; dance/music/drama; crafts, weaving, art, basketry. About 12 per cent of the children are engaged in other activities.

Table 6: Percentage distribution of Children's Use of leisure

	M(102)	F(104)	ALL
Sports/physical activity	37.0	22.8	29.9
Reading	39.0	49.5	44.3
Games (non-physical)	11.0	9.9	10.4
Dance/music/drama	1.0	4.0	2.5
Crafts, Weaving, art, basketry	-	2.0	1.0
Others	12.0	11.9	11.9

Source: Field Survey, 2003/2004 (Child-centred questionnaire)

Negative Changes On Children

The children were asked on the particular negative changes they had observed in what they could do in the past compared to the present. The data (see Table 7) shows clearly that food and leisure were the most affected. About 39.5 percent of the children reported having less food to eat, this is more prominent among the males. In terms of negative change on their leisure, at least one-fifth of the children reported that they now have less leisure time compared to the past, with the impact on the females (26 per cent) being higher than on the males (16.8 per cent). This may partly be due to the fact that a higher proportion of female children work for wages after school, are involved more in housework, playing with other children. About 16 per cent of the males who were schooling reported that their attendance at school had dropped, while 8.5 per cent of them also said that their grades in school worsened. Among the female children interviewed school attendance dropped for about 9.4 per cent of those currently in school and 8.3 per cent of them mentioned that their grades in school worsened.

Table 7: Percentage distribution of Negative Changes on children

	M(102)	F(104)	ALL
School attendance dropped[8]	16.0	9.4	12.6
Grades in school worsened[4]	8.5	8.3	8.4
Child has less food	43.6	35.6	39.5
Child has less leisure time	16.8	26.0	21.5
Others	8.9	11.5	10.2

Source**:** Field Survey, 2003/2004 **(**Child-centred questionnaire)

Child Communication

The children were asked whom they would prefer to talk with when they have problems or are worried, and who would be an alternative peradventure the first person is unavoidably absent. The data shows that, about 69.3 per cent of the children would talk to their mother, while only 19 per cent of the children reported that they would first talk to their fathers. This may be due to the fact that about 47 per cent of them live with their mothers.

Table 8: Percentage distribution of Person child discusses with when worried or has a problem

		M(102)	F(104)	ALL
First person	Father	23.8	14.4	19.0
	Mother	64.4	74.0	69.3
	Siblings	3.0	4.8	3.9
	Friends	3.0	3.8	3.4
	Others	5.9	2.9	4.4
Next person if First person not available	Father	24.0	29.4	26.7
	Mother	24.0	15.7	19.8
	Siblings	18.0	22.5	20.3
	Friends	5.0	3.9	4.5
	No one	13.0	11.8	12.4
	Others	16.0	16.7	16.3

Source: Field Survey, 2003/2004 (Child-centred questionnaire)

Stigma And Discrimination

Table 9 shows the percentage distribution of the respondents' opinion regarding stigma and discrimination children undergo. The result shows that about 40 percent confirm that children of households affected by AIDS are treated differently compared to other children in the society. Neglect and avoidance being the major negative treatment that the children suffer (87.0 percent). Neglect and avoidance was closely followed by verbal abuse as reported by 53.7 percent of respondents. About 66.7 and 51.1 percents of male and female respondents agreed that the children suffered from verbal abuse and

[8] For those currently in school

teasing. At least a quarter of the respondents reported that some of the children drop out of school. Also one-fifth reported the children are physically abused. As regards sexual abuse, only 2.2 per cent of the female respondents agreed that children from HIV-afflicted homes do suffer sexual abuse. Only female respondents (13.2 per cent) agreed that these children are underfed. Only female respondents, 8.9 per cent alluded to the fact that properties are taken away from children of HIV/AIDS household.

Table 9: Percentage distribution of parents' perception of stigma and discrimination

STIGMA & DISCRIMINATION	M	F	ALL
Orphans treated differently	30.0	42.9	40.0
Neglected/avoided	100.0	84.0	87.0
Verbally abused/teased	66.7	51.1	53.7
Physically abused	33.3	17.8	20.4
Sexually Abused	-	2.2	1.9
Underfed	-	13.2	11.1
Not allowed to go to school	22.2	28.9	27.8
Property taken	-	8.9	7.4
Made to do more chores	-	4.4	3.7
Others	11.1	-	1.9

Source: Field Survey, 2003/2004 (Adult-centred questionnaire)

CHILDREN'S NEEDS

The needs as perceived by the children are as shown in Table 10. The data shows that education-related issues rank highest in the reported needs of these children. Majority (48.1 percent) reported need for school items such as school uniform, bag, pair of sandals and textbooks. About 16.5 percent reported their wish to continue education. These, obviously, are children who have had to drop out of school as a result of their situation. Other major request mentioned was the general need for financial assistance, as mentioned by 17.5 percent.

Table 10: Percentage distribution of children's needs

Reported Needs	**Percentage**
School uniform, bag, pair of sandals, text books	48.1
Financial assistance	17.5
Continue education	16.5
Nothing	8.3
Better feeding	6.8
Cloths, better accommodation, games	6.3
Want to change school to a better one	4.9
Medicine for sick parent	2.4
Wrist watch	1.5

Source: Field Survey, 2003/2004 (Children-centred questionnaire)

The children require more efforts from their parents in relation to the following; schooling, feeding, clothing, accommodation and improvement in parents' health in order to be able to care for them (Table 11). The main issues identified are critical to children's health, future development and self-esteem, and as such require urgent attention.

Table 11: Percentage distribution of Children's perception of what their parents need to do more

NEEDS/REQUIREMENTS	**M (102)**	**F (104)**	**All**
Financial assistance to complete school	37.3	34.6	35.9
More clothes, food	27.5	29.8	28.6
Qualitative education	6.9	3.8	5.3
Get well, live more years &care for us	-	1.0	0.5
Accommodation and liberty	2.9	-	1.5
Nothing more	15.7	12.5	14.1

Source: Field Survey, 2003/2004 (Children-centred questionnaire)

Children's perception of the reason why their parents have been unable to meet their needs was also sought and the responses are presented in Table 12. All the reasons given are associated with the HIV/AIDS status of one or both parents. A little above one-fifth identified the illness of parents as reason for parent(s) inability to meet their expectation. This factor is followed by decline in household income, which is a concomitant of parent(s) illness.

Table 12: Percentage distribution of Child's perception of parent's inability to meet his/her expectation

	Total		
	M (102)	**F (104)**	**All**
Decline in income/lack of money	10.8	17.3	14.1
Mother not being able to work anywhere	6.9	-	3.4
Ill health of parent	23.5	21.2	22.3
Father jobless, mother not making enough money	2.9	2.9	2.9
Father dead, financial burden on mother too much	3.9	3.8	3.9
Too busy doing other activities	2.9	1.0	1.9
Parents are separated	1.0	1.0	1.0

Source: Field Survey, 2003/2004 (Children-centred questionnaire)

DISCUSSION

The study shows that HIV/AIDS affects the survival and development of children greatly in terms of health, education, social welfare and protection. The most significant effect of HIV/AIDS on the social welfare and protection of children is the disintegration of traditional support structures and "social safety nets". As the number of affected children increases, the capacity of the community to support these children is being stretched significantly. The death of one or both parents and the resulting increased household expenditure on health, place more economic responsibilities on children. Many are forced to drop out of school and take up work to contribute to family incomes. A study in Burundi also found that children in AIDS affected households begin work for income at younger ages compared to unaffected households, becoming involved in petty trading and running errands at the ages of six or seven (Roudy et al. 2001).

Growing household poverty and the increase in demand for uninfected younger sexual partners has the tendency to increase the numbers of children who may become sexually abused and may virtually get involved in commercial sex. This inevitably puts children, especially girls, at extreme risk of contracting HIV. Children who are orphaned may be at greater risk of being trafficked and sexually exploited. In seriously affected communities the whole nature of childhood is changing fundamentally.

Children begin to be affected well before the parents die. Denial of education and involvement in informal sector labour can lead to reduced play opportunities and socialisation is adversely affected, impeding self-esteem development. Orphans often are deprived of education as foster parents (often mistakenly) assume the child is HIV positive and consider the opportunity costs of education as too high. Infected children are sometimes denied school-fees from caregivers due to impending funeral costs (Alidri 2001). For those remaining in school, performance deteriorates due to worry, depression and other physiological manifestations of anxiety.

It has been suggested that HIV/AIDS will be the main obstacle to reaching national poverty reduction targets and the UN Millenium Development Goals. Hitherto most policy responses internationally have been focused on prevention, control and treatment. There has been little on mitigation, even less specifically on orphans (Loewenson and Whiteside 2001). Yet AIDS and impacts cause and deepen poverty. HIV/AIDS is directly and indirectly linked to a host of negative outcomes that include reduced social sector spending, giving rise to a lack of access to affordable health care and prevention services; and lower education status; falling household per capita income, increased spending on medicines and

funerals; lost productivity, disrupted farming cycles and systems; increased dependency ratios, worse gender inequalities, increased number of orphans, street children, crime, and commercial sex work. These outcomes inevitably and unavoidably give rise to perverse household risk management strategies including sale of land and assets (Cohen 1998; Hunter 2000; Loewenson and Whiteside 2001; Adeyi et al. 2000)

CONCLUSIONS

The study identified a clear impact of HIV/AIDS at the family and individual levels. The analysis further made clear that in several respects the impact of HIV/AIDS could be related to the specificity of this disease. At the family level, it was observed that the serological status of individual members is rarely known. The taboo that characterises the disease continues to influence this, and was found to be strongly related to the stigmatisation it was likely to provoke when the serological status of individuals would be known. The risk of stigmatization appeared to exist not only at the level of communities but also within families.

For HIV/AIDS-infected families, health care expenses constitute a heavy burden, and this is reflected in the importance attached to this need by respondents and its impact on provision of other needs in the household. The presence of HIV/AIDS in families entails a variety of forms of instability and thus contributes to unstable and progressively degrading living conditions for children. In addition, the disease was found to explain several forms of matrimonial instability as well as the decline of social networks over time. This obviously worsens the living conditions of children. Finally, HIV/AIDS appeared to have a strong impact on self-perception, emotional stability and the construction of individual and family identities, among children.

The results of the present study suggest that if the programmes which aim to reduce the presence and impact of HIV/AIDS were to be strengthened, these should come to include specific components that focus on children and families that are vulnerable to HIV-infection, notably in the field of communication on HIV/AIDS. These programmes would not be limited to prevention efforts but should cover care for the infected as well.

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