

Sickness, death and poverty – our bequest to orphans

By: CHRIS DESMOND, Research Fellow, and JEFF GOW, Research Associate at the University of Natal's Health Economics & HIV/AIDS Research Division (HEARD), summarise a survey on the impact on households of adult illness and death and the taking in of orphans.

At the time of writing, no household studies specifically on the impact of HIV had been completed in South Africa, although a number were under way. For this reason, this paper draws on a study examining the implications of adult illness and death, and of taking orphans into a household. This survey was conducted in Bergville, KwaZulu-Natal, in 2000.

The overall objective of the survey was to investigate the impact of serious adult illness (a proxy for HIV) on family livelihoods in the greater Bergville community. This was to inform a project with the overall goal of 'Strengthening the capacity of vulnerable households and communities to respond to the economic, social, and health impact[s] of HIV/AIDS on their households.' (WorldVision, 1999: 9).

Data Collection and Sources

The sampling frame consisted of all of the households that belonged to the Amazizi and Amangwane Tribal Authorities, as well as wards from the 11 Settlements. A household scan was conducted in August 2000. Every third household was asked to respond to a one-page questionnaire on household structure, illness and orphans. Based on this survey, households were divided into three categories: households with an adult aged 15-49 who had been so ill in the last two weeks that they had not been able to attend work for more than five days or were bed ridden (illness households). Households that contained children whose mother was not alive (orphan households) and households that had neither orphans nor illness (control households). Sixty households from each group were randomly selected. Those households that contained both an ill adult and an orphan were placed in both orphan and illness groups prior to random selection.

In late 2000, DRA Development surveyed 178 households using a survey instrument based upon a research design from HEARD.

Conditions for undertaking the survey included:

- That households had already been identified, approached and agreed to participate in the survey;
- That two key informants were available to be interviewed per household (this is necessary as usually the people in charge of spending the money are not the same as the people who earn the money);
- That identified households were in no more than 15 'walking distance' clusters – i.e. 12 households from each cluster, with a mixture of different types of households;
- The fieldwork took place over weekends to maximise the probability that all key informants were at home.

Limitations:

The primary limitation of the survey is that it is not clear how good a proxy adult illness is for HIV illness. It was assumed to be close; given that in 1998 prevalence among women attending antenatal clinics in the area was already over 21%, HIV should be accounting for a high proportion of adult illness.

Secondly, some households when revisited no longer belonged in their original group. For example, some households were found not to have orphans. They had said they did, believing that some assistance might follow. Other households no longer contained adults who were ill. Households which had changed group were re-classified on data capture to the correct group. This is what accounts for the slightly uneven split between the groups.

Finally, the survey suffers the same limitation as any other cross-sectional assessment of impact. Unless it can be assumed that prior to the impact of illness, HIV-affected households had similar characteristics to a random sample of non-infected households the survey cannot measure impact.

Results and Discussion:

Following the re-classification and data coding, results for 178 households have been analysed based on the following division:

Table 1. Number of households, by household status

Orphan	63
Illness	59
Control	56
Total	178

Household characteristics:

Households on average contained 9.3 members and this did not differ significantly across the groups. Female-headed households were the majority only for orphan households and, on average, heads of households of orphan households were older.

Table 2. Average age of household heads

	Percentage female head	Average age of household head
Orphans	57	59
Illness	47	52
Control	42	54
Total	49	55

The above provides evidence of the much-reported care of orphans by grandmothers. Another much reported phenomenon is child-headed households. In the sample, however, no households headed by a person below the age of 20 were found.

Household members were engaged in a number of different activities, mostly determined by age with little variation by gender.

Table 3. Vocation of all members by household status

	Orphan	Illness Control	Male	Female	Total	
Baby, pre-school or crèche	88	84	91	137	126	263
Scholar/student	238	184	198	306	314	620
Schoolgoing age not attending	11	20	14	20	25	45
Retired	38	26	23	23	64	87
Disabled - not seeking work	6	10	4	12	8	20
Housewife/unpaid work	16	20	23	0	59	59
Unemployed - seeking work	77	90	82	135	114	249
Unemployed - not seeking work	18	20	24	23	39	62
Employed full time	29	23	30	48	34	82
Employed part time	48	30	33	54	57	111
Self-employed	17	24	11	14	38	52
TOTAL	586	531	533	772	878	1650

The high proportion of retired persons in orphan households again suggests orphans staying with their grandparents and, based on the gender breakdown, they are staying with their grandmother. Examination of the marital status of adults also shows a higher proportion of widows/widowers within orphan households: 10% compared to 6% (illness) and 7% (control). The results of the marital status variable also began to raise the question of mobility and migrants. In both the orphan and the illness households the majority of married couples were not living together.

Over 4% of adult members – that is 15–49 year-olds – of the surveyed households had died in the previous 12 months. Unsurprisingly, orphan households had experienced the highest level of death, accounting for 57% of reported deaths. This corresponded to 7% of orphan household members. Illness and control households had experienced the same number of deaths. In percentage terms these were both 3% of household members.

A wide variety of illnesses were reported as the causes of death. Significantly, AIDS was only specified once out of 72 deaths.

Existing poverty and economic structure:

Even before considering the impact of adult illness and death, and orphaning, it is essential to note the existing poverty and violations of children's rights. Houses in the area are primarily (91%) made from traditional materials: mud, brick and dagga. The most common source of drinking water for all households in the sample was a borehole, followed closely by free public taps, combined accounting for 69% of households' supply. Only one household had piped internal water. Over 82% of households used basic pit toilets, while 16% had no toilet facilities other than the bush or rubbish dump. Of the entire sample, only 37% were connected to electricity and 29% had TVs. Wood is the primary energy source used for cooking (62%) and heating (81%).

Of the 1650 individuals in the sample households, 369 individual income earners were identified with 15 of those earning income from two sources. 22% of the members of all sampled households were earning income - this from an economically active group of 33% of individuals in the sample.

Employment, whether formal or informal, made up 50% of income sources for members of all households earning income. The informal sector contributed 32% and the formal sector 18%, which reflects the lack of economic activity in the Bergville district and the high levels of unemployment.

Self-employment was also a significant source of income, with 17% earning their own income. Pensions were also a source of income for 18% of the income earners. This mainly reflects the large number of grandmothers in the community.

With small incomes available to households (approximately R1000 per month) expenditure was targeted toward essential items like food, housing, transport and education.

Food Expenditure:

Between 37% and 40% of expenditure across all three types of household went on food. Around 35% of total household expenditure went on regular non-food items like loan repayments, transport, entertainment and utilities. Occasional non-food expenditure on items like education, insurance and cultural activities like funerals, weddings and the payment of *ilobolo* accounted for 10% to 18% of household expenditure. While these cultural activities are infrequent, they are major expenses when they occur.

Impact of HIV/AIDS on Children:

The impacts on children at a household level can be divided into three phases: illness, death and orphan-hood. This paper focuses on the economic and social impacts; the psychological implications must, however, be kept in mind.

The economic impact originates from the economic strain placed on the household and manifests itself in many forms. Analysis of monthly income, however, yielded strange results.

Table 4. Individual Household and per capita mean monthly

	<u>Individual Earner Mean</u>	<u>Household</u> <u>Mean</u>	<u>Per capita Mean</u>
Orphan	597	1328	142
Illness	612	1366	168
Control	485	1009	117
Total	567	1240	143

Both orphan and illness households reported incomes greater than the control group. There are a number of possible explanations for this. Households with greater status in the community may be more prone to infection as members have greater access to sex. Income in these households may fall following illness, but may have been much higher to begin with. Households with greater income may also be more prepared to absorb orphans. The orphan households appear to have more income earners. Income in orphan households is bolstered by the presence of older members who obtain state pensions, in addition to the earnings of working adult members.

Although the impact of illness is unclear, the impact of death is unambiguous. The mean household income across the sample was R1330 for those who had not experienced a death in the last 12 months and R848 for those who had. Funeral costs represented, on average, twice household monthly income. Unsurprisingly the majority of funerals in the sample have been paid for by orphan households, over 50% of whom had suffered a death of a household member in the previous 12 months, compared to 25% of illness households and 21% of control households. In response to such an impact, households have adopted a number of strategies.

Table 5. Death: financial coping strategy

	Orphan	Illness	Control	Total
Sell assets or use savings	6	1	3	10
Borrow money from money lender	3	2	1	6
Borrow money from family or friends	7	8	5	20
Borrow money from stokvels	1	2	0	3
Get non – financial help from others	1	0	0	1
Use insurance / medical aid	2	0	0	2
Financial support from employer	1	1	1	3
Do nothing	11	1	2	14
Total	32	15	12	59

Such responses raise a number of concerns. The sale of assets, particularly if they are productive, has long-term implications for the well-being of the household. Borrowing money from family, friends or *stokvels*, although possible now, may become increasingly difficult as AIDS deaths escalate...

Aside from an examination of the economic impacts it is essential to examine the living arrangements following death. Even before the loss of a parent, children often do not live with them.

Table 6. Which parent(s) all children live with

	Yes	No	Total
Natural mother	391	52	443
Natural father	266	123	389
Total	657	175	832

This is a result of adult migration and orphanhood. Adult migrancy is common for both men and women. What is also common is the death of a parent. Across the sample, 100 children have lost their mother and 104 their father. Many of these losses were recent.

Table 7. Number of years since parent's death

	Frequency
Less than a year	29
1 year	38
2 years	35
3 years	16
4 years	14
5 years	9
6 years	9
7 years	4
8 years	6
9 years	1
10 or more years	11
Do not know	2
Total	174

The loss of parents means the loss of both financial providers and caregivers.

Table 8. Parents who were the financial provider/caregiver to the child prior to their death, by gender

	Provider			Caregiver		
	Mother	Father	Total	Mother	Father	Total
Yes	92	66	158	95	58	153
No	8	35	43	5	46	51
Do not know	0	3	3			
Total	100	104	204	100	104	204

After the death of their mother, many children become members of their grandmother's household; this is even more marked when both parents have died.

Table 9. Relationship to the head of orphan households of children under the age of 16 who have lost their mother

	Lost mother	Lost both parents
	Frequency	
Son/daughter	14	-
Adopted/foster child	1	1
Grandchild	59	15
Brother/sister	2	2
Niece/nephew	9	4
Other relative	5	5
Total	90	27

The reliance on grandparents to provide care after the death of parents is dangerous and will become increasingly so as the epidemic progresses. Grandparents will be more likely, excluding the impact of AIDS, to die than their children, so children face being orphaned again. And the question of who will care for them then is unanswered. Furthermore, grandparents generally rely on state pensions. Although this represents a stable income, it is fixed and they have little opportunity to increase it. They, therefore, may be able to cope with a few orphans, but as numbers increase and income does not, their ability to meet the financial costs of care will be strained. The grandparents of the future are also dying in the present. Who will care for the children 15 years from now?

Conclusion:

In Bergville, as in many South African communities, HIV will impact on an already poor society. Many children's parents already live away from home. Many children are not attending school. Measuring the economic impact of illness has been difficult, but the impact of a death of a household member is clear and major.

Illness does, however, appear to have a negative impact on the realisation of children's rights. Children living in households containing ill adults are more likely not to attend school than children from orphan or control households. This is at present mainly a result of child illness, in addition to the economic strain faced by all the households.

The care of orphaned children by their grandparents appears to lessen the impact of death on children. A higher proportion of children in orphan households attended school. Consumption in part was affected by high levels of expenditure on funerals, but expenditure on food and education appeared relatively stable compared to control households. Although such a finding is encouraging, the sustainability is questionable. Many of the orphaned households had sold assets to mitigate the short-term financial impact. In the long term this may have serious negative implications, particularly if the assets were productive. Households also borrowed money. As the epidemic progresses, and as deaths become more common, the capacity of family and friends to lend will be eroded and interest rates of micro lenders may increase.

Adult illness and death, within a household, have a number of serious economic, psychological and social impacts on child members. This paper has concentrated on the

economic impact, but the psychological impacts, the stigma and the affect on social capital must always be kept in mind.

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