

The Hidden Battle: HIV/AIDS in the Family and Community

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Abstract

The AIDS epidemic will cause significant increases in illness and death in prime age adults. This will affect both households and communities. Prime age adult illness and death will manifest itself through negative social, economic and developmental impacts.

The economic impacts at the household level of the epidemic are decreased income, increased costs, decreased productive capacity and changing expenditure patterns.

Three coping strategies are observed: altering household composition; withdrawing savings or selling assets; receiving assistance from other households.

Following death, the impacts break out of the family into the community, primarily through orphaning. In the near future, the sheer number of orphans may overwhelm the capacity of existing community resources to cope.

The distribution of the impacts of the AIDS epidemic falls unevenly among the genders. Women have higher infection rate and bear a disproportionate burden of the care of HIV-positive people. Orphaned girls are more vulnerable to exploitation.

INTRODUCTION

HIV infects the individual, but individuals rarely live in isolation. The illness and death of individuals affects the various institutions to which they belong. The household is one such institution and possibly the worst affected by the HIV/AIDS epidemic. The characteristics of the virus, its concentration in particular groups, the mode of transmission and progression, and the stigma attached to HIV/AIDS can seriously affect the economic welfare of a household.

In Africa the HIV/AIDS pandemic is concentrated in the most economically productive segment of the population (15-49 years old). Deaths in this group lead to the loss of a productive household member, which results in loss of income and productive capacity as well as increased costs and changing expenditure patterns. The implications are, however, on closer examination, even more far-reaching and complex.

The declining productivity of HIV-positive individuals is primarily and initially felt within the family. However, the severe illness and subsequent death of those individuals have external effects. The loss of adults in their productive prime also reduces the capacity of communities. Simultaneously, extra costs are imposed upon these same communities. The main manifestation of these costs is orphaning resulting from AIDS deaths.

Foster¹, in her case study of Zambia, identified three 'phases' in the cycle of illness and death from AIDS:

1. the illness;
2. the period following immediately after death; and
3. the longer-term aftermath.

¹ Foster S, *The Socioeconomic Impact of HIV/AIDS in Monze District, Zambia*. Unpublished PhD Thesis, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, October 1996.

Before analysing the impacts at each of these phases, it is worth noting the concentration of the pandemic in poorer communities as poverty plays a major role in determining a household's susceptibility to infection and its vulnerability to the negative implications.

Cohen² has provided a conceptual economic analysis of the two-way relationship between HIV/AIDS and poverty. The poor are characterised by weak endowments of human (education, literacy) and financial resources, few marketable skills and generally poor health, all of which result in low productivity. These characteristics increase the risk of infection: an example is untreated STDs (a co-factor in the transmission of AIDS). Inadequate access to health facilities in poor communities lead to higher numbers of untreated STDs, which facilitate the transmission of HIV. The situation in which the poor find themselves in often prompts them to behave in ways which increase their chances of infection: migrant labour and sex work are examples. HIV infection, therefore, is concentrated in poor communities, and the effects of infections within them impoverish them even further.

PHASE 1: ILLNESS

The concentration of HIV infection in the productive age group has significant implications for the productive capacity and income of affected households.

During the illness phase, one of the first responses for those working in the informal sector is to move from directly productive activities into service-oriented jobs, (farming to selling goods) which are usually lower paid.³ This change allows the infected person to work when they can, as service jobs are generally less physically demanding. As a result, income falls, and as the illness progresses the ability to work decreases, dragging income down further. A study in Côte d'Ivoire found that income

² Cohen D, *Poverty and HIV/AIDS in Sub-Saharan Africa*. UNDP HIV and Development Programme. Issues Paper 27. New York: 1998.

³ Foster S, op. cit.

in affected households was half that of the average household income.⁴ This reduction is often due not only to the loss of income associated with the ill member of the household, but also to the diversion of activities of other members. For example, as HIV progresses to AIDS the level of care required increases, placing increased demands on other members of the household.⁵ Women are often given the added burden of having to care for the ill, in addition to the household duties they typically perform, while possibly also being infected. Alternatively children, particularly girls, are taken out of school to care for the sick or help with other household duties. If women are infected they require not only care, but also someone to take over their workload. Again, children often have to fill this gap. If a male is infected, his illness leaves a gap in the production process, which women or children are required to fill. Evidence of women taking on roles traditionally associated with men has been found in Zimbabwe: where women are moving into the carpentry industry.⁶

At the same time as income falls, costs increase, especially for time, transport and medicines.⁷ Health facilities are often located far from home and frequent journeys can be costly. The time involved in treatment places an added constraint on household labour. The medication required for the treatment is costly and requires re-balancing of the family budget.⁸ In the Kagera, Tanzania study, it was found that people diagnosed with AIDS were more likely to seek medical attention than other terminally ill people, and were therefore more likely to incur out-of-pocket medical expenses.⁹ Moreover, household medical expenses tended to be much higher for AIDS than for other causes of death.

⁴ Bechu N, 'The impact of AIDS on the economy of families in Cote d'Ivoire: Changes in consumption among AIDS-affected households', in Ainsworth M, Fransen L and M Over (eds.), *Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report*. European Commission: United Kingdom, 1998.

⁵ Loewenson R. *Impact of HIV/AIDS: Zimbabwe*, Geneva:WHO, 1998.

⁶ Deen T, *AIDS shifts gender roles and destroys extended families*. Health Link posting 500 www.hivnet.ch:8000/Africa/zambia

⁷ Loewenson R, op. cit.

⁸ Bechu N, op. cit.

⁹ Ainsworth M and Over M, *Confronting AIDS : Public priorities in a global epidemic*. A World Bank Policy Research Report. United Kingdom: Oxford University Press, 1997.

Expenditure patterns also change as a result of the illness. In the Côte d'Ivoire study it was found that the largest difference in household expenditure was spending on health care – which almost doubled. The majority of this increase was for the benefit of the infected adult. Although total household expenditure on health care increased, the non-infected members received less than average because of the disproportionate amount used to care for the ill adult. The risk of illness and infection of other household members increased as a result of this disproportionate division. Over time the allocation to health care showed an increase as the illness progressed, and then spending fell in the advanced stages. The fall was particularly marked for modern medicine: this was attributed to the disheartening effect of treatments that failed to cure. The increase in health care expenditure and the fall in income are accompanied by a fall in expenditure on basic needs. The shrinkage and reallocation of the budget reduces food security within the home. The chances of malnutrition and sickness of other members are thereby increased. The weaker members within the household face greater risks. Children, in particular, occupy weak bargaining positions and therefore face the greatest risks. In the Côte d'Ivoire study two patterns were immediately evident in consumption.¹⁰ First, total consumption fell and later partially recovered. Second, basic needs, which include food, fell less than other categories of expenditure, and then almost fully recovered as families reduce other categories of expenditure to maintain consumption of necessities.¹¹

Decreased income, increased costs and the ability of the household to cope with these changes have been linked to a number of household characteristics. In the Côte d'Ivoire study the fall in expenditure on basic needs was greater if the infected adult were female and the expenditure on health was greater if they were male.¹² Loewenson¹³ found that peasant households incur greater costs than others, resulting from, inter alia, lack of social security cover and medical aid. Regression analysis

¹⁰ Bechu N, op. cit.

¹¹ Ainsworth M and Over M, op. cit.

¹² Bechu N, op. cit.

¹³ Loewenson R, op. cit.

conducted on Thailand household data found similar results.¹⁴ Female death was associated with a stronger negative impact on consumption expenditure, and average medical expenditure on terminally ill women was found to be less than the expenditure on men in the same condition. The level of education of the household head appeared to provide a degree of protection against the negative impacts of adult death. Furthermore the analysis suggested that the negative impacts of an AIDS death was greater than that of a non-AIDS death.

To summarise, the impact of HIV/AIDS illnesses at the household level is clearly serious. Household income falls while costs increase. High infection rates mean that the number of households adversely affected will be high. UNICEF estimates that by 1998, two million Africans had died as a result of HIV/AIDS. This figure represents ten times the number of people who died as a result of armed conflict that year.¹⁵

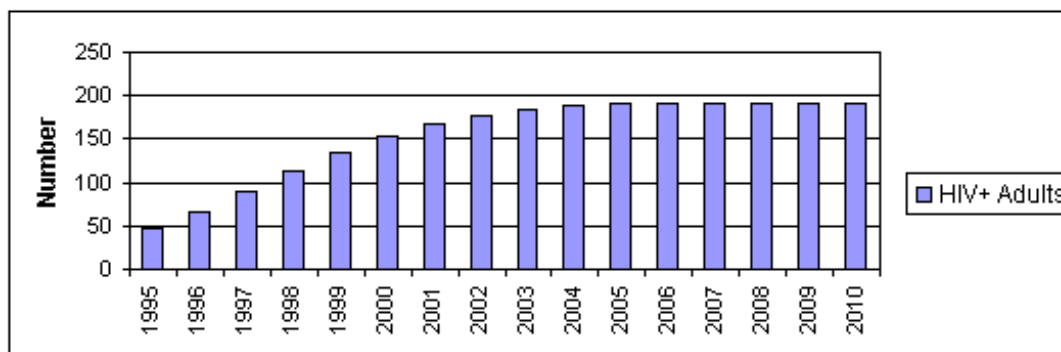
As an illustration, Figure 1 shows that in a typical community of 1000 people in KwaZulu-Natal in 1995, 49 people would have been infected with HIV.¹⁶ By comparison, an average KZN community this year is expected to have 154 infected adults, 7 infected children and 9 people living with AIDS. The burden on the community is clearly large and clearly increasing.

¹⁴Pitayanon S, Kongsin S, and W Janjareon, 'The Economic Impact of HIV/AIDS Mortality on Households in Thailand', in D Bloom and P Godwin (eds.), *The Economics of HIV and AIDS: The Case of South and South East Asia*. Oxford University Press: Delhi, 1997.

¹⁵ Williamson J, *The Orphan Generation : The Global Legacy of the AIDS epidemic*. Unpublished draft for discussion, 1999.

¹⁶ The projection is based on Scenario 243 of the Doyle model run for KZN. The figures represent the average level of infection for a population of 1000 people in 1995 and the resultant impacts, given the characteristics of KZN. The figures are averages and not based on any particular communities. In KZN infection is not evenly spread and the numbers will be very different in different communities.

Figure 1 HIV+ Adults in an average KZN community of 1000 people.



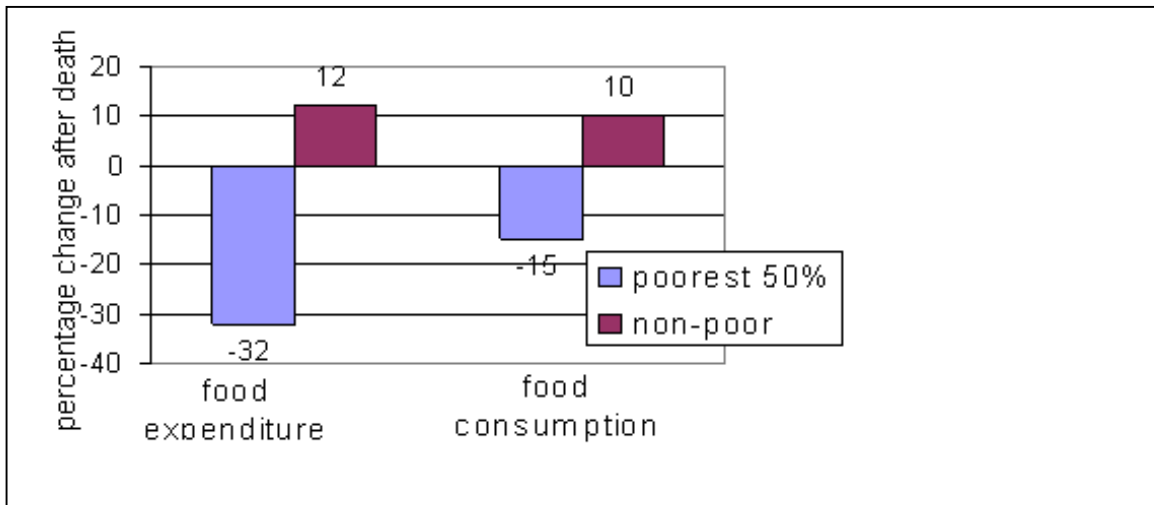
PHASE 2: DEATH

The death of a prime age adult is an obvious tragedy for any household. Survivors must contend not only with an emotional loss, but also with medical and funeral expenses, and the loss of income and services that a prime age adult typically provides.¹⁷

The economic impact of an AIDS death is larger on poorer households. Studies reveal that households experiencing an adult death draw on assets to cushion the shock of such an event. It follows that households with lower levels of assets will have more difficulty in coping with an adult death. Although studies indicate that households do employ coping mechanisms to overcome the prime age adult deaths, they also show that households are generally worse off after the loss of a productive member. The impact of an adult death on poorer households is most starkly illustrated by changes in food expenditure and food consumption, as illustrated in Figure 2. For the poorest 50 per cent of households in the Kagera study, food expenditure dropped by nearly a third, while in the other 50 per cent of Kagera households, intake of both food produced at home and purchased food rose.

¹⁷Ainsworth M and Over M, op. cit.

Figure 2 Short-term impact of death of adult household member on food expenditure and food consumption per equivalent adult member, 1991-1993 , Kagera, Tanzania.



In most African countries a large funeral is an important statement. The transportation and feeding of guests and the cost of the coffin can drive families into debt and financial devastation.¹⁸ In the Kagera study, households that experienced a death had lower overall expenditures and devoted a larger share of their expenditure to funeral costs. It was also found that these households spent one-third less on items such as batteries, soap and clothing. Finally, in households that experienced a death, food produced by the household represented a larger share of consumption than in other households, while purchased food represented a smaller share. Evidence of the high cost of illness and death of an AIDS victim as compared to other deaths was found in an interpretation of the Rakai, Uganda study.¹⁹ It was found that while households that had not experienced an adult death in the period had increased ownership of durable goods, and households that had experienced a non-AIDS death remained the same, those with AIDS deaths had suffered a decrease in ownership of these types of goods. Furthermore, livestock deaths and sale of draught power animals were higher and crop output lower in AIDS death households. On average,

¹⁸ Foster S, op. cit.

¹⁹ Menon R, Wawer M, Konde-Luli J, Sewankhambo, N and Li C, 'The economic impact of adult mortality on households in Rakai district Uganda', in Ainsworth M, Fransen L and M Over, (eds.), *Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report*. European Commission: United Kingdom, 1998.

households spent nearly 50 per cent more on funerals than they did on medical care. A similar study in Chiang Mai, Thailand, where per capita income is 10 times that in Tanzania, corroborated this finding.²⁰

Two broad observations can be made on the basis of these two studies: first, medical costs are only a portion of the cost of a prime age adult death; and second, non-medical costs are likely to be similar regardless of the cause of death. Where these observations hold true, the direct impact of an AIDS death is not much different from that of a non-AIDS death. Thus, the high costs to households from AIDS is due to the significant increases in deaths caused by the epidemic, rather than by the fact that these deaths are caused by AIDS.²¹

COPING STRATEGIES

A prime age adult death is the most important impact of HIV/AIDS. Survivors suffer economically, and the extent of this economic stress can be measured by the impact of an adult death on social indicators such as orphanhood, schooling, child nutrition and health, and poverty. By worsening these measures, HIV/AIDS has the potential to widen the gap between the rich and the poor.

The economic shock of a prime-age adult death is mitigated to some extent by a variety of strategies that households use to cope. Survey data show that in coping with the *economic* impact of such a loss, households are surprisingly resilient. Data on the mix of household coping strategies to the loss of an adult breadwinner come mostly from sub-Saharan Africa.²²

To varying degrees, three coping strategies are observed in Africa:

1. altering household composition; or
2. withdrawing savings or selling assets; or

²⁰Pitayanon S, *et al*, op. cit.

²¹Ainsworth M and Over M, op. cit.

²² Ainsworth M, and Over M,op. cit.

3. receiving assistance from other households.

These coping strategies are themselves likely to produce unexpected medium to long-term economic shocks within the households. A case study from Kenya²³ aptly illustrates the point. When the male head of a household fell ill, he disposed of his maize-milling machine to obtain cash for his medical expenses. In time, all his savings and assets were disposed of in trying to obtain a cure. As the milling machine brought steady income into the household, the sale of working capital meant that the family soon had no money to hire labour or buy inputs for their sugar-cane plots. Cane production ceased, and so did income from the cane crops. The new owner of the milling machine moved it to a distant location. The absence of the machine was felt by other households in the village, and women went back to pounding maize, which increased their workload. Similarly the sale of livestock means that the household cuts off its own access to fresh meat, dairy and eggs.

ALTERING HOUSEHOLD COMPOSITION

The death of a family member often has implications beyond the family's economic circumstances. The composition of households following an AIDS death appears to differ from that following a non-AIDS death. On average, households where a death had occurred, AIDS related or otherwise, were smaller.²⁴ Prior to death, however, households of all groups had the same average size. Although both AIDS deaths and non-AIDS deaths households fell in size, the composition of the households were not the same. The percentage of the elderly in AIDS death households was found to be higher, while that of adults in prime working age appeared lower. Similarly in Rakai, the average dependency ratio of households that experienced an AIDS death increased.²⁵

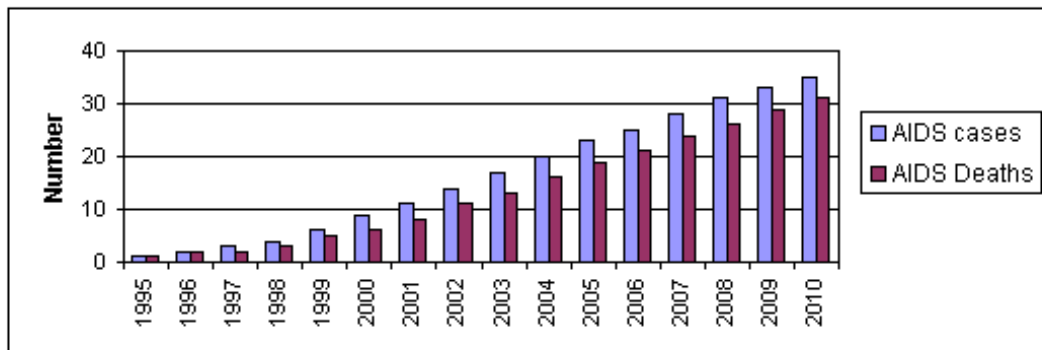
²³ Rugalema G, *HIV/AIDS and the Commercial Agricultural Sector of Kenya*. Geneva: FAO, 1999.

²⁴ Pitayanon S, *et al*, op. cit.

²⁵ Menon R, *et al*, op. cit.

The total population with AIDS and AIDS deaths for an average community of 1 000 people in KwaZulu-Natal is shown in Figure 3. Clearly the impacts associated with AIDS deaths will be widespread.

Figure 3 AIDS Cases and Deaths in an average KZN community of 1000 people.



DISSAVING AND SALE OF ASSETS

The second coping mechanism of households is dissaving and sale of assets. Evidence from Kagera, Rakai and Chiang Mai suggests that households draw down savings or liquidate assets in response to a prime age adult death. For example, in the Kagera and Rakai surveys, radio ownership increased in households with no deaths and decreased in households that experienced death²⁶. Additional evidence of households drawing down savings was seen in Kagera where, in the first wave of the study, 51 per cent of the 80 households that experienced an adult death were member of savings and credit associations. By the end of the survey, participation had dropped to 36 per cent.²⁷ A full 41 per cent of households in the Chiang Mai study reported having sold land, 57 per cent reported some dissavings and 24 per cent reported borrowing from a co-operative or revolving fund to finance the adjustment to the death.²⁸ Borrowing from micro-finance organisations is also a common means of boosting the coping capacity

²⁶ Menon R, *et al*, op. cit.

²⁷ Ainsworth M and Over M, op. cit.

²⁸ Pitayanon S, *et al*, op. cit.

of households. These bodies make loans to self-selecting groups, particularly women. Organisations in Rakai have enjoyed a high level of participation and repayment.

In Zimbabwe, households were found to be selling land and cattle, and taking children out of school to meet increased costs.²⁹ Although the sale of assets is a means of coping with the increased costs and reduced income, it has a series of negative implications for future economic potential. Similarly, reductions in expenditure on basic needs and substituting cheaper, less nutritious food for the usual staples invariably introduced new problems.

ASSISTANCE FROM OTHER HOUSEHOLDS

The third mechanism used by households to cope with the death of a prime age adult is to use assistance from other households. Help from neighbours and relatives is an important supplement to the efforts of a household facing an adult death. In Kagera, it was shown that 80 to 90 per cent of bereaved households were likely to receive assistance in cash or kind from other households. Focus group interviews in the sample villages found that besides the traditional savings and mutual assistance associations, residents of many villages had launched associations to help families affected by an AIDS death. Most of the associations were launched and operated by women, and many have regular meetings at which members make contributions in cash or kind.³⁰

It follows that households with lower levels of assets will experience greater difficulty in coping with the death of a prime age adult than households with more assets. The coping strategies employed by households to adjust to the shock of a prime age adult death hold many implications, particularly for the children of poor household. AIDS

²⁹ Kwaramba P, *The Socioeconomic Impact of HIV/AIDS on Communal Agricultural Systems in Zimbabwe*. Economic Advisory Project, Working Paper No. 19. Belgravia: Friedrich Ebert Stiftung, 1998.

³⁰ Liwuhla G, 'Variability in savings and assistance behaviour in households across ethnic groups in Kagera Region, Tanzania'. in Ainsworth M, Franssen L and M Over, (eds.), *Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report*. European Commission: United Kingdom, 1998.

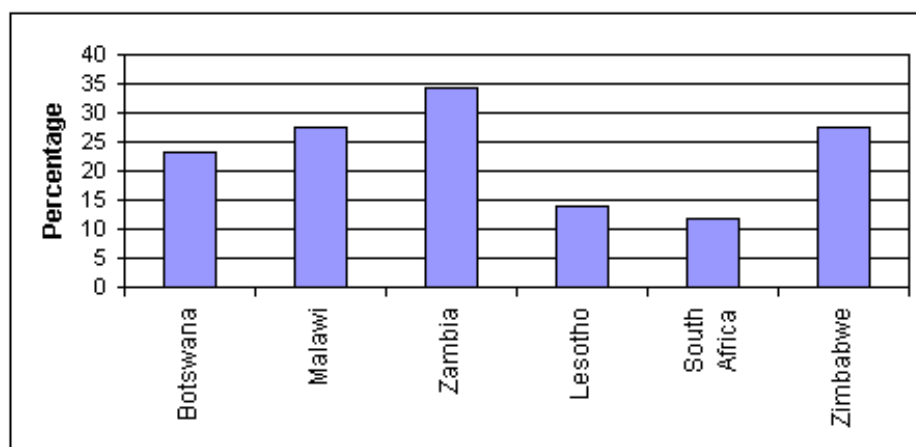
will greatly increase the number of prime age adult deaths, and in so doing significantly increase the level of orphaning.

PHASE 3: LONG TERM IMPACTS

There are many impacts of HIV/AIDS that have clear short-term negative effects. These, as well as the adjustments which households undertake, have been discussed in some detail. The direst long-term consequence of the AIDS epidemic is orphaning.

The figures are nothing less than mind-numbing. UNAIDS estimates that by 1997, there were 8,2 million cumulative maternal orphans (children who have lost only their mothers). Ninety-five per cent of all children who are maternally orphaned through AIDS live in sub-Saharan Africa. USAID estimates that in the 23 worst affected countries, thirty-five million children under the age of 15 will have lost one or both parents to HIV/AIDS by 2000. As AIDS mortality rises, growing numbers of children will be orphaned by the disease. By increasing the number of children who lose one or both parents, AIDS will exacerbate poverty and inequality. In South Africa current rates of AIDS mortality are just the tip of the iceberg, and so too, are current levels of orphaning. As Figure 4 indicates, the worst is still before South Africa.

Figure 4 Orphans as a percentage of children under 15 by 2000



(Source: US Bureau of the Census, 1996)

The prognosis for orphaned children is bleak. Apart from the unquantifiable pain and grief that is experienced by children who lose a parent, orphaned children generally experience measurable declines in nutritional status and reductions in schooling. These experiences can cause lasting physiological and psychological damage to a child, and can greatly reduce a growing child's ability to acquire skills and knowledge to escape deprivation. The poorest families are likely to be most severely affected.

AIDS orphans face a unique set of severe problems. Very young orphans, whose mothers die of AIDS, have higher mortality rates than other orphans because approximately one third to one half of babies born to infected mothers are themselves infected with HIV through mother-to-child transmission. AIDS orphans are also more likely to be two-parent orphans because AIDS is transmitted sexually. For example, in a population-based survey of rural areas of Masaka District, Uganda, 10 per cent of all the children under 15 had lost one or both parents to AIDS³¹. Fifteen per cent of the surviving parents of single parent orphans were infected with HIV, three times the parental infection rate among non-orphans. Finally AIDS orphans are likely to suffer the social stigma of having lost their parents to a sexually transmitted disease.

³¹ Ainsworth M and Over M, op cit.

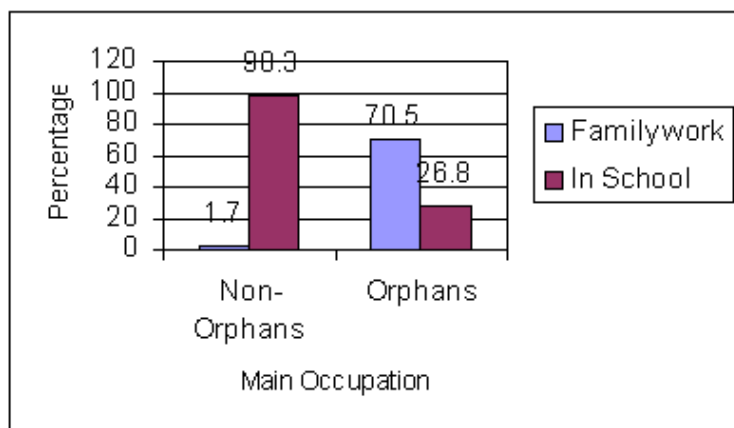
Children typically occupy weak positions within the households, with little bargaining power. Children face problems both during the illness in a prime age adult within the households, and after the death of the adult. These problems include withdrawal of children from school, decreased access to food and medicines, and psycho-social neglect. After the death of a parent, particularly the mother, an orphan may face an additional set of problems, such as a lack of accommodation and income, theft of property and inheritance, sexual abuse, economic exploitation and further declines in health status.

Orphaned children are in many instances removed to the house of a relative, but there is evidence of a growth in the number of child-headed households. Both situations contribute to the vulnerability of orphaned children. Reports from Rakai suggest that the overwhelming majority of orphans were living within extended families, in their own communities, under great stress.³²

The death of a parent or adult may lower the nutritional status of surviving children by reducing household income and food expenditure, and by reducing adult attention to child-rearing. The lack of adequate nutrition even for a year can have profound consequences for the development of children. For orphans, childhood malnutrition is perhaps the most severe and lasting consequence of prime age adult death. Figure 5 shows the impact of adult death on stunting among children under five. What is striking about the sample is that orphaned children in the better-off households show the same rate of stunting as orphans in the poorer households.

³² Williamson J, op. cit.

Figure 5 Stunting among orphaned and non-orphaned children under 5, by household assets, Kagera, Tanzania.



(Source : Confronting AIDS, World Bank, 1997)

Several explanations could account for this phenomenon. One is that stunting in both groups of orphans is due to paediatric AIDS or HIV-related disease such as tuberculosis. Another possibility is that some stunted orphans in households with more assets originally came from poor households and the stunting is a legacy of earlier poverty. It may also be the case that childhood nutrition deteriorates sharply after the death of an adult even in better-off households, because, the surviving spouse is failing with child-rearing responsibilities due to depression and grief.³³

A prime age adult death is also likely to reduce school enrolment by reducing the ability of families to pay for schooling, or by creating a demand for child labour. The Kagera study found that the level of household assets had little significance on whether or not orphans were enrolled. It was discovered, however, that in households that experienced the death of a prime age female, children had lower enrolment rates and were more likely to assume the activities that women typically carry out. Older children were more likely to drop out of school. These effects were not observed in households with a male death.

³³ Ainsworth M and Over M, op cit.

A survey of 646 orphaned and 1 239 non-orphaned children in Kenya³⁴ showed that 52 per cent of children orphaned by HIV/AIDS were not in school as compared with 2 per cent of children in the control group. In the sample of orphaned children, 56 per cent of girls as opposed to 47 per cent of boys had dropped out of school within the 12 months following the death of a parent. The study also showed that children orphaned by HIV/AIDS performed more poorly in school and were more likely to be unhealthy. Orphaned children were sick an average of 28 days in the twelve months prior to the study, as compared with 9 days of sick leave taken by children in the control group. Overall, 98 per cent of children in the control groups, as compared with 48 per cent of orphans, were in school.

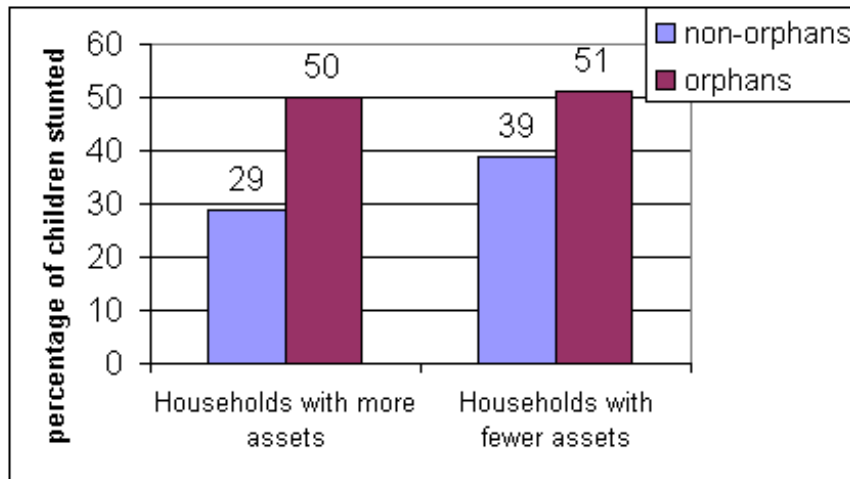
Child-headed households are likely to be among the poorest, with older siblings often having to leave school in order to take care of the household. Figure 6 shows a comparison of some key indicators of orphaned and non-orphaned children. The evidence from Kenya indicates that the huge increases in prime age adult death caused by AIDS have some critical implications for the welfare and development of children in sub-Saharan Africa. It was found that 48 per cent of orphans were in full-time paid work as opposed to 2 per cent of cases in the control group.

A rapid appraisal was conducted by the Botswana Ministry of Health of the orphan situation in 1998. A majority of 4 496 orphans were registered in 10 villages and towns. The majority were between 11 and 15 years old and AIDS was the major cause of death of parents (51 per cent). Thirty per cent of orphans had dropped out of school and a further 30 per cent were homeless.³⁵

Figure 6 Comparison of key indicators for orphans and non-orphans.

³⁴ Notes from a presentation by Dr. Michael Elmore-Meegan at the Collaborative Symposium on AIDS, January 1999, Nairobi, Kenya on research by ICROSS, for which publication is pending.

³⁵ Muchiru S M, *The rapid assessment on the situation of orphans in Botswana*. Botswana:Ministry of Health,1998.



(Source: Elmore-Meegan, M., Conroy, R. and Tomkins, A. 1998)

While studies show that extended families and communities are currently willing to absorb orphaned children, it remains unknown whether families and communities will be able to provide assistance to the sheer numbers of orphans in the near future. A study in the Zambian Copper Belt³⁶ showed that the willingness of families to absorb orphaned children is conditioned by the relationship between the orphan and the caregivers. Seventy-three per cent of respondents showed a willingness to care for orphans that are related to them, while 42 per cent of respondents were willing to take in strangers. Families are far more willing to care for orphans if some sort of support, such as free education, free health care and food supplements, is offered. However, extended family structures are being eroded by urbanisation and HIV/AIDS, and thus the efficacy of extended families as social support networks is also being undermined.

Those orphans that are not absorbed into extended family structures will face life inside child-headed households or on the streets. Their options are limited to finding jobs or resorting to crime. It is unlikely that these children will be protected by the welfare safety net if it exists or is functioning. It is estimated that in South Africa, only 49 per cent of children have birth certificates. This lack of vital registration means that children will not be able to access to welfare grants.³⁷

³⁶ McKerrow N & A E Verbeek, 'Paper presented at the CINDI Conference, Models of Care for Children in Distress.' 1995.

³⁷ Smart R, 'Children Living with HIV – A Rapid Appraisal'. Unpublished, 1999.

Girls are particularly vulnerable to exploitation and abuse. The highest rates of HIV infection are found amongst young people. Between 1997 and 1998, there was a 65,4 per cent increase in HIV infection in the 15-19 year old population who attended antenatal clinics.³⁸ Girls and young women are particularly susceptible to HIV infection because they are less able to control the situations in which they have sexual intercourse. Figures from the First World Congress against Commercial Sexual Exploitation of Children suggest that more than 1 million children enter the sex trade every year. Most of the girls in the industry are aged between 13 and 18. Sexual abuse has already been identified as a significant problem in South Africa. The HIV/AIDS epidemic will increase opportunities for sexual exploitation and abuse, particularly of orphaned children.

There are 16,3 million children in South Africa (almost half the population). Six million of these children are under the age of six, and it is estimated that 61 per cent of them live in poverty. By the year 2015, 3.6 to 4.8 million children under the age of 15 will be orphaned by the AIDS epidemic in South Africa. It is likely that these children will grow up with very few means of care and support.

The main community response to the AIDS epidemic is to take care of children orphaned by the disease. Whilst one adult member of a family is available to care for an adult with AIDS the negative impacts of the disease are usually contained within the family.

Subsequent to a death of one parent or the death of both parents, the impact of the disease spreads out of the family into the community as resources (both human and physical) to maintain households are lost, and children do not possess the wherewithal to maintain them. In many cases the extended family is willing and able to absorb orphans: however, it is clear that many orphans are abandoned or left to fend for themselves because of the lack of resources within the extended family.

³⁸ Department of Health, Republic of South Africa, *Epidemiological Comments*. Vol 1(2), June 1999.

Strengthening extended family resources is critical to stemming abandonment and the associated social problems that accrue from orphaning. The orphaning problem will dramatically worsen in the next 10 years.

CONCLUSIONS

The HIV/AIDS epidemic has arrived late to South Africa compared to other sub-Saharan African countries. Manifestations of the epidemic (large-scale illness and death) occur AFTER significant numbers of the population are already HIV-positive. This scenario has already been played out in other African countries, notably Uganda and Rwanda where a 'missing generation' of people is now lamented.

The conditions for a replication of this horrendous scenario exist in South Africa today. Ignorance, denial and unchanging sexual behaviour in the absence of direct verifiable local evidence of the growing AIDS epidemic are the pre-conditions for the 'missing generation' scenario to be replayed in South Africa. Despite the words and beliefs to the contrary, AIDS will occur in all untreated HIV-positive people. Without strong words from the nation's leadership and much more importantly, strong and effective sexual behaviour change messages, the epidemic's effects will be of a scale not easy to comprehend and it will basically run unchecked.

The clear message to be taken is that this epidemic is still 'hidden' within the family through ignorance and taboos. The community impact is also 'hidden', although the impact is clearly manifesting itself on an increasing scale every day. Yet the full magnitude of the coming disaster is already predetermined by the epidemiology of the epidemic.

It is highly likely that only through bringing the impacts of the epidemic into the clear light of day will attitudes toward risky sexual behaviour change, although by that time the price paid for the lesson will already be enormous in terms of illness, death and other social impacts, especially large scale orphaning. It will be too late by then.

There is a clear need to break the ignorance and taboos around HIV/AIDS early in the cycle of the epidemic. The imperative now is not to prevent the epidemic but to

reduce the magnitude of the negative impacts, from enormous to merely large. In the case of South Africa this opportunity has thus far been lost.