

**SOCIAL AND ECONOMIC CONSEQUENCES OF
HIV/ AIDS ON CHILDREN**

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By

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INTRODUCTION

This is a baseline study on the situation of children affected by HIV/AIDS in a high density local community, Mabvuku in Harare conducted by the author in October 2006. Mabvuku, with a total population of 300 000 persons lies 20 kilometers East of Harare, the capital city of Zimbabwe. This is an impoverished community which carries a high burden of orphans and vulnerable children (OVCs).

AIDS has emerged as one of the most serious diseases facing the developing world, particularly sub-Saharan Africa. Today, of the estimated 38.6 million people living with HIV globally, two-thirds are in the sub-region especially southern Africa (UNAIDS 2005). In many societies, it is becoming clear that HIV/AIDS has substantial social, economic, and demographic impact on individuals, households, communities and nations, particularly women and children. It is against this background that this paper seeks to improve understanding of the social and economic consequences of HIV/AIDS on children.

BACKGROUND

It is estimated that there are presently some 8 million children in Africa who have lost one or both parents to HIV-related illness and that by 2010 these numbers will have increased to some 40 million. In many countries the proportion of children who have lost one or both parents will be as high as 20 to 25% by the end of the first decade of the new millennium. These trends have direct implications for intergenerational poverty and impose immense challenges for policy makers (Cohen, 2002).

There is great commonality in the plight of children, families and communities affected by HIV/AIDS in the Southern African region. However the situation of children

affected by HIV/AIDS in Zimbabwe is expected to be worse-off due to worsening social, economic and political circumstances in the country. According to Richter, Manegold and Pather (2004) since the advent of the HIV/AIDS pandemic, there have been frantic efforts by Governments, non-governmental organisations and community-based organisations to curb its spread. However, the situation of children and families affected by HIV/AIDS still remains adverse.

Mhloyi (2005) noted that much attention has focused on prevention. Care and support to children in AIDS-affected families and communities has been given little attention. Care for HIV/AIDS orphans often falls on the traditional system of extended families, stretching the capacity of these social safety nets. It has further been observed that these children are less likely to attend school, more likely to be malnourished, less likely to receive healthcare and usually very poor (Richter et al. 2004). They most often end up on the streets where they pursue survival strategies that put them at high risk of contracting HIV. According to Mhloyi (2005) addressing the needs of orphans and vulnerable children, their caretakers and communities, has emerged as a major strategy in the fight against HIV/AIDS.

Richter et al. (2004) further show that direct impacts of HIV/AIDS on families and households are discernible as families attempt to adjust to the stresses of economic decline and demoralisation and these include the emergence of child - or adolescent - headed households, separation of siblings, family breakdown, child abandonment and remarriage.

Mhloyi (2005) further observe that apart from economic issues, such as the livelihood activities of household members, a number of key demographic dimensions such as gender, ages of affected children and the location of the household mediate the impact of HIV/AIDS, families and communities.

The impact that HIV/AIDS has had on children in Zimbabwe has been particularly devastating, especially, in the light of the deteriorating socioeconomic environment. In Zimbabwe, with a national HIV prevalence rate of 18.1 percent (CSO/ MACRO Inc, 2007) among the adult population and the resulting morbidity and mortality, the impact of HIV and AIDS on vulnerable groups like children and women, especially those living in poor high density suburbs such as Mabvuku is enormous. Issues such as loss of income when breadwinners lose the capacity to work, loss of labour for subsistence production, increased expenditure on modern and traditional health care, and loss of assets and inheritance, have been reported to have a great impact on children (Mhloyi 2005).

The impact of HIV/AIDS on traditional household coping mechanisms can be simplified as follows: increase in mortality and morbidity results in shortage of labour, loss of agricultural and community organisational skills and increased poverty among families. As a result of such mortality and morbidity households lose cash income, credit, general income, and supply services (Richter et al. 2004).

Women, as widows are affected more acutely as they are forced to relinquish their family possessions to the late husband's next of kin. At the family level, adults with AIDS drain household resources, reduce work output, increase medical expenses and diminish income earned by the person infected as well as the person caring for him/ her. In turn, the reduced income threatens food supply, the ability to pay for education or health care for surviving members, and the ability to invest in productive inputs such as education for children (Mhloyi 2005).

A large number of papers document the impact of HIV/AIDS on children (for example, Caldwell 1997; Desmond, Richter, Makiwane and Amoateng 2003; Strode and

Bannet- Grant 2003; Mhloyi 2005). While these studies are highly commendable, none to date have shown linkages between the degenerating political and economic circumstances in Zimbabwe and HIV/AIDS. Zimbabwe is thus an interesting case to study the consequences of HIV/AIDS on children. The high prevalence of HIV in the country and the unrelenting decline in the standard of living in both rural and urban communities make it crucial to carry out a study of this nature. It is necessary that further research, preferably on a broad national scale be carried out to establish the situation of children, families and communities affected by HIV/AIDS viz-a-viz the current difficult social, economic and political situation in Zimbabwe.

The objective of the baseline study was to improve understanding of the social and economic consequences of HIV and AIDS on children and households in Mabvuku (a high density community in Harare) with specific regard to education, health and welfare, living conditions and psychosocial well-being with a view to generating findings and recommendations for use in designing appropriate interventions to ameliorate the plight of children affected by AIDS.

METHODS

Survey Method

A household survey was undertaken in the survey area in April 2006. The first step was the selection of households in each of the three wards in Mabvuku, Ward 19, Ward 20 and Ward 21. The sampling frame was the total number of households in each of the three wards. A representative sample of 236 households was selected and successfully interviewed. They comprised of 185 CABA (children affected by AIDS) and 51 non-CABA households. Therefore 236 parents/ guardians were interviewed. A total of 245 children were selected

and interviewed. They comprised of 193 CABA and 52 non-CABA. This representation was deemed statistically appropriate for analytical purposes. CABA was the treatment group while non-CABA was the control group.

Sample Size Determination

The sample size required was determined through a combination of the following factors:

- Reasonable estimates of key proportions to be measured in the study. To get these estimates we assumed proportions of the variables of interest to be above 50% of the sample. This maximised the expected variance and therefore indicated a sample size that is sure to be large enough.
- The degree of accuracy of 0.05. This means that deviations of sample estimates from the true population will only be considered accurate if the significance level is 5% or better.
- Confidence interval of 95%. This is the degree to which one is confident of the sample estimates. The customary 95% confidence interval will be adopted.
- Size of population which is at least 10 000 persons. In this case the size of the population that the sample is to represent is above 10 000 persons. On the basis of this premise, the sample size was calculated using the following formula:

$$N = Z^2 pq / (d)^2$$

Where:

N = the desired sample size,

Z² = the standard normal deviate usually set at 1.96 which corresponds to 95% confidence interval,

p = the proportion in the target population estimated to have a particular characteristic,

$q = 1.0$,

d^2 = degree of accuracy desired. This is set at 0.05 in this study.

In calculating the sample size the population data for Mabvuku from the Zimbabwe 2002 Population Census was used, as well as Ward maps obtained from the Central Statistical Office. The EPI - INFOR STATCAL programme uses the above stated formula in computing sample household sizes. The response rate from the survey was 100%.

The Household Survey

The household survey consisted of children, that is, CABA (treatment group) and non-CABA (control group) and guardians/parents of both groups. CABA included children below 18 years living with AIDS orphans, children below 18 years living with a chronically ill person and AIDS orphans below 18 years. It is important to note that one cannot scientifically conclude that children orphaned and affected by HIV/AIDS are worse off if there is no comparative group. Thus children in similar age groups who were not affected by HIV/AIDS were sampled. For example, if in household X there was a child affected by AIDS who was included in the survey; a child not affected by AIDS was randomly selected from a household not affected by AIDS in the same neighbourhood. Similar neighbourhoods were necessary in order to control for the impact of variable socio-economic contexts. The age group of children interviewed in the survey was 10 to 18 years. Additionally, a special psychosocial instrument was specifically administered directly to children aged 10 to 18 years, while similar information was collected from the guardians of those children aged 5 to 9 years.

Data Analysis

Survey data was captured and analysed using the Statistical Package for Social Sciences (SPSS). A simple but detailed descriptive analysis detailing the situation of CAB and non CABA was undertaken.

RESULTS

Introduction

This section presents the findings from the survey. The data are presented thematically as follows: demographic profile, education, socio-economic needs, health and other basic needs, child welfare and psychosocial well being. As stated earlier, the respondents in the household survey were children and adults. As stated earlier in this paper, CABA was the treatment group while non-CABA was the control group. In order to measure the impact of HIV/AIDS on orphans and vulnerable children, we constantly draw comparison between these two groups in the analysis in this paper.

Demographic Profile

Geographical Distribution of Respondents.

Of the 193 CABA interviewed, 30.6% (59) were enumerated in Ward 19, 31.6% (61) in Ward 20, and 37.8% (73) in Ward 21. Of the 52 non-CABA interviewed, 38.5% (20) lived in Ward 19, 55.8% (29) in Ward 20 and 5.8% (3) in Ward 21, see Figure 1. Of the 185 CABA guardians surveyed, 29.2% (54) were in Ward 19, 34.1% (63) were in Ward 20, and 36.8% (68) were in Ward 21. Of the 51 (non-CABA) parents surveyed, 31.4% (16) lived in Ward 19, 38.1% (19) in Ward 20 and 30.5% (16) in Ward 21, see Figure 2. The distribution

of CABA and non-CABA by gender was such that 52.3% of CABA (101) were females and 47.7% (92) were males. Of the non-CABA 43.1% (22) were females while 56.9% (30) were males.

Household headship CABA and non-CABA.

The children in the survey were asked to mention the head of household. We observed that only 5.2% of CABA had their father as the head of household while 32.5% in the same category reported that their mother was head of household. A fifth of CABA in the same category reported that their maternal grandmother was the head of household. Eight percent had either a sister or brother as the head of household. Of the non-CABA, 73.1% had either their mother or father as the head of household. In the same category of children none reported their sister or brother as the head of household.

Marital Status of Head of Household, CABA and non-CABA.

As expected, 50.3% of the CABA reported that the head of household was widowed. Two fifths of the non-CABA reported that the head of household was married while 13.5% said the head of household was widowed.

Education

School Enrolment.

An analysis of school enrolment data for CABA and non-CABA illustrates that school enrolment dropped from the year 2005 to 2006. For CABA school enrolment decreased by 6.4% from 2005 to 2006. The school enrolment rates for 2005 and 2006 were 85.8% and 79.4%, respectively. The corresponding rates for 2005 and 2006 for non-CABA were 90.4% and 80.8%, respectively. Hence for non-CABA school enrolment dropped by

9.6%. These findings have implications for the accelerated learning programme implemented by various NGOs in the study area. There is definitely need to expand the programme so as to be able to reach out to all needy and vulnerable children. However, further investigation is required into why non-CABA seem to have dropped out of school at a higher rate than CABA.

Reasons for not Being at School.

Twenty-one percent (40) of the CABA were not in school as compared to 17.3% (9) non-CABA. The main reason cited for not being at school was lack of money 65% (26) CABA and 88.9% (8) non-CABA). Thirteen percent (5) of the CABA were not in school because they did not have birth certificates. Again there is need to expand the accelerated learning programme to cater for those children orphaned by HIV/AIDS, the bulk of whom have no one to pay school fees for them. The school dropouts programmes implemented by Department of Social Welfare and non Governmental Organisations (NGOs) need to respond to the growing challenges of the increasing numbers of children not at school and/or dropping out of the school system.

Asked on whether they would like to go to school 90.2% (36) of the CABA and 98% (9) of non-CABA said they were willing to go to school. An issue that requires further investigation is that 9.8% (4) of CABA not at school said they did not want to go school. One of the reasons cited by one such child was: *"Even If go to school I would still be hungry since we have no food to eat here at home. It is better for me to roam the streets because eventually I find something to eat from my friends and other well wishers."*

Food Provision

Supply of Food.

Thirty-three percent (63) of CABA said their relatives supplied them with food compared to 17.3% (9) of non-CABA. NGOs supplied food to 7.7% (15) of CABA and 1.9% (1) of non-CABA. The school supplied food to 14.0% (27) of CABA and 42.3% (22) of non-CABA.

Access to Food.

The children were asked the type of food they had access to. Ninety-nine percent of CABA said they had access to the local staple food, maize/sadza while 96.2% of non-CABA reported the same. Ninety-three percent of CABA and 98.1% of non-CABA said they had access to vegetables. Only 11.9% of CABA and 11.5% of non-CABA had access to milk. A third of CABA and half of non-CABA had access to meat. A quarter of CABA as compared to a third of non-CABA had access to bread. Only 9.8% of CABA had access to rice, as compared to 23.1% of non-CABA.

Number of Meals per Day.

In order to assess the provision of food to children, children in the survey were asked the number of meals they had per day. Only 24.9% (48) and 40.4% (21) of non-CABA said they had at least three meals per day. None of the CABA and only 1.9% of the non-CABA said they had at least four meals per day.

Adequate Food All the Time.

Adequate was taken to imply from the child's perspective whether the child thought the food he/she got was enough. It is important to note that what the survey sought was the child's own subjective perspective and perception on the adequacy of the food. Hence there was no systematic measurement of what was adequate. "*Rarely*" was taken to clarify once per week. The children in the survey did not experience any difficulties in responding to this question. Twenty-two percent (42) of CABA and 42.3% (22) of non-CABA said they always had adequate food. Twenty-nine percent (55) of CABA and 26.9% (14) of non-CABA said they rarely had adequate food. Eleven percent (22) of CABA and 9.6% (5) of non CABA rarely had enough food.

Child Health

Child Morbidity.

A quarter of CABA and non-CABA reported that they had been sick in the last month. The common ailments reported were cough (24.0% CABA and 21.4% non-CABA), headache (20.0% CABA and 28.6% non-CABA) diarrhoea (22.0% CABA and 14.3% non-CABA).

Person Responsible when Child is seriously Ill (N = 245).

The children were asked whom they thought would be responsible for them in the event that they fell seriously ill. Their responses are shown in Figure 3. As expected 69.2% of non-CABA said their parents would be responsible for them as compared to 34.4% of CABA. Similarly 25.5% of CABA cited their guardian as the responsible person as compared to 17.3% of non-CABA.

Child Welfare

Visiting/ Checking on Children.

The children in the survey were asked to state whether anyone visited/ checked in them. This question was necessary in determining the social well being of children. Checking on the children was taken to imply visits by persons such as caregivers. Forty-five percent (110) of the children (76 CABA and 34 non-CABA) responded that someone visited/ checked on them.

Data in Figure 4 reveals that both CABA and non-CABA had persons and/or organisation that visited/ checked on them. However, non-CABA were more likely than their CABA counterparts to be visited/ checked on (57.7% non-CABA compared to 41.1% CABA). The majority of CABA (67.1%) and non-CABA (64.9%) were visited by relatives. NGOs visited 7.9% of the CABA and none of the non-CABA.

Relationships with other Children.

Children were probed on how other children whom they stayed with related with them. It was encouraging to note that children tended to create an enabling healthy environment for their counterparts. Close to 63% and 72.5% of CABA and non-CABA, respectively, responded that other children they stayed with treated them in a friendly manner. A third of the CABA said they were treated like a family member. Only 3.7% of CABA and 4.0% of non-CABA said they were either beaten or scolded by other children they stayed with.

Treatment of Child by Parent/ Guardian.

The survey further sought information on how children were treated by their parents/ guardians. Seventy-one percent of CABA and 74.5% of non-CABA said that their parents/ guardians regarded them as children. It is however worrying to note that there were some children, particularly CABA who reported ill-treatment from their guardians, 2.1% were overworked, a similar proportion were scolded while 0.5% were denied either food or education.

Psychosocial well-being.

The survey had a psychosocial assessment component as an integral component. Basically this was meant to provide the benchmark upon which to determine the psychosocial well-being of children in the survey. A standard checklist obtained from the Family Support Clinic in Harare was adopted for this assessment. CABA were more likely than non-CABA to experience bad sleep badly (17.6% vs. 11.8%), feel tense and nervous and worried (22.3% vs. 17.6%), and feel that one is a worthless person in life (17.2 vs. 0.0%). Headaches were predominant among CABA and non-CABA, 39.4% and 35.3%, respectively. The non-CABA were more likely to experience the following than CABA, feel unhappy than usual (31.4 %vs. 28.6%), have lost interest in things (23.5% vs. 8.9%), experience poor digestion (15.7% vs. 12.4%) and feel easily frightened (19.6 %vs. 18.7%).

DISCUSSION

This study has shown that HIV/AIDS has adverse impacts on children. The consequences of HIV/AIDS on children include depression, reduced well-being, increased malnutrition and starvation, loss of health status, loss of educational opportunities, increased street living and exposure to HIV infection. However, what is even more important from this study is that the general well-being of all children in the study area is being compromised. The results are consistent with observations from other studies conducted in Botswana, Zambia and South Africa. Richter et al. (2004) concluded that quality and availability of health, welfare and education systems in southern Africa are deteriorating because of demands caused by HIV/AIDS for resources and services because of loss of staff due to AIDS illness and death, and because of a reduced tax base.

This study showed a gloomy scenario for both CABA and non CABA across all the socio-economic indicators studied. This agrees with the observation that the problems of HIV affected children, families and communities overlap considerably with the problems associated with poverty. However, HIV/AIDS exacerbates these problems, partly because of stigmatisation and partly because multiple stressful events are repeated in affected families and communities. The major conclusion to be drawn from this study is that the consequences of HIV/AIDS on children, families and communities are influenced in the main by the broader socio-economic status of individual families and communities including access to basic services, and the acceptance of HIV/AIDS as a problem that affects everyone.

The social networks have to a large extent been constrained by persistent poverty, unemployment and political mayhem in poor high density communities in Harare. The social

networks are resultantly less supportive. Caregivers are frequently absent as a result of livelihood activities and this leaves children less protected. Kin and neighbours have taken the support of affected families, thus stretching the resources of everyone.

According to the Jaipur Paradigm developed by Barnett, Whiteside and Decosas (2000), the speed and extent with which the HIV/AIDS epidemic affects communities depends on the overall wealth of the community and the degree of social cohesion that pertains in the society. By social cohesion is meant the strength of community groups such as parent-teacher associations, faith based groups, and others who are in a position to act in a united way to mitigate the effects of the epidemic on the children.

CONCLUSIONS

Overall in the findings, high levels of various types of suffering and distress are found among CABA; sometimes these levels are very similar to those observed among non-CABA. The findings present a picture of general disadvantage among children in Harare, with a sometimes elevated degree of hardship found among CABA. Therefore the focus of policy measures should be on mitigating the suffering of all children which will elevate the quality of life for CABA and non-CABA.

The impact of HIV and AIDS on children has been exacerbated by the political turmoil and socioeconomic difficulties being experienced by families in this community. There are no short cuts or quick solutions. A sustained commitment to protecting and improving the lives of these children needs to link community programmes and actions with those at the global level, so that new interventions can achieve the widest possible impact.

Families need support to deal with the burden of additional children in the household caused by HIV/AIDS morbidity and mortality. Such assistance can be targeted to

particular children or households identified to be exhibiting emotional problems or it can be offered on a wide scale in the whole community. Literature concurs on the overlap between problems of HIV affected children, families and communities and poverty (Mhloyi 2005; Richter et al. 2004; Barnet, Whiteside and Decosas 2000). It is in order to advocate for the need to address the worsening socio-economic and political situation in Zimbabwe along with programmes towards mitigating the suffering of all children and families.

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APPENDICES

Figure 1: Distribution of CABA and Non-CABA by Ward in Study Area (n = 245)

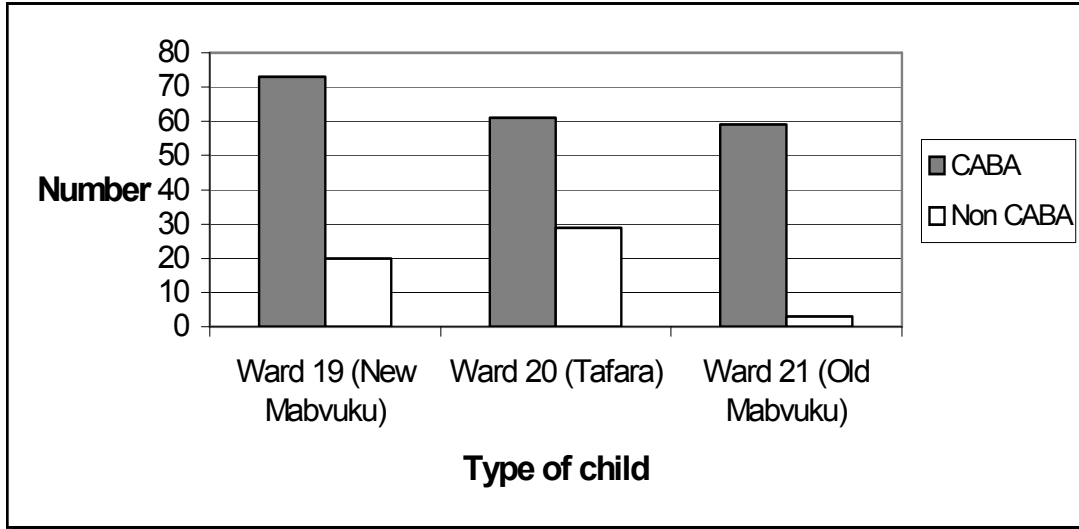


Figure 2: Distribution of Guardians and Parents Interviewed by Ward (n = 236)

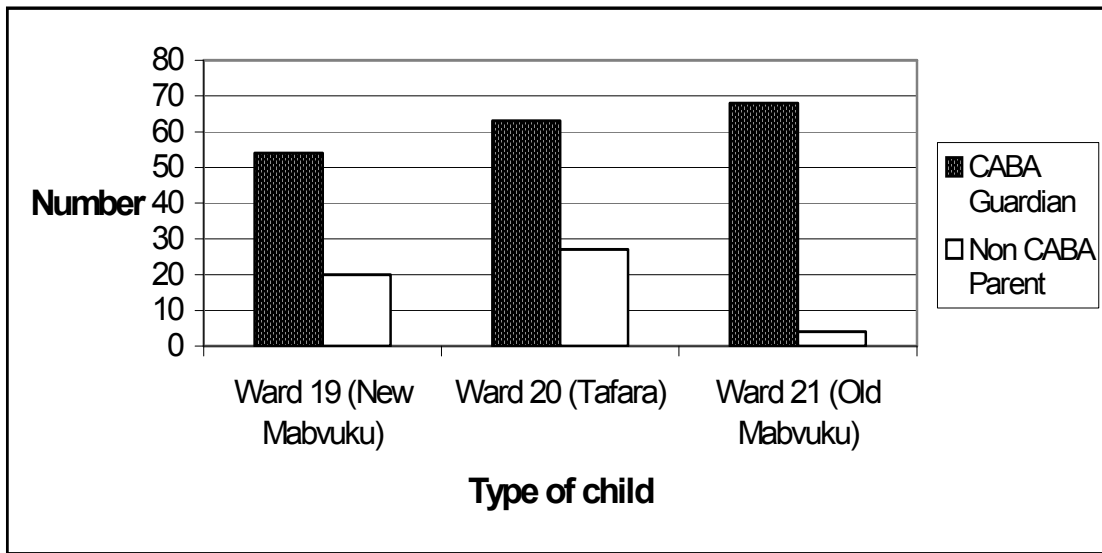


Figure 3: Percent Distribution of Children by Person they thought would be

Responsible for them in the Event that they Fell Seriously Ill (n = 245)

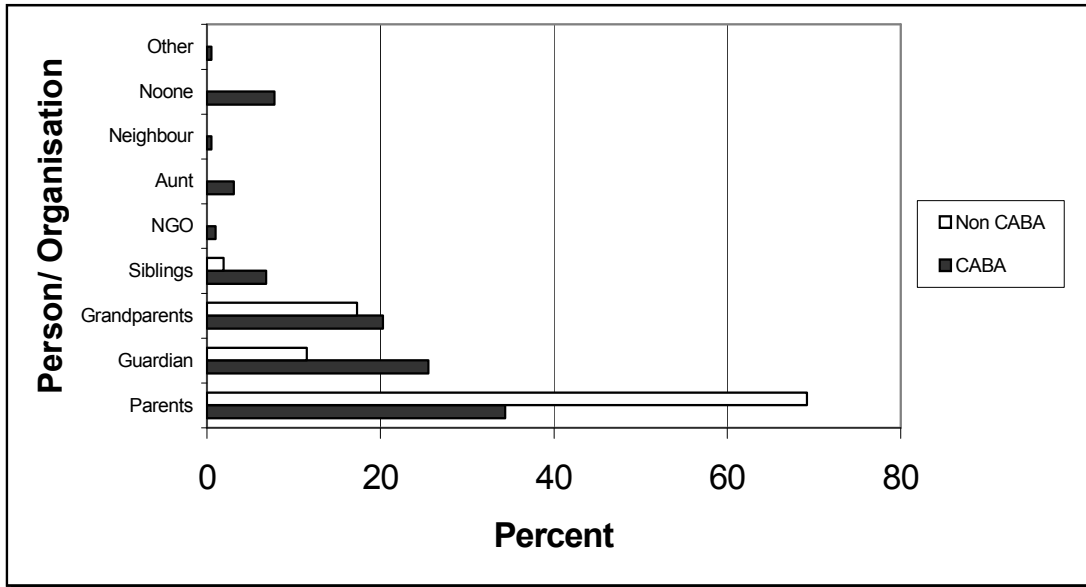


Figure 4: Percent Distribution of Children by whether or not anyone Visited/

Checked on them (n = 245)

