Social Tract

Module on

The impact of HIV on families, vulnerable groups and youth

LEARNING OUTCOMES FOR ALL TEAM MEMBERS

After completion of this module the learner should:

- Understand the impact of HIV and AIDS on families, youth and other vulnerable groups.
- Be able to explore strategies to ensure that these groups have access to services.

1. FAMILIES

The family is one of the primary building blocks of society and forms the net that holds communities together. Families, by nature, are pre-existing networks of care and support and form a very important social resource in South Africa's response to the challenges of HIV and AIDS. On the other hand, HIV and AIDS pose one of the greatest challenges to families in history.

HIV and AIDS touches at the very heart of families, drawing them closer together or driving them further apart. The illness and resulting death of fathers, mothers, children and siblings changes the very structure of this primary building block and is further exacerbated by the additional financial constraints placed on the family. The nodes of care within the immediate and extended family is impacted upon as the burden of care starts to exceed the levels of resilience within the family.

Families can be and have been constituted in many ways in South African history and various forms of the traditional 'family' have been formed in South Africa's troubled past. Contrary to the western, post-industrialised, notion of a nuclear family; the extended family is more common in South Africa and Africa. Owing to globalisation, nuclear families are however not uncommon in South Africa. As the onslaught of HIV and AIDS on families continues, families are headed by grandparents, in the absence of parental figures headed by children and families of mixed race. In some cases families are headed by only men or only women in the absence of a gender and families are starting to be constituted of mixed kin and blood. Single parent families are becoming more common as well.

Within these 'new' families the traditional care roles need to be taken into account and reassessed when family care networks are activated.

Group discussion

- How do these changes in family and networks of care impact on our roles and capacity as health care workers?

2. ORPHANS

HIV/AIDS contributes to orphanhood, and for this reason there is an interest in estimating the magnitude of the orphanhood problem. The study found that 13% of children aged 2-14 years had lost father, mother, or both. The study also found that 3% of children had lost a mother. In addition this study found that 8.4% of children had lost their father (*Nelson Mandela/HSRC Study of HIV/AIDS*, 2002).

The orphan crisis in South Africa is placing an unprecedented challenge on the notion of family. In the past orphans were to be taken care of by the extended family, but the shear extend of the orphan crisis is challenging the capability and ability of this form of family. Not only is it challenging the financial means of the family, but also the coping and caring skills of this family at psychosocial levels. Researchers also claim that the South African form of the extended family is weaker than others in Africa as it was already disrupted during apartheid.

The challenge to the orphan starts prior to the death of a parent or both parents, as the initial household ability to care and support was changed. In the event of the newly orphaned child being placed in the extended family the orphan now takes the

place of the disease in the new family. Where in the child's original family, AIDS posed challenges and changed the family; the orphan now challenges the financial and social means of the extended family and subsequently changes it. As a result of this orphans placed in new families loose their right to property inheritance and are forced to leave school and have to work to contribute to the household income. Physical and sexual abuse is also common with orphans in extended families where the limits of 'care' and 'support' have been exceeded.

The orphan problem in worsens poverty in communities as families with orphans becomes poorer as the number of income generating adults in the family decrease and the number of dependent children increase.

Orphanhood on children poses a lot of psychological problems. Studies suggest that children orphaned by AIDS suffer from a low self esteem and display more aggression, anxiety and depression than other children. In the event that children become abandoned by the extended family tend to become street children and engage in antisocial behaviour or prostitution. This in turn places them at high risk of HIV infection. Without sufficient social and welfare structures uncared for orphans can result in significant problems with juvenile crime in communities.

Group discussion

- How can care in support structures for families and orphans be strengthen in communities?
- Do you think the health sector can play a role in this?

Child-headed households

Many community-based assistance programmes report an increase in households headed by children, or consisting only of children. However, no additional data on child-headed households has yet been reported. In this survey, just 3% of households reported as being headed by a person between the ages of 12 and 18 years of age, and could thus be called child-headed-households. The percentage observed was 3.1% in urban formal areas, 4.2% in urban informal areas, 2.8% in tribal areas and 1.9% on farms (*Nelson Mandela/HSRC Study of HIV/AIDS*, 2002).

Many child-headed households are dealing with trauma of multiple familial deaths unassisted. The pressures on the family social unit prior to HIV/AIDS means that many children have only one parent to lose, generally their mother; as many fathers have long since abandoned the family prior to a mother's illness. The Kaiser Family Foundation found in this context that 72% of the households it surveyed were female headed (*Hitting Home*, 2002).

Looking at child-headed households a critical question arises: "who is the legal guardian or head of the household?" Will this 'head of the household have access to government grants? In most cases the answer to the last question will be no. These heads of households are not recognised by law and they are not eligible for support grants. What changes are required in our support interventions to make them available to our child-headed families?

Children are forced prematurely into roles of parents and primary care givers. How are these children able to access education? Children enter the economy prematurely and are often exploited once they enter employment.

The burden on young girls is often doubled, as they not only have to take care of siblings and extended family members but also children of their own. This as a result of a consensual sexual relationship, but more often sexual abuse.

In some cases children heading families are overwhelmed by the burden of care and they often ran off and abandon the family. The onus of being the 'head' of the family will have to be taken over by another child. Young girls often have to resort to transactional sex as a means of survival and young boys will often resort to crime.

Therefore, while it is vital that children are fed, children's needs are not only limited to these basic survival requirements. If children are to develop into contributing, resourceful members of society, they will require a range of other forms of support – emotional, psychological, social and intellectual – in order to be able to fulfil even some of their potential and ultimately the potential of society as a whole (*(Over) extended: AIDS Review 2003,* 2003).

Group discussion

- Child-headed households require new thinking and understandings of the way in which families are constituted, what changes in your view, will help communities and families to cope with the impact of child-headed households?

Grandparent-headed households

Grandparents often forms the foundation of extended families, according to a UNICEF report in 2003 the percentage of orphans taken care of by grandparents in Namibia increased from 44% in 1992 to 61% in 2000. These figures might be worse in South Africa.

One of the consequences of the HIV and AIDS epidemic is the obligation of care that falls on grandparents, and disproportionately on grandmothers. They suffer a great amount trauma when their children die of HIV and AIDS and are then compelled to look after their grandchildren. Grandparents often care for several of their grandchildren having old age pension as their only source of income. Many of these grandparents are unaware of the social grants that they can access.

Group discussion

- What special needs to grandparents taking care of orphans have?
- What community education efforts are needed to ensure that they know about support grants?

3. YOUTH

*Young people between the ages of 15 and 24 are both the most threatened—globally accounting for half of all new cases of HIV—and the greatest hope for turning the tide against AIDS. The future of the epidemic will be shaped by their actions. Experience proves this. The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer behaviour choices among young people (*UNAIDS*, 2004 Report on the Global AIDS Epidemic).*

More than 40% of South Africa's population is below the age of 18. Several factors make youth particularly vulnerable to HIV infection including their age, biological and emotional development, and their financial dependence. In many parts of the world and in South Africa they have limited access to health care services (in places where these are available some youth my find them unfriendly and inaccessible) and reliable information about sexual activity and its implications. They are often unlikely or unable to protect themselves appropriately as they demonstrate an inclination to sexual experimentation, often with multiple partners. These sexual behaviours, and sex in conjunction with drug and/or alcohol use, may increase the likelihood of becoming infected with HIV. In addition, young people's sense of invulnerability ("It can't happen to me"), combined with lack of experience, may leave them unaware of the consequences of their actions and therefore less likely to take precautions against risk of infection.

Group discussion

- Do current service delivery by health services meet the needs of youth?
- Can they be made more youth 'friendly?

4. VULNERABLE GROUPS

Many groups find themselves at the margins of society, unable to access mainstream services and information and at increased risk of HIV. These groups are not always able to articulate their needs or influence overall AIDS policy. These groups include, but are not limited to:

- **Gay men:** this group find themselves at the borders of 'conventional' masculinity as they do not conform to traditional masculinity and are often the victims of violence. They are at increased risk because of a lack of information; the majority of prevention programmes are targeted at the heterosexual communities.
- **Men who have sex with men (MSM):** this vulnerable group should not be confused with gay men. This group of men have sex with men but they do not identify themselves as 'gay'. These will men often have sex with both men and women. Men who have sex with men are found at every level of society, with a higher incidence in prisons and single-sex living quarters. This group also include gay men, who because of fear of rejection and stigma, refuse to identify themselves as gay and then choose a dual lifestyle.
- **Lesbian women:** challenges notions of femininity in similar ways that gay men challenge masculinity. Lesbian women are often the victims of verbal and physical abuse, and this physical abuse often result in rape (as rape often seen by men as a cure for their sexual

preference). Owing to high incidences of rape, this group are at great risk of HIV infection.

- **Migrants and refugees:** Economic migration is a common feature of many developing world economies. Whatever their age or sex, and whether they are single or separated from their partners, many migrants face isolation and poverty in the countries where they seek or find work. Without the support of their community and the social rules and regulations that guide behaviour at home, both men and women are likely to turn to sex as a source of comfort or of income.
- **Prisoners:** Prevalence rates in prisons are usually higher than that of the general population. Prisoners are exposed to gangs, drug use, violence, high incidences of men who have sex with men and rape. Prisoners under the age of 18 are at increased risk of HIV as they find themselves to be favoured by older prisoners as sexual partners. The HIV risk of female prisoners, though lower than male counterparts, should not be ignored.
- **Sex workers:** this group is often blamed for the rampant spread of HIV but not often targeted by prevention and support programmes. As sex work is not legal in South Africa and severely stigmatised, sex workers do not always access mainstream services and have difficulty reporting sexual violence and abuse, which renders them more vulnerable, to police and authorities. Women and men engage in sex work, where male sex workers predominantly sell sex to other men.
- **Intravenous drug users:** this group is not well documented in Africa; although studies have indicated that intravenous drug use do occur, but mostly in urban areas. In Europe prevention programmes promoting needle exchange programmes proved to be successful.
- **Truck drivers:** this group is a highly mobile population at increased risk of infection, sometimes owing to multiple sexual partners and alcohol abuse. A lack of prevention services and education targeted at them add to this.

Group discussion

- How do we make our programmes and facilities more accessible to the vulnerable and marginalised groups?
- Do stigma and prejudice on our behalf cause these groups not to access services available to them?