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Adult illness and death, taking in of orphans: Impact on households

Chris Desmond, research fellow, and **Jeff Gow**, research associate, at the University of Natal's Health Economics & HIV/Aids Research Division (Heard), give a brief summary of a survey on the impact on households of adult illness and death and the taking in of orphans.

At the time of writing no studies specifically on the impact of HIV on the household had been completed in South Africa, although a number were underway. 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 impacts of HIV/Aids on their households.

The sampling frame consisted of all the households within the Amazizi and Amangwane tribal authorities as well as wards from the eleven 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 three months that he or she 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, the organisation that led the data collection with the support and assistance of the local community, 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 money are not the same as the people who earn the money);

- That identified households were in no more than fifteen 'walking distance' clusters - that is, twelve 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.

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 that 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.

Following the re-classification and data coding, results for 178 households have been analysed and put into the following categories: Orphan (63), illness (59) and control (56).

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 with 57% of the orphan category headed by a female. A woman was head in 47% of the illness category and 42% of the control group. On average, the heads of households in the orphan category were older. The average age of the household head in the orphan category was 59, the illness group 52 and the control group 54. Although child-headed households are a much-reported phenomenon, no households headed by a person below the age of 20 were found in the sample.

Household members were engaged in a number of different activities, mostly determined by age with little variation in gender. Of the 1650 household members 620 were scholars or students; 249 were unemployed and seeking work; 263 were babies or attending pre-school; 111 were employed part time; 82 were employed full-time; 52 were self-employed and 62 were unemployed and not seeking work.

The high proportion of retired persons in orphan households (38 household members out of 586) again suggests orphans staying with their grandparents and, based on the gender breakdown (23 male and 64 female across all three categories), 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 the members 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 an equal number of deaths which, in percentage terms, were both 3% of household members.

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

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, which together accounted 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 televisions. 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. Off all sampled only households 22% were earning income and this was from an economically active group of 33% of the 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 R1 000 per month) expenditure was targeted toward essential items like food, housing, transport and education.

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 weddings, marriages 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.

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. Both orphan and illness households reported incomes greater than the control group. The individual earner mean in orphan households was R597, in illness R612 and in the control group R485. The household mean for the orphan category was R1 328, illness R1 366 and control R1 009. The per capita mean for orphan R142, for illness R168 and for

control R117.

There are a number of possible explanations for the greater reported incomes in the two groups. 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 R1 330 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.

Of those households sampled ten sold assets or used savings, six borrowed money from a money lender, 20 borrowed from family or friends, three borrowed from a stokvel, one got non-financial help from others, two used insurance or medical aid, three got financial support from an employer and 14 did nothing. 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. This is a result of adult migrants and orphans. 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. Of 174 children, 29 had lost their parents in less than a year, 38 in one year, 35 in two years, 16 in three years, 14 in four years, 11 in ten years or more and two did not know. The loss of parents means the loss of both financial providers and caregivers. 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.

The reliance on grandparents to provide care after the death of parents is dangerous and will become increasingly so as the epidemic progresses. Grandparents are more likely, excluding the impact of Aids, to die earlier 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 opportunities 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 in 15 years?

In 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 large. 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. High levels of expenditure on funerals partly affected consumption 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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