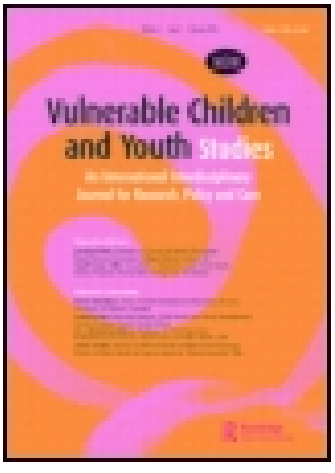

Vulnerable Children and Youth Studies: An International Interdisciplinary Journal for Research, Policy and Care
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rvch20

Orphans and vulnerable children in Botswana: the impact of HIV/AIDS

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Published online: 30 Nov 2006.

To cite this article: R. Arnab & P. A. E. Serumaga-Zake (2006) Orphans and vulnerable children in Botswana: the impact of HIV/AIDS, Vulnerable Children and Youth Studies: An International Interdisciplinary Journal for Research, Policy and Care, 1:3, 221-229, DOI: 10.1080/17450120600973445

To link to this article: http://dx.doi.org/10.1080/17450120600973445

Vulnerable Children and Youth Studies, December 2006; 1(3): 221–229

Orphans and vulnerable children in Botswana: the impact of HIV/AIDS

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Abstract

The purpose of this research was to investigate the plight of AIDS orphans and vulnerable children in Botswana. The results reflect the poor socioeconomic situation of orphans in the country. Their number, especially in rural areas, is very high (i.e. 15% of all the children in rural areas). On average, 4.2% of the orphaned children of Botswana are household heads. The percentage of child heads of household (including non-orphaned) is greatest in the Central district (37.5%). Most of the orphans are raised by their relatives; for example, by grandparents (33.7%) and uncles (30%), the African tradition of the extended family which should be encouraged. Because orphaned children are, in most cases, not well educated and trained, they end up performing menial work or odd jobs, which are the lowest on the earnings ladder. The results also indicate that very few young people, especially those in the 10–14-year age group (less than 28%) know how HIV transmission can be prevented. There are some indications that young people are beginning to change their sexual behaviour; for example, a Central Statistical Office (CSO) (2005) report indicates that condom use among young people aged 15–24 increased from 81.5% to 87.1% between 2001 and 2004, while the number of people with more than one sex partner reduced from 10.6% to 5.5% for the same period. The provision of antiretroviral therapy to Botswana citizens and the different HIV/AIDS initiatives, programmes or partnerships now taking place in the country, such as the African Comprehensive HIV/AIDS Partnerships (ACHAP), should be applauded. However, much more should be done in terms of AIDS awareness and helping orphans, both socially and economically. For example, the government could create incentives for relatives and neighbours to take responsibility for orphans. This could be done, for instance, in the form of a foster care grant for each child they take into their care. Intervention could be better targeted; for example, children in the 10–14-year age group and districts such as the Central district, Kweneng and the Southern district should be given the first priority, as they have many child-headed households. It is also recommended that AIDS policy should be gender-biased towards women, and HIV/AIDS initiatives and programmes should be integrated with poverty reduction strategies for sustainable development.

Keywords: *HIV/AIDS, orphans, vulnerable children, oral mucosal transudate (OMT) specimens*

Introduction

The vulnerability of AIDS orphans (in most cases) starts well before the death of a parent/primary caregiver. Children living with parents/caregivers who have HIV/AIDS or any terminal illness tend to experience many negative changes in their lives and can begin to suffer

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ISSN 1745-0128 print/ISSN 1745-0136 online © 2006 Taylor & Francis
DOI: 10.1080/17450120600973445

neglect long before the death. The emotional suffering of the children usually begins with their parents' distress and progressive illness. Finally, the impact of the loss causes a child's life to fall apart; in most cases, he/she becomes destitute.

According to studies conducted, the trauma and hardship that orphans are forced to endure cannot be overemphasized, as there is usually little family planning for the children's future, especially in sub-Saharan African countries (see UNAIDS, 2004, 2005; USAID, 2005). As soon as the mother or father falls sick with the disease, children usually begin to take on a greater responsibility for income generation, food production and the care of other family members. They then face decreased access to adequate nutrition, basic health care, housing and clothing. In most cases, it also becomes more difficult for the children (especially young girls in most African countries) to attend or continue with schooling. More details are available from UNAIDS (2004, 2005), USAID (2005) and UNICEF (2005) websites. The traditional system of the extended family has helped to look after orphans, but unemployment and poverty are making people increasingly reluctant to bear the burden of looking after children who are not necessarily their own (UNICEF, 2005).

Botswana has been hit hard by the HIV pandemic. In 2003 there were an estimated 350,000 people in Botswana living with HIV, according to UNAIDS (2005). With a total population of 1.6 million, this gives a prevalence rate of 36.5% for Botswana (the second highest in the world after Swaziland). Life expectancy is only 39 years instead of 72 years – the difference being attributed to AIDS. It is estimated that 110,000 children had lost their parent(s) to AIDS by the end of 2003 (UNICEF, 2005). According to UNICEF (2005), 'orphan and vulnerable children constituted 19.6% of the child population of year 2001, made up 111 512 orphans and 33 380 non-orphan but vulnerable children'. In Botswana, 77% of the orphans are due to AIDS (USAID, 2005). In 1999 a National Orphan Programme was established to respond to the immediate needs of orphaned children; a major goal of this programme is to develop a comprehensive National Orphan Policy, based on the Convention on the Rights of the Child. For more references please see Arnab and Serumaga-Zake (2005), UNAIDS/WHO (2004), AVERT (2005, 2006) and ACHAP (2006), among others.

Botswana aims to provide antiretroviral therapy to its citizens on a national scale, and there are now many different HIV/AIDS initiatives, programmes or partnerships taking place in the country, such as the African Comprehensive HIV/AIDS Partnerships (ACHAP) (an organization owned by the Government of Botswana), the Bill & Melinda Gates Foundation and the Merck Company Foundation. ACHAP aims at decreasing HIV incidence and significantly increasing the rate of diagnosis and treatment of the disease by rapidly advancing prevention programmes, health care access, patient management and the treatment of HIV/AIDS. Other AIDS programmes taking place in Botswana include the following: Public Education and Awareness, Education for Young People, Condom Distribution and Education, and Prevention of Mother to Child Transmission (MTCT). A rights-based approach is emphasized in the interventions, i.e. the right to food, clothing, shelter, education, health and psychosocial care.

The aim of this study was to investigate the plight of AIDS orphans and vulnerable children in Botswana. Specifically, the objectives of the study were to answer the following questions: exactly how many orphaned children or vulnerable children are living in Botswana? Where do AIDS orphans live? What type are they? What is their age distribution? What kind of jobs are they doing? How many child-headed households are there in Botswana? What types of support do they have? An attempt was also made to assess the knowledge of AIDS that children in Botswana have in general; for example, the knowledge

of how HIV transmission can be prevented (i.e. AIDS awareness). For the purpose of this study, an orphan is defined as a child under the age of 18 years who has lost one or more parents, while a vulnerable child is also under 18 and is in a risky situation where he or she may suffer significant physical, emotional or mental harm due to the recent death of a household member where he or she resides.

Research methodology

Relevant data were accessed from the Botswana AIDS impact survey II (BIAS II) conducted by the Central Statistical Organization (CSO) between 12 February 2004 and 31 July 2004. The sampling frame was based on the 2001 Population Housing Census. This comprised the list of all enumeration areas (EAs), together with the number of households. Stratification was performed such that all districts and major urban centres became their own strata. A sample of 8380 households was selected by using a stratified two-stage probability sampling design using EAs as primary sampling units and number of households in the EAs as measure of size. These data were supplemented by the report 'Analysis of child focused indicators' based on the 2001 Botswana population and housing census. To establish the prevalence of HIV/AIDS, tests were performed using oral mucosal transudate (OMT) specimens. Verbal consent was sought from each of the members of the sampled households for collection of HIV specimens. For children and minors (under 18 years of age), parental or guardian consent was sought on their behalf.

Key variables

This paper focuses on the following key variables: district, area of residence (i.e. rural and urban), orphan type, age, relationship to the household head, occupation, type of support for orphans, HIV prevalence rate, knowledge of prevention of HIV transmission and HIV/AIDS awareness. Information on these variables is essential for enabling the government to formulate better-targeted strategies for fighting the AIDS pandemic. For example, we need to know the districts or areas of residence which have been hit hardest by the disease in order to target AIDS interventions more effectively. There are three orphan types, namely, paternal, maternal and double. Paternal orphans are children who have lost their father, maternal orphans are those who have lost their mother and double orphans are those who have lost both parents. The orphans were divided into four age groups (as used in BAIS II): 0–4, 5–9, 10–14 and 15–17 years, for easier interpretation of the data. For relationships to the household head, we look at how an orphan is related to the head of a household; these include son/daughter, child-in-law, stepchild, nephew/niece, etc.

Child-headed households tend to be the poorest of all for the simple reason that a child, unlike an adult, may not yet be ready and fit (both physically and constitutionally) to work in order to earn a living but circumstances force him or her to work for pay. Also, orphans tend to have relatively low education. Because orphans are, in most cases, destitute and vulnerable they are tempted to perform any type of work, even when it is unconstitutional to do so.

For type of support, we looked at how regularly orphans receive help (i.e. frequency), the kind of support received by orphans (i.e. money, food, medicine, etc.), who provides the support (e.g. religious support) and the income-generating projects by which orphans are supported. HIV prevalence rate measures the proportion of people living with HIV/AIDS. The AIDS virus can be transmitted in various ways, and children must know them to be able to prevent their becoming infected. Basically, these include mother-to-child-transmission, using HIV-infected blood in blood transfusion and engaging in unprotected sex.

Results

Children population

The size of children population for age groups 0–4 and 5–9 years did not increase significantly during the 10 years between 1991 and 2001, while there were 14% and 27% growth rates for age groups 10–14 and 15–17, years respectively. With regard to the composition of children for the different age groups, there was some decrease for age group 0–4 (from about 29% in 1991 to 26.50% in 2001) and age group 5–9 (from about 29% in 1991 to about 28% in 2001).

Orphaned children

The number of orphaned children is very high, at about 15% of the total number of children in Botswana. No significant difference between male and female orphans was observed. The percentages of male and female orphans are the same (7.5%). Rural areas have slightly more orphans (8.2%) than urban areas (7%). The percentage of orphans is lowest in age group 0–4 (1.7%) and highest (5.6%) in age group 10–14. There is little variation of orphaned children rates for the different districts (Table I). However, the percentage of orphans in rural areas (53.85%) is much greater than that in urban areas (46.15%). The percentages of paternal, maternal and double orphans are 63.2%, 23.77 and 12.99, respectively.

There is a remarkable difference in the orphan population between the 10–14 and 0–4 age groups. The percentage of orphans is highest (36.94%) for the 10–14 age group for all types, namely parental, maternal and double, while it is lowest for the 0–4 age group (11.04%) – with 12.7% and 9.2% of the orphans being of paternal and maternal types, respectively (see Table II).

According to UNICEF (2005), 4.2% of the 8660 child heads are orphans. No detailed information on orphaned child heads is available. The central district (37.5%), Kweneng (14.7%) and Southern district (12.5%) are the worst in this regard (Table III).

Table I. Percentage distribution of orphaned children according to district (2001).

District	Orphan	All children	%
Gaborone	6595	56,840	11.6
Francistown	4735	31,150	15.2
Lobatse	1496	10,557	14.2
Selbi-Phikwe	2572	18,165	14.2
Orapa	269	2867	9.4
Jwaneng	565	5252	10.7
Sowa Town	131	961	13.6
Southern	11,594	83,302	13.9
South East	3067	22,932	13.4
Kweneng	14,664	103,207	14.2
Kgatleng	4086	31,902	12.8
Central	40,905	246,017	16.6
Nort East	4855	25,375	19.1
North West	11,403	65,437	17.4
Ghanzi	2091	14,607	14.3
Kgalagadi	2800	18,670	15.0
Total	111,828	737,241	15.2

Table II. Percentage distribution of orphans according to orphan type and age (2001).

Age (years)	Paternal	Maternal	Double	Total
0–4	12.7	9.2	6.6	11.0
5–9	25.3	25.7	22.0	25.0
10–14	35.3	39.5	40.3	36.9
15–17	26.8	25.6	31.0	27.0
Total	100	100	100	100

Table III. Distribution of child heads of households according to gender and district (2001).

District	Male	Female	Total	%
Gaborone	197	361	558	6.4
Francistown	126	187	313	3.6
Lobatse	37	58	95	1.1
Selbi-Phikwe	78	104	182	2.1
Orapa	13	26	39	.5
Jwaneng	7	37	44	.5
Sowa Town	6	12	18	.2
Southern	734	350	1084	12.5
South East	82	85	167	1.9
Kweneng	814	463	1277	14.7
Kgatleng	244	119	363	4.2
Central	1858	1390	3248	37.5
Nort East	142	147	289	3.3
North West	362	323	685	7.9
Ghanzi	94	46	140	1.6
Kgalagadi	98	60	158	1.8
Total	4892	3768	8660	100
%	56.5	43.5	100	

Most of the orphaned children are raised by their grandparents (33.7%), uncles 30.3%, other relatives (13.3%), nephew/niece (10.1%) and brother/sister (8.6%) (see Table IV). Information on the relationship between non-orphaned children and the other household

Table IV. Percentage distribution of orphans according to relationship to head of household (2001).

	Head		
Relationship to head	Male	Female	Total
Head	3.4	1.4	2.0
Spouse/partner	0.2	0.0	0.1
Son/daughter	14.8	37.6	30.3
Child-in-law	0.1	0.0	0.0
Step child	1.4	.6	0.9
Grand child	32.2	34.4	33.7
Brother/sister	10.7	7.6	8.6
Nephew/niece	16.1	7.3	10.1
Other relative	15.2	9.5	13.3
Not related	6.0	1.5	2.9
Total	100	100	100

members was not available at the time the study was conducted; it would be interesting to know the rates for non-orphanhood.

Some orphans are employed, as follows: 14.5% service, 15.5% craft, 33% craft and the remainder 36.9% other activities. The details are given in Table V. Orphans are helped by their relatives (34.3%) and others (65.7%) on a daily (1.9%), weekly (4.5%) or monthly (88.8%) basis in various ways. These are shown in Table V.

According to Table V, only 0.6% of the orphans receive monetary help, 44% receive food help, 1.6% receive medical help, 7.2% receive child care and 40.7% are helped with school expenses, and 0.4% are helped through income-generating projects. Only 0.4% receive counselling services, and about 1.65% are given religious support and are associated with support groups. Approximately 34% of the orphans receive help from relatives.

The HIV prevalence of the entire population of Botswana is 17.1%. The prevalence rate for females (19.8%) is higher than that for males (13.9%). The prevalence rates in cities, towns, urban villages and rural areas are, respectively, 20.2%, 21.3%, 17.4% and 15.6%. The age group with the least HIV prevalence is the 10–14 (3.9%) agr group; for others, it ranges from 6.0% (5–9 years) to 6.6% (15–19 years). Female children (9.8%) are more vulnerable to HIV/AIDS than male children (9.1%). The data on orphaned children relating to HIV prevalence are not available.

The results indicate that children in the 15–19 age group are far more familiar with HIV/AIDS-infected people than those in the 10–14 age group. For example, about 31% of the children in the 15–19 age group know AIDS-infected people compared to about 16% of those in the 10–14 age group. The attitudes of children towards prevention of HIV and knowledge of prevention of HIV transmission are satisfactory.

A small percentage of children with a positive attitude towards HIV/AIDS-infected people was observed. For the 10–14 age group only 3% had a positive attitude, while for

Table V. Percentage distribution of orphans according to frequency of help, kind of help, type of income-generating project and donor (2004).

Frequency of help	Percentage
Daily	1.9
Weekly	4.5
Monthly	88.8
Once	4.2
Other	0.6
Kinds of help	
Counselling	0.4
Money	0.6
Food	44.0
Medicine	1.6
With child care	7.2
School expenses	40.7
Income-generating projects	0.4
Food preparation	1.4
Religious support	1.7
Support group	1.6
Hospice	0.4
Donors	
Relatives	34.3
Others	65.7

the 15–19 age group only 2.1% showed a positive attitude. 'Positive attitude' was for participants who answered 'yes' to each of the following questions. (i) 'Have you ever shared a meal with a person you knew or suspected had HIV/AIDS?'; (ii) 'Are you willing to take care of a family member sick with HIV/AIDS?'; (iii) 'If a teacher has HIV/AIDS and not sick, he should be allowed to continue teaching'; (iv) 'Are you willing to buy food or vegetables from a shopkeeper who has HIV/AIDS?'; and (v) those who answered 'No' to the question: 'You would not want to keep it a secret if a family member is infected with HIV/AIDS'.

The knowledge of the children, of three ways of prevention of HIV transmission, namely (i) having only one faithful unaffected sex partner; (ii) using a condom every time; and (iii) abstaining from sex was tested. The percentages of children knowing the above methods of prevention are, respectively, 6.1%, 50.8% and 31.4% for the 10–14 age group and 21.5%, 75.2% and 61.2% for the 15–19 age group. The percentages of children who know all three ways, at least one way or none of the ways for age groups 10–14 and 15–19 were found to be 4.0%, 59.8% and 40.2%, and 15.5%, 87.9% and 12.1%, respectively.

The results indicate that the knowledge of misconceptions about HIV/AIDS is poor, especially for children in the 10–14 age group. About 31% of the children in the 10–14 age group did not identify misconceptions about HIV/AIDS transmission correctly compared to about 8% of those in the 15–19 age group.

Participants were asked about their knowledge of AIDS transmission from mother to child and how it can be avoided. Questions were, for example, 'Please answer "yes" or "no" to the following statement. AIDS transmission from mother to child can be avoided by using antiretroviral therapy'.

Children in age groups 10–14 and 15–19 have acquired sufficient knowledge about HIV transmission from mother to child and about AIDS prevention. About 78% of the children in the 10–14 age group do not know any specific way of avoiding HIV transmission from mother to child, compared to about 43% of those in the 15–19 age group. The situation is better for correct knowledge of HIV transmission from mother to child; the corresponding percentages are 48% and 15%, respectively.

About 10% of children have been tested for HIV in the 15–19 age group compared to only 0.6% for the 10–14 age group. More than 93% of children, especially in the 10–14 age group, were not counselled about HIV when they had received results. Also, more than 70% of children in age groups 10–14 and 15–19 have heard about HIV/AIDS and know the means of transmission of HIV/AIDS, and 25% of them have some awareness about the prevention of HIV/AIDS.

Discussion

Children in the 10–14 age group are more at risk of contracting HIV/AIDS than those in the 15–19 age group. According to BAIS II (2005), the prevalence of HIV/AIDS is lowest in rural areas (15.6%) and highest in cities (20.2%). Because orphaned children are, in most cases, not well educated and not well trained, they perform mainly menial work or odd jobs for survival.

It appears that the number of young people and women aged 15–19 who know how HIV transmission can be prevented is still very low (28% and 15.8%, respectively). This calls for a more aggressive AIDS awareness campaign.

More people are seeking counselling services and are going for voluntary HIV testing. The percentage increased from 19.3% in 2000 to 31.2% in 2004. The percentage of orphans receiving care and support increased from 3.3% in 2001 to 34.3% in 2004.

Attendance at school by orphaned children is relatively high; 92% of orphaned children in the 10–14 age group are attending primary school compared to 93% non-orphaned children in the same age group (UNICEF, 2005).

The number of orphans, especially in rural areas and mainly in the 10–14 age group, is still very high at 15%. It has been found that 4.2% of the orphans are heads of households. Some of the orphans engage in waged employment at a young age, supposedly to be able to look after their siblings and other relatives. Even if 40.7% and 44% are receiving educational and food help, respectively, very few (7.2%) are receiving childcare support. Also, HIV among children is still high, at about 6%. The strategy of using income-generating projects to help orphans is good because it impacts positively on poverty. However, very little is being done in this regard considering the proportion of orphans enjoying support.

Conclusion

The results reflect the poor socioeconomic situation of orphans in Botswana, which is extremely high (15%). There is little variation in orphaned children rates among the different districts of Botswana; however, substantial variation exists between rural (53.85%) and urban areas (46.15%). Most of the orphans are of the paternal type (63.2%). It is during ages 10 – 14 years when children are most likely to become orphaned. This is also the age group which is most at risk of contracting HIV/AIDS. The 0–4 age group is associated with the smallest number of orphans. On average, 4.2% of the orphaned children are household heads.

Most orphans are raised by their relatives; for example, grandparents (33.7%) and uncles (30%), in the traditional African system of the extended family, which should be encouraged. Because orphaned children are, in most cases, not well educated and trained, they end up performing menial work or odd jobs, which are the lowest on the earnings ladder. They are supposedly forced to work in order to look after their brothers and sisters. Orphans are, in most cases, helped monthly (88%) with food (44%) and school expenses (41%). Very few orphans are engaged in income-generating projects (1–2%). The results also indicate that very few young people (less than 28%) know how HIV transmission can be prevented. This calls for urgent attention. There are some indications, however, that young people are beginning to change their sexual behaviour and more are seeking counselling services and, with time, are attending for voluntary HIV testing.

Recommendations

The provision of antiretroviral therapy to the citizens of Botswana and the different HIV/AIDS initiatives and programmes and partnerships now taking place in the country should be applauded. However, much more should be done both in terms of AIDS awareness and the support given to the orphans, especially through income-generating projects. The government can create incentives for relatives and neighbours to take responsibility for orphans. This could be achieved, for instance, in the form of a foster care grant for each child they take into their care. State-funded centres for orphans can also be opened where orphans, especially from child-headed families, could find meals and company, and these centres could be run for example, by social workers and retired nurses (to look after their health). The results suggest an AIDS policy with a gender bias towards women. AIDS intervention should be prioritized. For example, children in the 10–14 age group and districts such as the Central district, Kweneng and the Southern district, with relatively many child-headed households, should be given the first priority. HIV/AIDS initiatives and

programmes that are integrated with the poverty reduction strategies should be encouraged for sustainable development.

Acknowledgements

The authors thank the editor and the reviewers for their helpful comments, which greatly improved this manuscript.

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