



LEARNING GROUP 1: STRENGTHENING FAMILIES

CHILD, YOUTH, FAMILY AND
SOCIAL DEVELOPMENT

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“...the vast majority of children, whether affected or infected by HIV and AIDS, live in families and households.”

DEMOGRAPHIC EVIDENCE OF FAMILY AND HOUSEHOLD CHANGES IN RESPONSE TO THE EFFECTS OF HIV/AIDS IN SOUTHERN AFRICA: IMPLICATIONS FOR EFFORTS TO STRENGTHEN FAMILIES

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INTRODUCTION

HIV can no longer be considered as a new or emerging disease in sub-Saharan Africa. More than two decades on from the start of the epidemic, several countries in Africa have maturing HIV epidemics with stable or declining incidence. During the HIV epidemic, families and households have continued to be formed and built, and have survived and dissolved, bearing and rearing children. They pass through various life-cycle stages while continuing to function as the primary units of reproduction and production. Children who survived the risk of contracting HIV through mother-to-child transmission in the 1980s have already started the next generation of families and households.

While central to their direction and force, the HIV epidemic is only one aspect of the demographic, social, economic and political determinants shaping family outcomes. To discern whether, and how, HIV and AIDS have changed families and households supporting children, we need to understand these broad, historical trends and how they impact families.

The most studied aspect of family demography is adult AIDS mortality, and associated changes in household size, livelihoods and household dissolution. Within this area, the greatest attention has been given to the consequences of parental death on the living arrangements, schooling, mental health and economic prospects of orphaned children. In contrast, we know far less about the impact of HIV/AIDS on key aspects of family life cycles, such as partnership dynamics, marriage and fertility. In the paper, the similarities and differences among families and households are explored, particularly with respect to relationships, co-residence, and shared economy.

METHODS

The paper is based on a comprehensive and systematic review of literature, and consists of five sections: 1. Introduction and conceptual model; 2. The impact of HIV/AIDS on unions, stability and fertility; 3. Household stability and dissolution; 4. Changes in the living arrangements of children; and 5. Consequences of treatment on reproduction.

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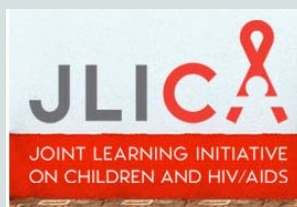
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“In seeking to strengthen families and households, more attention should be given to understanding and mitigating the impact of the HIV epidemic on the stability of marriages and partnerships.”

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KEY FINDINGS

Two decades into the HIV epidemic in Africa, and despite a growing body of evidence from quantitative studies, we are still not able to draw definitive conclusions about the demographic impact HIV and AIDS has had on families and households. Why?

The most important reason is that it is near impossible to isolate many of the effects of the epidemic from other social, economic and demographic changes already underway for some time in Africa, or recently started. Furthermore, complex inter-relationships exist between many family and household processes and the HIV epidemic itself.

A particularly striking example is long-distance circular labour migration. Labour migration, predominantly but not exclusively of men, was a determinant in the emergence and rapid spread of the epidemic throughout the region. However, well-entrenched patterns of circular migration have also influenced patterns of marriage, partnership and union stability, as well as family and household residential arrangements and the care of children, since well before the epidemic emerged.

A second reason is that there remains a considerable gap in our knowledge. This arises as much from fixed and widely promulgated beliefs about the epidemic's impact on families and households, as from the challenges of collecting detailed, longitudinal population-based data in sub-Saharan Africa.

Available evidence does, however, suggest that the epidemic has and will continue to exert a considerable toll on families and households. Contrary to expectations though, this impact does not include many of the stereotyped extreme demographic phenomena to which advocates so often draw our attention. In fact, phenomena such as child-headed and skip-generation households (households with only older people and children) remain quite rare. Rather, the impact of the epidemic is long-term and will be felt most keenly on the normative processes of family formation, such as marriage and childbearing.

Several population-based studies from national household surveys and demographic surveillance sites report few if any **child-headed households**, despite high levels of orphanhood and increases in adult mortality. The reported rates are seldom above 1% - 2% (Monasch & Boerma, 2004; Floyd et al, 2005; Hill et al, 2008; Hosegood et al., 2007a; Madhavan & Schatz, 2007; Richter & Desmond, 2008; Wittinson & Collinson, 2007), and many are found to be data errors. The results from these, and other studies, suggest that such households may emerge following the death of an adult, but they tend to be temporary with adults moving in to care for children, or children moving to join other households. These findings are in stark contrast to numbers reported by small, qualitative studies; for example, 38% of households in Botswana's Central district were reported to be headed by children (Arnab & Serumaga-Zake, 2006). Differences may be due to the purposive nature of programmes attempting to service vulnerable children, and to varying definitions of households—where adults may be temporarily absent as a result of labour migration. Similar findings have been reported with respect to **skip-generation households**. The majority of older people (87%) tend to live in three-generational households (Hosegood & Timaeus, 2005). Reference details can be found in the Hosegood paper on the websites.

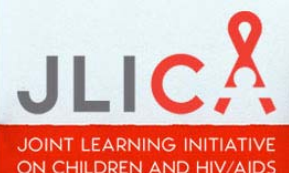
This review was based on an examination of the evidence within the conceptual framework of the family/household life-cycle. This highlighted those demographic impacts that have received little research or programmatic attention. It also identified anticipated impacts that are unsupported by available evidence, or that cannot be assessed due to insufficient or inadequate data.

KEY FINDINGS

1. Substantial changes in fertility, marriage and household size and composition were occurring prior to the start of the HIV epidemic in sub-Saharan Africa. For example, the mean age of marriage was rising, as was premarital sexuality and non-marital cohabitation.
2. HIV is associated with a drop in fertility as a result of the biological effects of infection as well as potentially altered reproductive behaviour; however, fertility was declining in the region well before the epidemic.
3. The impact of HIV on individuals, families and households is difficult to isolate from these secular changes. In addition, there is wide variation among households across the region and HIV-positive individuals remain a minority in even very high HIV prevalence settings.
4. HIV may increase both household dissolution and migration - although it is difficult to distinguish between the latter - through adult death, economic vulnerability and remarriage. Although frequently assumed to be negative effects of HIV, dissolution and migration may also reflect individual and household capacity and resources to explore alternatives. Death, especially of a household head, is a major precipitator of household migration and dissolution.
5. Longitudinal population-based studies demonstrate a strong proclivity for households to survive rather than to dissolve. Generally, household sizes have increased in the region, rather than decreased as predicted would occur with urbanization, although any specific relationship with HIV is difficult to distinguish. Nonetheless, it does appear that households are replenished by the addition of adults, as well as children, which suggests that the impact of HIV/AIDS on household composition and survival may not be as severe, or take the forms predicted.
6. Orphaning is increasing throughout the region as HIV epidemics mature and adult deaths increase. However, single-parent and double orphans are a minority of all children even in countries with high HIV prevalence. Furthermore, most orphaned children continue to live with surviving parents, close family and kin.
7. A pattern of residential separation of children from parents, irrespective of parental death, emerged from a long-established pattern of labour migration and comparatively lower levels of marriage in southern Africa than elsewhere on the continent. It is difficult to discern how HIV/AIDS is affecting the pattern of substantial numbers of children living apart from parents.
8. Despite the attention given to child-headed and skip-generation households by policy makers and community programmes, population-based studies find very small numbers of these households.
9. Expansion of ARV treatment is likely to have considerable impact on families and households. Earlier detection of HIV and longer survival will result in increased numbers of HIV and AIDS-affected families, some with two or more generations of people on treatment. This is likely to increase household stresses associated with care and support. HIV/AIDS programmes will need to address these issues, as well as the choice of people on treatment to have, or continue to have, children.
10. Longitudinal population-based studies with microeconomic data are needed to better understand the impact of HIV and AIDS on families and households.

“...far less has been published about the effects of HIV and AIDS on other major determinants of family and household demography, including marriage and partnership dynamics, and fertility.”

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“Young adults are the drivers of family and household life as they form relationships and families, bear and raise children. They are also the main role-holders in households for earning income, providing labour and care, and ensuring social networks are fostered and maintained”.

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RECOMMENDATIONS

- Prioritise efforts to strengthen families by supporting parents**

Parents are the most appropriate and sustainable source of family and household stability and wellbeing for children. Even where care and support of children is provided by other members of the household, these arrangements are often made by parents. Thus, household composition and living arrangements where orphaned or non-orphaned children are not co-resident with a parent, should not be used in isolation as a screening indicator of vulnerability.
- Recognise that the scaling-up of effective HIV treatment may have a profound effect on families and households affected by HIV and AIDS**

Treatment has the potential to modify many of the family and household responses to HIV and AIDS that have been shown in the pre-treatment era. The experience of coping with HIV-positive members who have the potential to be treated, or are being maintained on treatment creates, the potential for a radically different health, psychological and economic context for those affected. The experience of treatment participants and their families have been well-documented in high and middle-income countries with established programmes. This body of knowledge provides a starting point to move quickly to ensure that we monitor the consequences for family and household demography as effective HIV treatment is scaled up.
- Actively explore ways to integrate family and support services in the rapidly expanding public HIV treatment programmes**

There are several areas where affected families and households may be brought into the programme. These include the disclosure and testing of partners, and children, couple and family counselling. Health services should provide young positive and negative adults with ‘family planning’ in its broadest sense. Programmes must begin to formulate and deliver reproductive advice, as well as simple and cost-effective interventions to women and men, including contraceptives and safer fertility technologies to reduce the risk of vertical transmission in infected men and women who intend to have children. Family observational and intervention studies examining aspects of positive prevention in negative concordant couples are also required.
- Improve our understanding of the effect of HIV infection on the dynamics of marriage and partnership**

Most children in Africa are born within unions, mostly marital unions. In seeking to strengthen families and households, more attention should be given to understanding and mitigating the impact of the HIV epidemic on the stability of marriages and partnerships. Support to couples facing the challenges of coping with HIV and AIDS as partners and parents may take many forms ranging from seeking to involve partners in HIV/AIDS prevention and treatment programmes to couples-focused counselling covering wider issues of communication and coping strategies. Uptake of treatment may be conditional on supportive family circumstances since many ART programmes require participants to attend treatment with a support partner.