CHAPTER 2

THE IMPACT OF HIV/AIDS ON THE DEVELOPMENT OF CHILDREN

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Introduction

This paper considers the psychosocial impact of HIV/AIDS—particularly the loss of caregiver support and the resultant stress on caregiving systems—on children's development and adjustment.

First, the paper reviews in general terms the expected effects on children in the domains of economic and food security, psychosocial care, education, health, family composition and stability of care. The close association between poverty and HIV/AIDS is then discussed and attention is drawn to the likely co-occurrence of HIV/AIDS, poverty, loss of caregivers and deprivation associated with deepening poverty. Finally, the argument is made that the impact on large numbers of children of the combined effects of poverty and HIV/AIDS—namely school drop out, child labour abuses and the sexual exploitation and trafficking of children—are likely to cause significant social disruption.

The potential impact of HIV/AIDS on children

There is growing research and programme literature on the impact of the HIV/AIDS epidemic on children. These impacts occur in a number of overlapping and interdependent domains, including children's psychosocial development. Some of these effects have been reviewed elsewhere[1] and the main points from these reviews are reiterated here as an introduction to considering the impact of HIV/AIDS on children's development.

- *Economic impact:* In several countries, income in orphan households has been found to be 20–30% lower than in non-orphaned households.[2] Studies in urban households in Côte d'Ivoire, for example, show that where a family member has AIDS, average income falls by as much as 60%, expenditure on health care quadruples, savings are depleted and families often go into debt

to care for sick individuals. Other studies have suggested that food consumption may drop by as much as 41% in orphan households.[3] Asset selling to pay for health care, loss of income by breadwinners and funeral costs may deplete all household reserves, as well as savings.

- *Migration* has been identified as an important family and community coping mechanism in the face of the HIV/AIDS epidemic. This is especially so in Southern Africa and, to a lesser extent, in Southeast Asia. Migration occurs for several reasons and people move both within and between rural and urban areas. Some identified forms of migration include 'going-home-to-die', rural widows moving to town to seek work or the help of relatives, and potential caregivers and dependants moving between kin households to achieve the most optimum care arrangements for all concerned. Children are frequently relocated. Adolescents are particularly affected by migration, as girls are sent to help out in other households, or as children are encouraged to try and fend for themselves by working—including street work.[4]

- *Changes in caregiver and family composition:* As a result of death and migration, family members, including dependent children, often move in and out of households. Caregivers change and siblings may be split up. Separation from siblings has not only been found to be a predictor of emotional distress in children and adolescents,[5] but children become more vulnerable when they are cared for by very aged relatives due to the conditions of mutual dependency that often exist between adult and child. Death and migration may also result in the creation of child-headed households. These are most likely to form when there is a teenage girl who can provide care for younger children, when there are relatives nearby to provide supervision, and siblings either wish to stay together or are requested to do so by a dying parent.[6]

- *New responsibilities and work for children:* Several studies have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents or caregivers become ill or die. In such circumstances, instances of work and responsibility being given to children as young as five have been observed.[7] Responsibilities and work in the household include domestic chores, subsistence agriculture and provision of caregiving to very young, old and sick members of the household. Work outside of the home may involve a variety of formal and informal labour,

including farm work and begging for food and supplies in both the community and beyond.[8]

- *Education:* In households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities, medication and health services. Even where children are not withdrawn from school, education often begins to compete with the many other duties that affected children have to assume. In addition, stigmatisation may prompt affected children to stay away from school, rather than endure exclusion or ridicule by teachers and peers. A study in Zambia, for example, showed that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children.[9] At a national level, a World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children by as much as 22% and secondary school children by 14% as a result of increased child mortality, and decreased attendance and dropping out.[10]

- *Loss of home and assets:* As effects on households deepen and parents die, children may suffer the loss of their home and livelihood through the sale of livestock and land for survival, as well as through asset stripping by relatives.[11] Loss of skills also occurs because fewer healthy adults are present in the household and/or are involved in livelihood activities.

- *Health and nutrition:* Children affected by HIV/AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet demonstrated increased morbidity and mortality among broadly affected children compared to unaffected control groups. In this regard, it has been suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic;[12] or alternatively, that orphans may not be worse off than peers living in extreme poverty. Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV/AIDS.

- *Psychosocial impact:* Affected and orphaned children are often traumatised and suffer a variety of psychological reactions to parental illness and death.

In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatisation as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of children's reactions suggest that they tend to show internalising rather than externalising symptoms in response to such impacts—depression, anxiety and withdrawal—as opposed to aggression and other forms of antisocial behaviour.[13]

- *Vulnerability to infection:* Apart from other impacts, children affected by HIV/AIDS are themselves often highly vulnerable to HIV infection. Their risk for infection arises from the early onset of sexual activity, commercial sex and sexual abuse, all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape. Some studies of street children, for example, show that vulnerable children do little to protect themselves from HIV infection because the pressures for basic survival—such as finding food—far outweigh the future orientation required to avoid infection.[14]

- *Long-term psychological effects of emotional deprivation:* Children who grow up without the love and care of adults devoted to their wellbeing are at higher risk of developing psychological problems.[15] A lack of positive emotional care is associated with a subsequent lack of empathy with others and such children may develop antisocial behaviours. Not all children are, however, affected or affected to the same degree. Protective factors—in the form of compensating care from other people, including teachers, as well as personality predisposition—may lessen the impact on children of reduced care in the home environment.

The listed effects of the HIV/AIDS epidemic on children are likely to vary considerably by age. One might expect preschool-aged children, for example, to show primary effects on growth and health, and school-aged children to show education, work, psychosocial and vulnerability effects. In addition, none of the effects cited have been shown to be specific to children affected by HIV/AIDS, even if such a category of children can be more precisely defined. It is also impossible to isolate and exclude the effects of conditions that pre-date the death of a caregiver. Such pre-existing or development influences include

poverty and social disorganisation, parental preoccupation, depression and social isolation.

Of greatest concern, however, is the generality of these effects and their strong association with poverty. The impact of the HIV/AIDS epidemic on children and families is incremental;[16] poor communities with inadequate infrastructure and limited access to basic services are worst hit. Poverty amplifies the impacts of HIV/AIDS on children and renders their effects on children unrelenting. At the same time, changes associated with the illness and death of caregivers and breadwinners can push children into conditions of desperate hardship. As John Williamson says:

> The common impacts [of HIV/AIDS] include deepening poverty, such as pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets. Psychosocial distress is another impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care.[17]

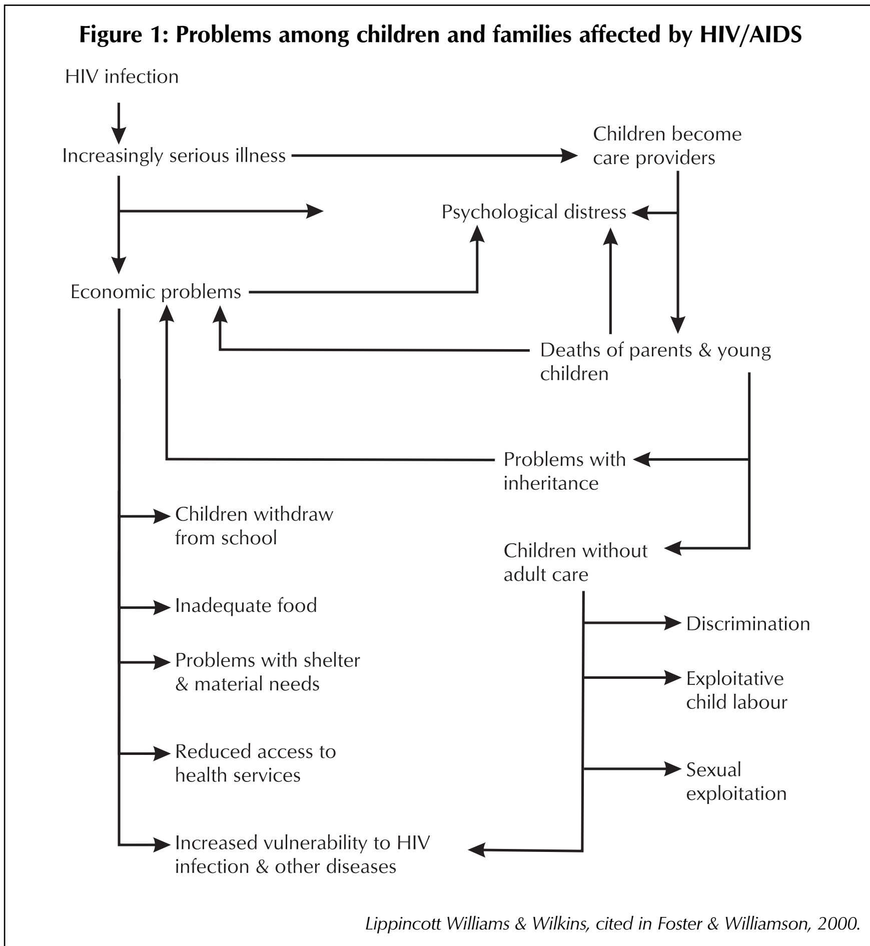
A model of the effects of HIV/AIDS on children has been developed, as reflected in Figure 1 (*over page*).

What data is available on affected children and what does it tell us?

There are three main sources of national level South African information on affected children. There is considerably less information from other countries, except from demographic and health surveys, on which estimates of orphans are based.[18] By affected children are meant orphans, fostered children and child-headed households. The term 'affected children' is also used to denote children living in households that have taken in orphans, who are sometimes referred to as co-residents. These children are affected in the sense that household resources are stretched by the increased dependency ratio created by additional children. This group of children is not, however, included here because there is limited information available about them.

The first source of data is the modelled increases in orphaning produced by the Actuarial Society of South Africa.[19] The second consists of the analyses of the

Figure 1: Problems among children and families affected by HIV/AIDS



Lippincott Williams & Wilkins, cited in Foster & Williamson, 2000.

1995–1999 October Household surveys, the 1998 Demographic and Health Survey and the 1996 Census done by Barbara Anderson and colleagues during her research residency with the Human Sciences Research Council (HSRC) in 2001–2002.[20] The third comprises data from the Nelson Mandela/HSRC Study of HIV/AIDS.[21]

Orphans

Contrary to popular usage, where an 'orphan' is generally considered to have lost both parents, several definitions of orphan status are widely used in the

current research and advocacy literature. Maternal orphans include children whose mother has died, while paternal orphans refer to children whose father has died. The term 'double orphan' refers to children who have lost both parents. Some definitions also consider children whose mother is seriously or terminally ill as maternal orphans, as the inability of the mother to provide care in these situations results in children becoming *de facto* orphans despite their parents being alive. For the purposes of this paper, following the Joint United Nations Programme on HIV/AIDS (UNAIDS) convention, maternal, paternal and double orphans are defined as children under 15 years of age whose mother, father or both parents have died.[22]

Figure 2 shows the data presented by Barbara Anderson and her co-workers, including a comparison with predictions from the Johnson and Dorrington model. Table 1 (*over page*) shows the percentage of maternal, paternal and double orphans reported in both the Nelson Mandela/HSRC study and the 1998 South African Health and Demographic Survey. Both Figure 2 and Table 1 illustrate a relatively slow pick-up in orphaning, which begins around 1998, and shadows HIV infections by eight to ten years. Table 1 also indicates that orphaned children most often have a surviving parent, usually their mother. This finding is supported by other studies. Ainsworth and Filmer, for example, argue that because mortality among men is still higher than among women of comparable ages, close to 70% of paternal orphans in the region live with a surviving parent, their mother.[23]

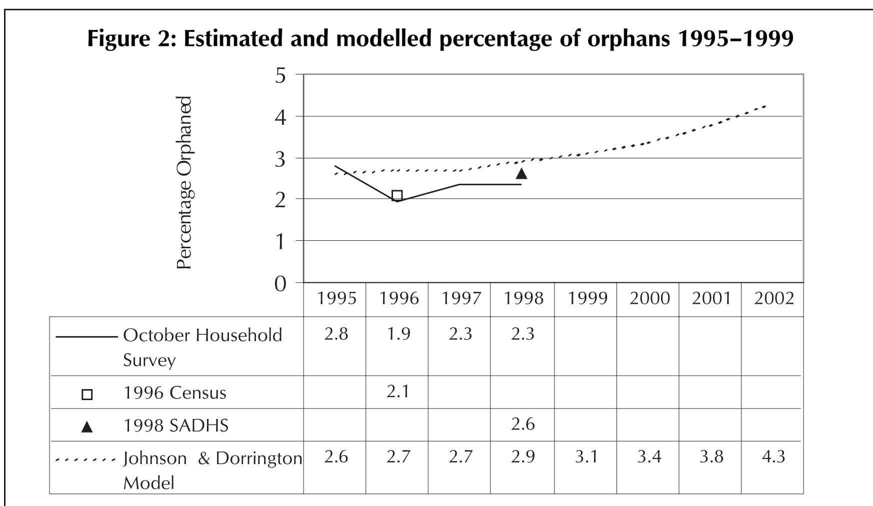


Figure 2: Estimated and modelled percentage of orphans 1995–1999

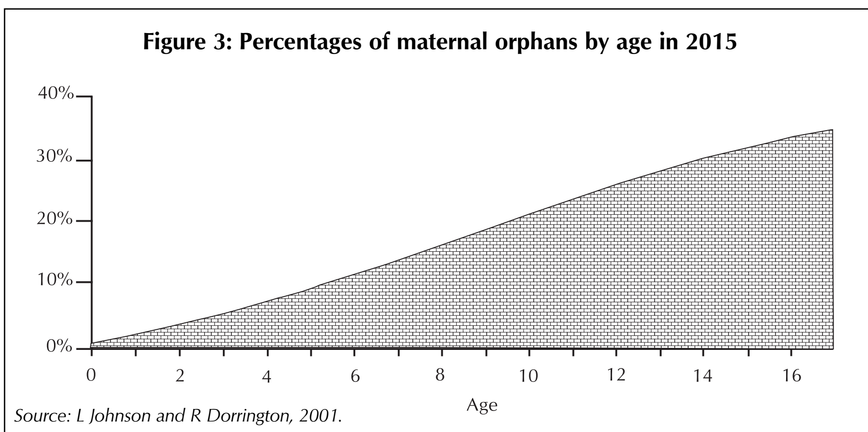
	1995	1996	1997	1998	1999	2000	2001	2002
October Household Survey	2.8	1.9	2.3	2.3				
1996 Census		2.1						
1998 SADHS				2.6				
Johnson & Dorrington Model	2.6	2.7	2.7	2.9	3.1	3.4	3.8	4.3

Table 1: Percentage orphans by age

	2002 NM/HSRC study			1998 DHS study
	2–9 years (n=1,722)	*10–14 years (n=1,157)*	*15–18 years (n=1,110)*	*<15 years*
Mother dead	3.6	2.2	4.0	2.1
Father dead	6.5	10.8	16.1	8.7
Both parents dead	0.5	3.5	3.9	0.7

Modelling by Rob Dorrington and his group at the University of Cape Town suggests that AIDS orphaning, defined as the death of a mother before the child's 15th birthday, is on a steep increase in South Africa. The number of orphans is predicted to peak in 2015 at about 1.85 million children, assuming no interventions to prolong the lives of parents and no changes in preventive behaviour. Figure 3 shows the percentage of maternal orphans under the age of 18, as predicted to occur in 2015.[24] The graph shows that the older a child is, the greater the chance that he/she will be an orphan.[25] Due to the association between child age and parental death, relatively fewer pre-school children will be orphaned as compared to older children, although loss of a mother at this young age may have the longest lasting effects on children. Between 20% and 30% of ten to 14 year olds, however, are expected to lose their mother, while more than 30% of young people over the age of 14 years are likely to be maternal orphans by 2015.

Figure 3: Percentages of maternal orphans by age in 2015



Source: L Johnson and R Dorrington, 2001.

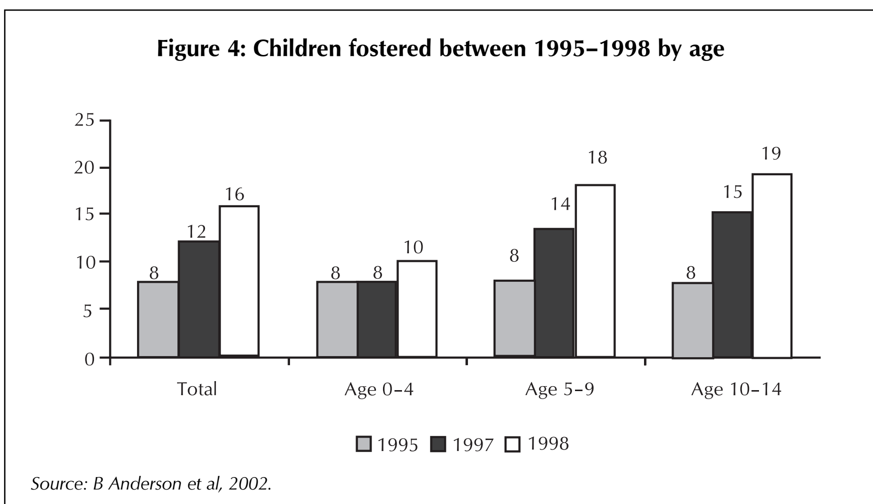
In *Children on the brink*, Hunter and Williamson provide regional information on orphaning calculated from data maintained by the United States (US) Census Bureau. This data suggests that the epidemic began earlier in Zambia, Malawi and Zimbabwe than in South Africa and, as a result, orphaning is peaking earlier in these countries. For example, they estimate that in 1990 approximately 2.6% of all children in South Africa were maternal or double orphans (all causes) as compared to 6% in Malawi and Zimbabwe and 8% in Zambia. By 2010 it is estimated that, with approximately 17% of children orphaned, South African will 'catch up' with Zimbabwe (19%) and exceed Malawi and Zambia (12%).[26]

Fostered children

Fostering refers to the presence of children who are not offspring of any of the adults in the household and whose biological parent(s) live elsewhere. However, although short- and long-term fostering is common throughout Africa, there is little quantitative information on the prevalence and effects of fostering on either fostered or co-resident children.

Figure 4 shows the rapid increase in fostering rates among three age groups of black children between 1995 and 1998, as found in the South African October Household surveys by Barbara Anderson and her group. Unfortunately, this data is difficult to interpret because available information suggests high levels

Figure 4: Children fostered between 1995–1998 by age



Source: B Anderson et al, 2002.

of baseline fosterage prior to 1995. Using the project for Statistics on Living Standards and Development Survey (SALSS) conducted in South Africa in late 1993, Kaufman, Maharaj and Richter[27] found that child fosterage in South Africa was high. Approximately 17% of black children aged 6–19 years were living apart from their biological parents, 12% of Coloured and just fewer than 5% of Indian and white children were also seemingly fostered. Most fostered children were grandchildren of the household head (60% and 53%, for black and Coloured children respectively). In addition, close to 30% of all black children and just over 20% of Coloured children, were living in a household with a fostered child or children. No definitive conclusions could be drawn about the impact of fostering on schooling, either among fostered children or co-resident children, assessed in terms of years of schooling and rate of progression through school.

Child-headed households

The only national data on child-headed households comes from the Nelson Mandela/HSRC study. This study found that between 1% and 2% of young people aged between 12 and 18 report that they are the head of the household in which they live. The study showed that young women were twice as likely to head a household as young men.

These figures should, however, be treated with some caution. There is ongoing debate about the meaning of both women-headed households and the criteria by which individuals are designated the head of the household. It is uncertain whether such designations are made on the grounds of moral authority, earnings, decision making or presence in the home and responsibility for day-to-day household functions. It is also not clear what level of responsibility is accorded, or expected of, people designated as household heads.[28] Given this debate, notions of what constitutes a child-headed household are even less clear. Teenagers have for many years looked after households in rural areas while mothers migrate on a weekly, monthly or longer-term basis to work as domestic workers in nearby cities and towns. Such figures also fail to reveal how many households consist only of children, or of the level and frequency of support available to them.

What are the implications of the information collected? On the basis of such data, a number of trends can be discerned. These include the following:

- Levels of orphaning vary across the region. Orphaning in South Africa is still at an early stage in the epidemic, although it is beginning to move up a very steep growth curve and will soon be comparable to neighbouring countries with more mature epidemics. While government and NGOs already feel the pressure from increased demands for services for orphans, the current level of orphaning in South Africa is less than a quarter of what it will become at its peak, without decisive intervention in the form of prevention and treatment. It is thus critical that plans are made and mechanisms of support devised at this early stage, to avert the potentially catastrophic effects associated with the precipitous rise in orphaning that is expected in the next decade.

- Children over the age of ten years are most vulnerable to becoming orphaned, but are a group neither specifically targeted by many current programmes nor by the increase in institutions to house affected children. For this older age group of children, family, community and school-based intervention is essential.

- As highlighted later in this monograph, fosterage and community-based family care are robust care mechanisms that have long existed in the region—both as a result of cultural practice and as a way of maximising family resources and access to education for children. Available national data does not indicate negative effects associated with fosterage, although Case and her colleagues argue that orphaned children who are fostered are at a distinct disadvantage in that they are less likely to attend school than co-resident children in the household.[29] Fosterage is a critical response mechanism and it is essential that comprehensive, targeted mechanisms are put in place on a very large scale to provide economic, social, legal and other support for foster families.

- Orphaned children most often have a surviving parent, usually their mother. The widespread absence of fathers and lack of support by men for families and children in South Africa is a major gap in potential resources for affected children. Statistics South Africa, for example, has estimated that close to half of all children under seven years of age live only with their mother, and fewer than half of all maternal orphans in South Africa live with their surviving father. In Zambia, where marriage rates are higher and fathers are more often present in the household, more than 65% of maternal orphans live

with their surviving father.[30] For this reason, the Child, Youth and Family Development research programme at the HSRC, in collaboration with the United Nations Children's Fund (UNICEF) South Africa, the South African Men's Forum and others, has launched a media and advocacy intervention to promote fatherhood.[31]

The need for a change in perspective

The intersection between HIV/AIDS and poverty necessitates a shift in perspective in approaches to meeting the needs of affected children. The familiar Introductory Psychology illustration of a figure–ground illusion shows that if you focus on the figure you see a chalice or vase; if you focus on the background, you see face-to-face profiles. The lesson from this illustration is that we respond to what we see, but it is possible to see things differently.

In the current situation, we can either focus on the HIV/AIDS epidemic and its impact on children (what I consider to be the existing foreground), or we can focus on the background—the pervasive and increasing poverty of certain vulnerable groups of children. The change in perspective necessitates a switch in the perceived scope and scale of the required response. An emphasis on the HIV/AIDS epidemic highlights a specific group of children, orphans and children affected by HIV/AIDS, and necessitates a focus on individuals. In contrast, an emphasis on poverty takes in a much larger group of vulnerable children and necessitates a focus on social determinants and interventions directed at social institutions.

According to a variety of measures—and without taking into account the effect of the HIV/AIDS epidemic on socio-economic conditions—it is estimated that an average of six out of ten children in South Africa live in poverty.[32] Using the Fifth Labour Force Survey, Ingrid Woolard[33] from the HSRC has calculated that an estimated 4.8 million children aged 14 years and younger, or 33% of all children in this age range, live in households where no one is employed. If a child is defined as a person of 18 years and younger, then 6.1 million South African children—again 33% of all children in this age range—live in workerless households.

A rough estimate, calculated with disregard for all kinds of potential confounders, is that one in five or six children is living with an infected mother.

There is likely to be a very large overlap between those children who live in poverty and those living with an HIV-positive mother. Poverty is the undeniable background to the HIV/AIDS epidemic and HIV/AIDS itself deepens the poverty of already vulnerable children. Owing to this, one needs to look beyond AIDS orphans to all vulnerable children. Our efforts need to be focused on poor children with tenuous social, institutional and material supports, as the situation of these children in likely to be considerably worsened by HIV/AIDS.

If we shift our perspective from individual children identifiably affected by HIV/AIDS to the large group of children made especially vulnerable by poverty and HIV/AIDS, a number of questions can be posed about the combined or synergistic effects of the epidemic on children in the region.

Individual suffering and social disorder

There is no doubt that the HIV/AIDS epidemic has, and will, precipitate enormous suffering for countless children, families and communities. Unknown numbers of children will go hungry, starve and suffer stunted physical and mental growth. Similarly, many children will endure enormous anguish as they potentially find themselves alone and unsupported, the butt of cruel commentary and behaviour, excluded, exploited, beaten, raped and forced into labour. Many children will have to make their own way in the world, sleeping rough, doing opportunistic work, begging and soliciting patronage and protection from street groups. None of this will leave anyone in South Africa or the region untouched.

However, individual suffering, even on a massive scale, does not necessarily imply that children will lack critical socialising experiences, or that they will become alienated, disturbed or pose a potential threat to social stability.

Mel Freeman,[34] former director of Mental Health and Substance Use in the South African Department of Health, expressed a view shared by a number of people in South Africa and beyond. He suggested that despite a large number of children affected by HIV/AIDS being taken into the stable and caring homes of family and neighbours, many are likely to develop mental health problems because they will not be exposed to several formative influences. Freeman speculates that these include the:

- early bonding experiences critical for good, caring human relationships;
- modelling, boundary setting and development of value systems necessary for moral development; and
- support, caring and discipline needed for emotional stability.

As part of the intrinsic processes which drive child development, however, children actively seek out these experiences—even in conditions of great difficulty. This is at the heart of what we know about the resilience of children growing up in extreme adversity.[35] As a result, these formative influences may be absent only in children lacking any adult supervision or support, in children subjected to cruel and dehumanising treatment, or reared in institutions over a long period of time.

A very small proportion of children affected by HIV/AIDS will find themselves subject to these depriving conditions. Knowledge gained from working with street children, displaced children and children in conflict and disaster situations demonstrates that even on the street, in conflict or under abusive and dehumanising conditions, children attempt to seek out bonding experiences with adults and engage their support.[36] Even low levels of support in childhood appear to enable quite dramatic compensatory responses in children.[37]

Determinants of psychological and social disorders in children tend to be non-specific: that is, no particular interpersonal or environmental determining condition is associated with a specific psychosocial manifestation. For example, although parental divorce is associated with psychosocial trauma in children, children whose parents get divorced do not all become depressed, wet their beds or suffer discernible signs of maladjustment. In fact, only a minority of children show ill effects when exposed to adverse conditions. Rather, children's response to high levels of stress is determined to a large degree by personality and temperament, learned coping style, age of exposure, the availability of caring adults and social supports in their environment and, critically, opportunities for recovery afforded by achievements, new relationships, changing circumstances and the like. About a third of children exposed to extremely disadvantaging conditions thrive, achieve high intellectual standards and are well adjusted. Less than a third of such children are affected in negative ways. The basis of so-called resilience is to be found largely in children's

ongoing relationships with caring others, and their continued membership of social networks and social institutions.[38] This is one reason why strong cultural effects are found in children's response to disasters; for example, children in cultural groups that have strong social connections through extended kin are less affected by events in the nuclear family than are children who have fewer and less intense kin networks beyond the household.[39]

The likelihood of maladjustment is increased when adverse conditions endure over time, when stresses are cumulative and when children are given few opportunities for support and hope. Thus, long-term maladjustment is dependent on the availability of conditions for recovery as much as, or more than, the form or severity of precipitating stresses.[40]

It is thus necessary to prevent the social conditions and poverty of families made especially vulnerable by HIV/AIDS from deteriorating to the degree that large numbers of children find themselves in these extremely difficult situations. It also means that the widespread institutionalisation of children in residential settings, which is almost invariably associated with abuse and delay, must be averted.[41]

On a very broad level, there are three main categories of 'determinants' of poor adjustment that are likely to occur in the context of the HIV/AIDS epidemic, given prevailing conditions:

- *Poverty:* As discussed, the HIV/AIDS epidemic is inextricably bound up with poverty. In general—and without considering associated confounding effects such as substance abuse in the home or residential instability and displacement—poverty is associated with deprivation syndromes in children. Deprivation syndromes include poor growth and health, decreased motivation, increased passivity, impoverished experience and frames of reference and lower cognitive performance.[42]

- *Loss, separation and bereavement:* Many children in the region are going to be separated from and lose their parents, caregivers and the breadwinners on whom they depend. Again, without considering associated confounding effects such as residential and school change and worsening socio-economic conditions, the loss of parents and loved ones is associated with internalising psychological conditions including anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem.[43]

- *Cruel and impersonal child care:* Children affected by HIV/AIDS may be subjected to impersonal and abusive child care through: exploitative family and community care; poorly chosen and supervised foster care; and long-term institution-based rearing. In general, and without considering associated effects such as pre-existing home conditions, separation and bereavement, impersonal and abusive care is associated with a range of psychological disorders, including a reduced capacity for affection and compassion, acting out and more aggressive coping styles.[44]

At this stage its unclear how many children are exposed to unmitigated poverty, multiple loss and bereavement, and/or cruel and impersonal care. Of those children who are exposed to these conditions, it is not known what proportion will succumb to the effects of the associated stresses and begin to show disturbed behaviour or diminished capacity.

Among children who do show disturbances or delays, it is not certain how many children will show enduring maladjustment because they have few, if any, opportunities for recovery. What we do know is that children exposed to multiple severe stresses, without compensating support, are more likely than other children to show disordered behaviour. At the level of the individual child, the programme implications are clear. Every effort must be made to ensure that affected children have stable, preferably family-based, care and adequate social support. As already described, children appeal to available adults and peers for social support in their efforts to cope with stressful situations.[45] Social support at the level of the family, school and the wider community reduces the impact of stresses on children living in adverse conditions.[46] Lack of social support—through poor coping by available adults, the depletion of social networks and isolation from regular social institutions—increases children's vulnerability to stress by reducing their resources for dealing with stress. The implications of this framework are, principally, the following:

- Individual or group predisposition to socially disordered behaviour does not necessarily accompany or follow from aggregated human suffering. Disordered behaviour of the kind that threatens security, such as widespread aggression and disregard for social norms, has a closer association with the weakening of social institutions than with individual-level experiences.

- For this reason, the strength and quality of social institutions, such as the

family, school, church and community associations are critical for children's capacity to cope with the effects of the epidemic, and to avert personal distress, maladjustment and social disorder. It is also true that these institutions are likely to be weakened as a result of the epidemic, as key individuals become ill and die, and as those people who remain become demoralised and overwhelmed by loss and the demands placed on them by difficult conditions. Therefore, every effort has to be made to support and strengthen these social institutions in the face of the epidemic, as they provide the cornerstone for the protection of children. In particular, schools need to be adapted to provide a range of supports for children: schooling must be available to all children and every effort must be made to ensure that all children remain in school; educators and older children can be sensitised and trained to provide support for children; food and clothing, especially uniforms, can be provided through schools; and shorter- or longer-term accommodation can be developed for children in especially difficult circumstances. Maintaining children's schooling is an important intervention in several ways. It retains children's connectedness to peers, familiar adults and to an institutional identity. Schooling provides children and society with future knowledge and skills. Keeping older children in school could also help to prevent vulnerability to HIV infection, by protecting children and reducing the child's need to seek shelter, food and clothing through risky encounters with unscrupulous adults.

- Every effort also needs to be made to avert conditions that result in impersonal and cruel child care. Orphanages and unstable foster care have been identified as high-risk environments for neglect and abuse.[47]

- Finally, it is critical to address the background poverty effects experienced by children affected by HIV/AIDS. Mechanisms exist to identify and target assistance to needy children and families. Children out of school, working children, children not living with either biological parent and adult sickness and death are all indicators of potential vulnerability. Such indicators need to form the foundation of an early warning system in which economic and other assistance is provided to families and children.

Social trends likely to impact on children

In addition to any personal psychological maladjustment that may be

precipitated in a small number of children who suffer extreme stress, a number of broader social trends are over the longer term likely to exert insidious and pervasively injurious effects both on children and on the society in which they live. Three such trends can be identified: school drop out; child labour; and sexual exploitation and child trafficking.

School drop out

According to the 1999 South African October Household Survey, as many as 35% of rural African children between the ages of six and 17 years do not attend school. In the sub-Saharan region, an estimated 44 million children, more girls than boys, are not attending school.[48] School drop out is likely to increase as families become unable to afford the costs of schooling and as children's contribution to care and work is required at home. Experience suggests that the most vulnerable orphans are those in their school years, aged ten years and older. Thus, despite all their shortcomings, schools have significant potential to play a critical role in obviating the worst effects of the HIV/AIDS epidemic on children. Apart from the accrued personal and social benefits of education for work and national development, schooling provides stability, institutional affiliation and the normalisation of experience for children. It also places children in an environment where adults and older children are potentially available to provide social support.

Child labour

Many children in South and Southern Africa already work hard. The Survey of Activities of Young People (SAYP) commissioned in 1999 by the South African Department of Labour found that more than half a million children between five and 14 years of age work for long hours, mainly collecting wood or water. Close to 400,000 children do night work; 183,000 do three or more hours a week of paid domestic work and 137,000 work with or close to dangerous machinery or tools. About 19,000 children (0.1%) beg for money or food in public for three or more hours a week. More than 70% of children work to help their families, either willingly or unwillingly. About 30% of children's work is in contravention of the law.[49] The International Labour Organisation (ILO) estimates that worldwide approximately 120 million children in the five to 14 year age group work on a full-time basis, and this figure rises to around 200 million when those for whom work is a secondary activity are included. Other surveys conducted

by the ILO have found that, over a 12-month period, the proportion of economically active children in the five to 14 year age group could rise to as high as 40% in developing countries. Such studies conclude that children's labour contributions are an important component of household income, in some cases amounting to as much as one-third of household income.[50]

While not all child labour is necessarily injurious—a moderate amount of responsibility can have a positive influence—illegal child labour can be damaging to children's physical and mental health, may prevent children from attending school and may be cruel and dehumanising. Child labour is likely to increase as economic conditions of children in families affected by HIV/AIDS deteriorate. Instruments dealing with child labour infringements—such as the Convention on the Rights of the Child and, in South Africa, the constitution and multiple laws—do not in their current form lead to financial assistance for the child or the family to ameliorate the economic conditions leading to child work.[51]

Sexual exploitation and child trafficking

There is very little hard data available on the extent and nature of human trafficking in either the region or beyond and much of what is available is based on relatively small-scale research.[52] According to the International Organisation for Migration (IOM), however, the trafficking of women and children is the third most lucrative type of organised crime in the Southern African region, following the sale of arms and drugs. A recent report released by the IOM suggests that considerable numbers of women and children are trafficked annually in the Southern African region. Trafficking in children occurs for the purposes of child prostitution, illegal and false marriage, illegal adoption and child labour. An unknown number of children are trafficked for body parts. In the Southern African Development Community (SADC) region, children are trafficked primarily as bonded labour and for the purpose of sexual exploitation. The IOM report highlights, as examples of trafficking in the region, a European-led child sex tourism industry in Malawi and the trafficking of Mozambican children into prostitution in Johannesburg.[53]

It is likely that as the ratio of dependent children increases as a result of the HIV/AIDS epidemic, so will the chances of children being lured into trafficking and sexual exploitation. Once imprisoned, or left without the means of escape, children are at their most vulnerable.

School drop out, child labour, sexual exploitation and child trafficking present real dangers to children as well as to society: they reduce individual and national developmental potential; marginalise and dehumanise children and separate them from available sources of help and support; engender widespread disregard for children; and have close associations with crime. Without schooling, both individual potential and social capital is lost, leaving affected individuals vulnerable to unemployment, menial working conditions and poverty. Similarly, child labour is often physically damaging, psychologically stunting and demeaning to the dignity of children whose labour is exploited. Together with sexual exploitation and the trafficking of children, school drop out and child labour indicate the disintegration of the social institutions that serve to protect and develop children and, by their existence, they further undermine fragile families and communities. In addition, child labour and sexual exploitation fuel crime as children become traded for profit.

Conclusion

The HIV/AIDS epidemic is going to be more terrible to live through than any of us can imagine. We are only beginning to experience the effects of AIDS deaths. The most important interventions for children are nationally oriented responses that identify, target and effectively implement mechanisms to provide economic and other assistance to poor families and to maintain and improve their access to services. In this way, the values and organising coherence of families, neighbourhoods and schools will assist children to cope with the increasing adversity accompanying the epidemic.

Notes

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