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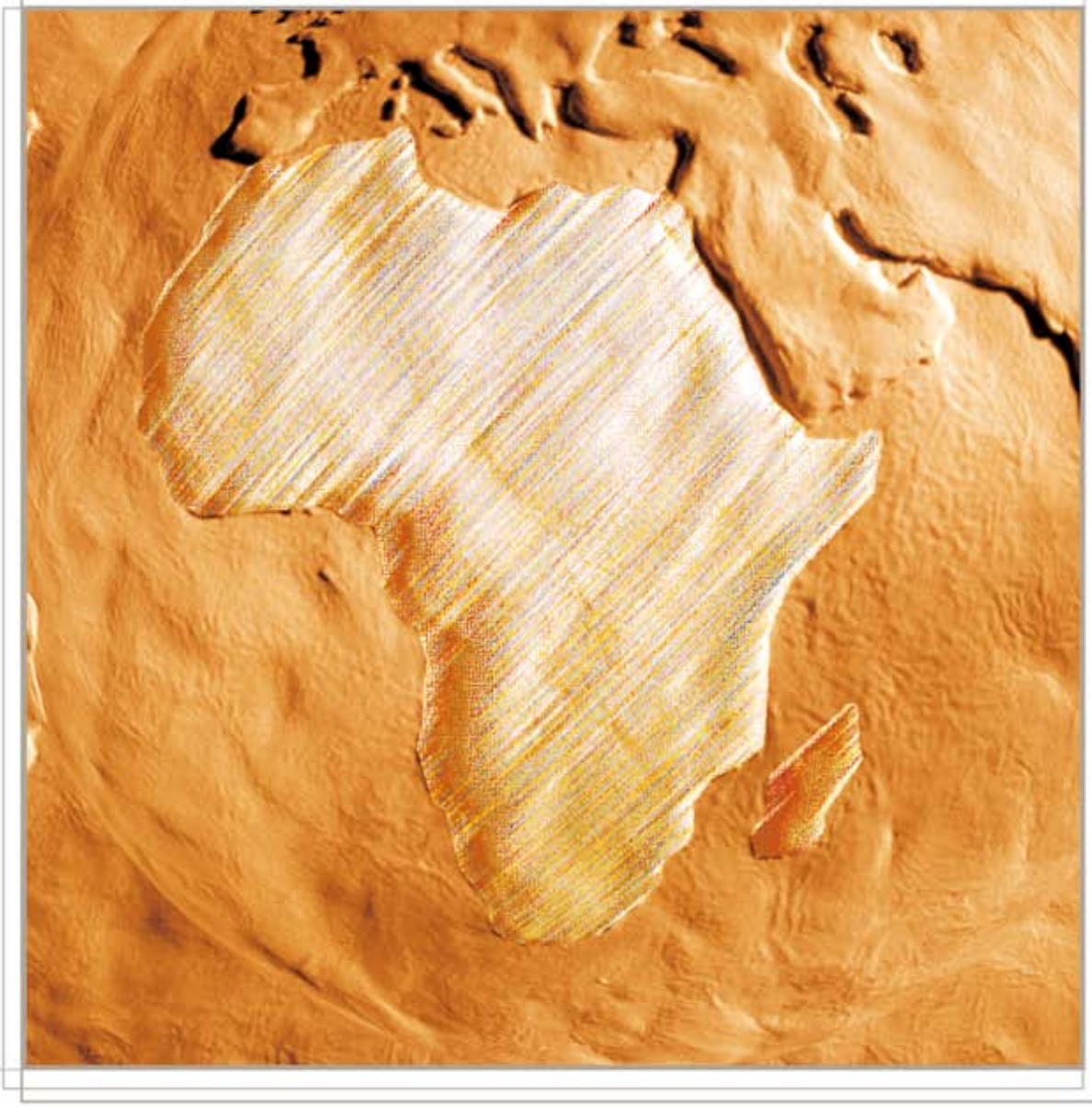
HIV/AIDS and child labour in sub-Saharan Africa: A synthesis report

no. 6



International
Programme on
the Elimination
of Child Labour
(IPEC)

HIV/AIDS and child labour

A state-of-the-art review with recommendations for action

Synthesis report

by

Bill Rau

Edited by: Anita Amorim and Collin Piprel

Paper No. 6*

International Labour Organization
International Programme on the Elimination of Child Labour (IPEC)

Paper No. 1: Combating child labour and HIV/AIDS in sub-Saharan Africa.
Paper No. 2: HIV/AIDS and child labour in Zimbabwe: A rapid assessment.
Paper No. 3: HIV/AIDS and child labour in the United Republic of Tanzania: A rapid assessment.
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Paper No. 5: HIV/AIDS and child labour in Zambia: A rapid assessment.
*** Paper No. 6: HIV/AIDS and child labour in sub-Saharan Africa: A synthesis report.**

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Executive summary

As the HIV/AIDS pandemic in sub-Saharan Africa grows in scope and intensity, the situation of children has become more precarious. Advances in the well-being of children in terms of social welfare and health, achieved over several decades, are being compromised. One significant change has been the impact of HIV/AIDS on child labour, especially in its worst forms. Where children are orphaned by the death of one or both parents, general well-being – including opportunities for schooling, proper nutrition and health care – is adversely affected. Given the impact of HIV/AIDS, many children are forced to work to assist, in addition to themselves and their siblings, their families and their guardians.

The ILO's International Programme for the Elimination of Child Labour (IPEC) commissioned rapid assessments (RAs) in four sub-Saharan countries – South Africa, the United Republic of Tanzania, Zambia and Zimbabwe – in order to better understand the linkages between the HIV/AIDS pandemic and child labour. This paper synthesizes the findings from those studies and others concerned with the impact of HIV/AIDS on children.

Section 2 focuses on how HIV/AIDS has exacerbated prevailing social and economic inequalities and conditions of poverty. It looks at how the situation among children has worsened. HIV/AIDS has intensified the economic factors that push children into the labour market, including the impoverishment of families and the death of one or both parents. The epidemics have also made long-term opportunities for decent lives more remote for hundreds of thousands – if not millions – of children in sub-Saharan Africa. Educational prospects for many affected children are cut short, while some kinds of work performed by children increase the risk of HIV/AIDS infection. Finally, this section describes national policy and programme responses to HIV/AIDS and how these have sought to mitigate the impacts of the pandemic among children.

Section 3 incorporates the major findings of the RAs within this wider analytical framework. Especially important is the concrete evidence of linkages between HIV/AIDS and child labour: many working children identified in the surveys are, in fact, orphans, and they work because of economic needs arising from the impact of HIV/AIDS. Household poverty – including recent impoverishment caused by HIV/AIDS – is the major factor contributing to child labour in each of the four countries where the RAs were conducted. Among girls in particular, the pandemic curtails educational and future employment opportunities since, to reduce household costs, these children are usually the first to be withdrawn from school.

Section 4 summarizes the main findings from the country RAs. It also presents recommendations for policy and programme initiatives, future research and international cooperation in addressing the linked issues of HIV/AIDS and child labour. It proposes priority initiatives, including the need to address the sexually exploitative role of men in increasing the risk among children of HIV/AIDS infection. Another priority is expanding both practical job training opportunities among children and job creation opportunities among youth.

Abbreviations

BCC	Behavioural change communication
CBO	Community-based organization
CRC	Convention on the Rights of the Child
DfID	Department for International Development (United Kingdom)
FGD	Focus group discussion
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IEC	Information, education, communication
ILO	International Labour Organization
IPEC	International Programme for the Elimination of Child Labour
NGO	Non-governmental organization
OVC	Orphaned and vulnerable children
PLWHA	People living with HIV/AIDS
RA	Rapid assessment
STI/STD	Sexually transmitted infections/sexually transmitted diseases
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

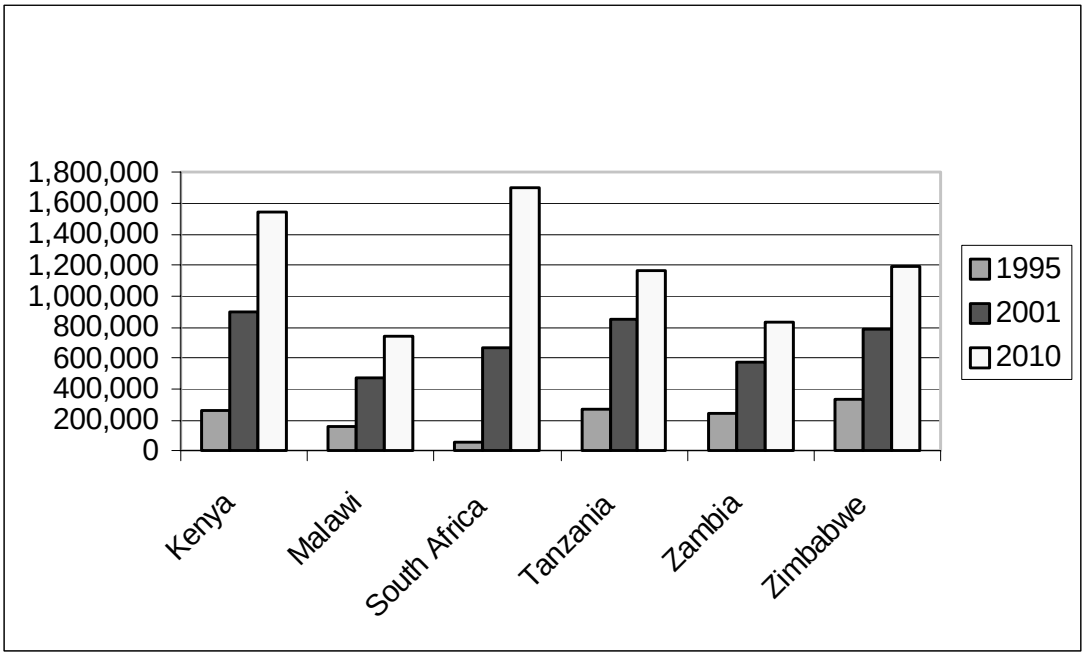
1. Introduction

1.1. HIV/AIDS and its impact on children

The effects of HIV/AIDS are compromising development achievements and initiatives. As the pandemic grows in size and intensity in sub-Saharan Africa, the situation among children becomes increasingly precarious. Advances in the well-being of children in terms of social welfare and health, achieved over several decades, are threatened in both the short and long term. Older children are at risk of becoming HIV-infected. Children, whose parents become infected and later fall ill and die, are affected in multiple ways. As of the end of 2001, an estimated 11 million children in sub-Saharan Africa had been orphaned due to the loss of one or both parents – a threefold increase since 1995, and a figure that will continue to grow for at least two more decades (see figure 1). Educational opportunities are compromised as children are withdrawn from school to assist in caregiving or to work. Many children have entered the world of work to supplement family income lost when an adult becomes ill or dies due to HIV/AIDS. The work done by children is often poorly paid, physically and emotionally difficult, and hazardous to their health and futures. Not the least of those hazards, in the era of AIDS, is sexual harassment, exploitation and the risk of HIV infection.

HIV/AIDS is just one of several causes of orphanhood. Many other diseases across Africa contribute to adult mortality. If 1995 is considered a "normal", or baseline, situation for the number of orphaned children, however, the demographic trends seen in figure 1 illustrate the dramatically projected increase above the "norm" in such children, largely due to the impact of HIV/AIDS.

Figure 1. Trends in number of orphaned children, 1995-2010, selected countries



Source: *Children on the brink: A joint report on orphan estimates and programme strategies*, UNICEF; UNAIDS, USAID, Washington, DC, 2002, App.1.

Child labour is filled with numerous risks for both sexual exploitation and HIV/AIDS infection. The logic of the connection between child labour and the HIV/AIDS pandemic, however, has been more implicit than explicit. Although more studies are appearing to

more fully document the extent of child labour,[1] the growing impacts of the pandemic on the number of orphaned children, on household financial security and in forcing children into work have yet to be adequately documented.

1.2. ILO/IPEC rapid assessments on HIV/AIDS and child labour

ILO/IPEC commissioned in 2001 qualitative rapid assessments (RAs) in four countries in sub-Saharan Africa: South Africa, the United Republic of Tanzania, Zambia and Zimbabwe. The objective was to better understand the complex relationships arising from the impact of the HIV/AIDS pandemic on child labour and the risks of HIV/AIDS infection to working children. The findings were expected to assist ILO/IPEC with further operational planning regarding policy and programme initiatives to eliminate child labour, including the "time bound programme". ILO/IPEC asked three basic questions of the RA teams about the linkages between HIV/AIDS and child labour.

- Are children entering the labour market, including the informal sector, as a result of the impact of HIV/AIDS on their families?
- Are working children at risk of sexual exploitation and HIV infection?
- Is the HIV/AIDS pandemic imposing a "care burden" – i.e. a marked increase in domestic work and household chores – on children?

All the RAs used a similar investigative instrument.[2] ILO/IPEC adapted the instrument from RA guidelines developed jointly by the ILO and UNICEF. Three methods of data collection were incorporated within the instrument: in-depth interviews with children, focus group discussion with children and key informant interviews with formal and informal authorities, including parents, aware of the situation among working children. In all four countries, the instrument was adapted to local realities encountered by the research teams. Urban, peri-urban and rural areas were chosen to conduct the RAs to provide a representative sample of national conditions (see Appendix 1 and the published country reports for a fuller discussion of the RA methodologies).

The countries selected – South Africa, the United Republic of Tanzania, Zambia and Zimbabwe – all are experiencing severe HIV/AIDS epidemics (see table 1). In each country, HIV/AIDS orphans number in the hundreds of thousands, and projections indicate this figure will approach or exceed 1 million children in each country by 2005. This report draws upon qualitative data generated by the country RAs and other analyses from across sub-Saharan Africa to clarify the linkages between HIV/AIDS and child labour and to discuss implications for children's schooling and future development.

[1] For example, see the series of ILO/IPEC/SIMPOC rapid assessment reports on child labour in various economic sectors in the United Republic of Tanzania (http://www.ilo.org/public/english/standards/ipec/simpoc/tanzania/index.htm).

[2] ILO/IPEC: *Investigating child labour: Guidelines for rapid assessment – A field manual*, draft (Jan. 2001), www.ilo.org/public/english/standards/ipec/simpoc

Table 1. HIV/AIDS prevalence and children orphaned by HIV/AIDS

	National adult HIV/AIDS prevalence, 2002 [+] (%)	Estimated number of children orphaned by HIV/AIDS, 2001	Projected number of children orphaned by HIV/AIDS, 2005	Projected percentage increase, 2001-05 (%)
South Africa	20.1	662 000	1 328 000	100.6
Tanzania, United Rep. of	7.8	815 000	1 090 000	33.7
Zambia	21.5	572 000	769 000	34.4
Zimbabwe	33.7	782 000	1 140 000	45.8

[+] UNAIDS, Epidemiological fact sheets for individual countries, 2002.

The country research teams focused on three target groups:

- children orphaned by the loss of one or both parents to HIV/AIDS; [3]
- children who are HIV-infected or who suffer a high risk of becoming infected with HIV because of the work they were doing; and
- children affected by HIV/AIDS (i.e. from households where an adult was HIV-infected) and forced to enter the labour market to contribute to household income and/or labour supply.

In addition, special attention was devoted to the impact of HIV/AIDS on the work burdens of girls, specifically, and on other gender aspects of child labour related to HIV/AIDS.

The RAs were able to shed light on the vulnerability of children in the workforce to abusive, sexually exploitative situations such as those coercing children into prostitution. The RAs have brought a clear and focused analysis to bear on the root reasons children enter the labour force; types of work where children are most vulnerable to the worst forms of child labour; and the factors that place working children at higher or lower risk of HIV/AIDS infection. The RAs help differentiate among conditions where child labour increases the risk of HIV/AIDS infection. The ability to distinguish these causes and conditions of risk permits more effective interventions in preventing both child labour and HIV/AIDS transmission.

Table 2 provides an overview of the structure of the RAs.

[3] It is important to note that across Africa, most governments and NGOs do not explicitly distinguish between children orphaned by HIV/AIDS and those orphaned by other causes. Similarly, many programmes treat orphaned children as being part of all vulnerable children; thus, the term "orphaned and vulnerable children" (OVC). In developing their samples, the four country RAs did not seek to identify children who were HIV-infected, but did include orphaned status among their criteria.

Table 2. Sites, dates and samples of rapid assessments

Country	Sites of RAs	Dates of RAs	Sample size	Defining criteria
South Africa	KwaZulu-Natal Province, urban Durban and suburbs; rural	Nov./Dec. 2001-Mar. 2002	218 children	Children were working; orphans
Tanzania, United Republic of	Urban and rural districts in Dar es Salaam and Arusha regions	Feb.-Mar. 2002	191 children 44 parents 42 key informants	Working and orphaned children
Zambia	Urban: Lusaka and Luanshya Rural: Eastern Province	Mar.-Apr. 2002	306 children	Working children
Zimbabwe	Midlands Province Urban Gweru and suburbs Rural: Shurugwi	Feb.-Apr. 2002	230 children	Working and orphaned children

Besides the four country RAs, ILO/IPEC commissioned two supplementary studies. The first was a background paper on concepts and views in the four southern African countries where the RAs on HIV/AIDS and child labour were to be conducted. [4] The report included an initial review of international literature examining the impact of HIV/AIDS on children's well-being, including their involvement in the labour force. The second study looked at existing policies, programmes and projects in South Africa and the United Republic of Tanzania that addressed linkages between HIV/AIDS and child labour. [5]

1.3. Purpose and structure of this report

This report draws together major findings from the four country RAs, placing them within a broader, state-of-the-art review of information from across sub-Saharan Africa regarding what is known about the relationships between HIV/AIDS and child labour. The analysis provides the most complete review to date of available information concerning the impact of HIV/AIDS on child labour and the risks of HIV/AIDS infection for working children.

Section 2 analyses the socio-economic context within which the HIV/AIDS pandemic and child labour must be seen. Section 3 discusses the evidence of linkages between HIV/AIDS and child labour, including that generated by the RAs. Section 4 summarizes the RA recommendations and provides suggestions for priority action. Appendices include additional information about the methodologies and approaches of the four country RAs and a summary of issues raised during an ILO/IPEC workshop in May 2003, at which the findings from the RAs were presented.

[4] P.N. Howell: "Background and technical information: Concepts and views in southern Africa on HIV/AIDS and child labour: The case of Tanzania, South Africa, Zambia and Zimbabwe", 2001.

[5] B. Rau: *Combating child labour and HIV/AIDS in sub-Saharan Africa: A review of good practices in policies, programmes and projects in South Africa, Tanzania and Zambia* (Geneva, ILO/IPEC, 2002).

2. Socio-economic context

The sub-Saharan African HIV/AIDS pandemic has exacerbated prevailing social and economic inequalities and conditions of poverty. Children are consequently living under appreciably worsened conditions. Not only is child labour more common now than it was two decades ago, it is more hazardous for some of the children involved, as several ILO studies on child labour in domestic work have documented.[1] Although HIV/AIDS is not the only factor,[2] the pandemic, reaching deep into societies, has been one of several major contributing factors to child labour since the mid-1990s. Over the first two decades of the twenty-first century, furthermore, HIV/AIDS and child labour are likely to remain closely linked.

HIV/AIDS has increased the number of boys and girls engaged in labour, including its worst forms. The disease has intensified the economic factors pushing children into the labour market. And the epidemics have made the long-term prospects for decent lives less likely for hundreds of thousands – if not millions – of children in sub-Saharan Africa.[3] This section outlines some of the intersecting economic, social and political factors that are making children across Africa more vulnerable to labour and HIV/AIDS.

2.1. Economic conditions

African countries continue to experience difficult economic conditions. Numerous indicators point to the problems in achieving sustained economic growth and development on the continent. High levels of poverty prevail and, in some countries, these have intensified and deepened for certain social groups. Formal sector employment provides only a small proportion of all the jobs, and official unemployment rates are high. In sub-Saharan African countries, some 60 to 80 per cent of workers are employed in the informal sector, and over 90 per cent of new jobs occur within this sector.[4] Most children work here, where incomes tend to be lower, less secure, and unbacked by the benefit packages found in the formal sector. In the United Republic of Tanzania, Zambia and Zimbabwe, publicly provided social services, including schooling and health care, have been cut back or had fees increased over the past ten years, adding to the cost of living for medium- and low-income households.[5] It is noteworthy, however, that after relatively short trials with school fees, a number of countries have realized that the indirect costs – including forcing

[1] Kadonya et at.: *Tanzania child labour in the informal sector: A rapid assessment*, op. cit., p. 3; D. Budlender and D. Bosch: *South Africa child domestic workers: A national report* (Geneva, ILO/IPEC, 2002). The latter notes that relatively few children are engaged in domestic work, but those who are run the risk of abusive work conditions, including sexual abuse.

[2] ILO Director-General: *A future without child labour: Global report under the follow-up to the ILO Declaration on Fundamental Principles and Rights at Work* (Geneva, 2002).

[3] B. Rau: *Intersecting risks: HIV/AIDS and child labour*, Declaration Working Paper No. 8 (Geneva, ILO, 2002).

[4] J. Xaba, P. Horn and S. Motala: "The informal sector in sub-Saharan Africa", Working Paper on the informal economy, No. 10/2002 (Geneva, Employment Sector, ILO), pp. 3-4; F. Fluitman: *Working, but not well* (Turin, ILO International Training Centre, 2001), pp. 20-21.

[5] For an overview, see *Progress against poverty in Africa* (New York, UNDP, 1998); P. Nanda: *Health sector reforms in Zambia* (Takoma Park, Maryland, Center for Health and Gender Equity, 2000).

children out of school and into the labour market – are greater than any short-term financial savings. Consequently, they are returning to no-fee schemes, at least for primary schooling.

All of the countries carry high international debt burdens, forcing the diversion of resources from internal needs to service the debts.[6] Extractive industries and commercial agriculture remain the primary sources of foreign exchange, despite numerous attempts over the past four decades to expand local manufacturing and increase local value-added outputs.

To date, most countries in sub-Saharan Africa have found it impossible to provide even a moderate portion (i.e. 30-50 per cent) of the resources needed for HIV/AIDS prevention, care, treatment and mitigation. It is difficult to accurately assess the price of dealing with HIV/AIDS, however, since numerous indirect costs are involved, among them staff time; high hospital-bed occupancy rates by people living with HIV/AIDS (PLWHA); support for care; psychological trauma among spouses and children; and lowered morale among over-stretched health service workers and among co-workers of infected workers.

Further, the direct and indirect costs of HIV/AIDS at all levels of society reduce real and potential investments in other social services and productive areas. In the Free State Province of South Africa, budgeting and building a primary health-care network was reportedly difficult in 2001 because "the burden of this [HIV/AIDS] epidemic along with TB was diverting funds and other resources needed for transformation".[7] The pressures on national economies are already evident. In 1995, HIV/AIDS accounted for 27 per cent of public health-care spending in Zimbabwe and 66 per cent in Rwanda.[8] Annual direct medical costs of AIDS (excluding antiretroviral therapy) was estimated at $30 per capita, at a time when public health spending was less than $10 per capita in most African countries.[9]

Rather than the availability of financial resources, argue some activists, it is a question of national and sectoral priorities that constrain investments in HIV/AIDS prevention and care and other social welfare programmes. This would seem to be especially the case with mitigating the impact of HIV/AIDS on households and children to reduce and prevent situations where children have to enter the labour market. Indeed, the four RAs note the limits on responses to orphaned children and child labour at all levels of society.

The RA sites reflected the broader economic conditions within each of the countries, being neither more economically advantaged nor more disadvantaged than other areas – although urban areas do offer the prospect for greater economic activity and social

[6] Nearly half of the United Republic of Tanzania's annual budget in the 1990s was allocated to servicing its international debt, a proportion at least four times greater than that provided for social services. *The state of the world's children* (New York, UNICEF, 2001), fig. 11.

[7] A. Thom: "Mixed performance by provinces at health budget hearings", 25 Apr. 2001 (http://www.health-e.org.za/view.php3?id=20010418). Also see P. Tibandebage et al.: "Expenditures on HIV/AIDS in Tanzania", Background paper for *Confronting AIDS* (Washington, DC, World Bank, 1997).

[8] T. Barnett and A. Whiteside: *AIDS in the twenty-first century: Disease and globalization* (New York, Palgrave MacMillan, 2002).

[9] R. Loewenson and A. Whiteside: *HIV/AIDS: Implications for poverty reduction* (New York, UNDP, 2001).

amenities than do rural areas, and these prospects continually attract children and adults with the hope of finding remunerative work. Luanshya, Zambia, site of one set of interviews, was reeling from the closure of a copper mine upon which most city residents depended, either directly or indirectly, for their livelihoods. Poverty rates in most of the sites in the four countries were high – the Tanzanian RA reporting that half or more people lived below the poverty line. In Zambia, some 70 to 80 per cent of the population live in poverty. [10]

Zimbabwe is one of the countries hardest hit by the HIV/AIDS pandemic. In addition, the country has been exposed to sustained and severe downward economic pressures for over a decade. As a World Bank assessment reports:

> Higher costs for food and social services, combined with declining formal sector wages and the lingering effects of severe drought in 1991-92, have left many of the poor worse off than before adjustment began. Although both the Government and the Bank tried to protect spending for health and education, large budget deficits fuelled inflation and led to growing interest payments, which contributed to declines in real health spending and real wages for health workers. [11]

The extent of health budget cuts was dramatic, declining 14 per cent in 1991-92 and another 15 per cent in 1992-93. [12] One survey found that, in a rural communal area of Zimbabwe, inequality had "definitely worsened" over just a four-year period of reforms in the mid-1990s [13] – a reflection of the multiple layers of pressure on most lower-income people. The same survey found that the poorest 40 per cent of the surveyed population had become poorer over the course of the study. [14] Thus, at a time when a vigorous health-care system was needed to deal with the emerging HIV/AIDS pandemic (and drought-induced malnutrition), such services were being de-funded in a devastating way. A similar conclusion was reached by independent researchers who were studying the impact of HIV/AIDS in Côte d'Ivoire. [15]

Growing disparities in incomes and assets were not noted by the RA teams, except in passing by the Tanzanian researchers. Yet limited evidence from elsewhere suggests that the HIV/AIDS epidemics are intensifying economic inequalities that were already growing because of structural adjustment programmes and other economic reforms. [16] As

[10] A. Kapungwe: "The poverty situation in Zambia (1999-2000): Evidence from household surveys", Paper presented at the First Annual Poverty Review Conference, Lusaka, Mar. 2002.

[11] World Bank: "Meeting the health care challenges in Zimbabwe", *Precis* No. 176, Operations Evaluation Department, 12 Jan. 1998.

[12] C. Harper and R. Marcus: "Child poverty in sub-Saharan Africa", Background paper for the 1999 Africa Poverty Status Report (Brighton, Institute of Development Studies, 1999), p. 14.

[13] W. Cavendish: "Incomes and poverty in rural Zimbabwe during adjustment: The case of Shindi Ward, Chivi Communal Area, 1993/94 to 1996/97", Report for DfID southern Africa (Oxford, Centre for the Study of African Economies, 1999), p. 1.

[14] ibid., p. 12.

[15] J.H. Petagatienan and D.A. Blibolo: "HIV/AIDS, lagging policy response and impact on children: The case of Côte d'Ivoire", in G.A. Cornia (ed.), *AIDS, public policy and child well-being* (Florence, Italy, UNICEF Innocenti Centre, 2002), Ch. 5.

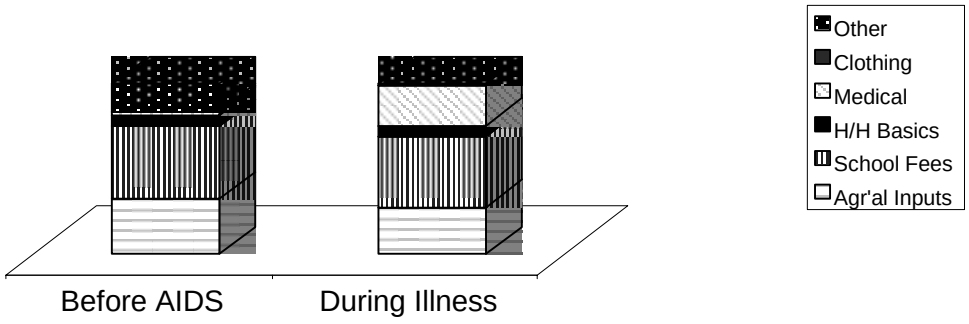
[16] This is clearly implied, if not empirically demonstrated, in S. Mbaya: "HIV/AIDS and its impact on land issues in Malawi", Paper presented at the FAO/SARPN Workshop on HIV/AIDS and Land, Pretoria, June 2002.

households lose productive members, incomes decline, at least over the medium term, and productive labour is shifted from generating income or food to care for sick family members. At the same time, health-care costs increase followed by funeral expenses. There are widespread reports of families selling or renting household goods and assets (from clothing and utensils to livestock and land) to get needed cash.[17] What has not been reported to date is who is acquiring these assets and how, or if they are being used for productive purposes. Grandparents or elderly guardians are likely to become primary caregivers for orphaned children and assume a heavy financial burden in the process.[18] It is within this context that children are withdrawn from school (to save money) and/or encouraged to work (to earn money), either to assist their families or provide for themselves. Figure 2 illustrates the changes in expenses among wealthier households in Kenya – including the dramatic increase in medical expenses – as HIV/AIDS tightens its grip. Poorer households, with less discretionary income, experience even greater constraints on productive investments such as agricultural inputs and payment of school fees for children.

In South Africa, "income dispersion among the self-employed hides a large majority of people far below the poverty line. At least 45 per cent of those self-employed in informal activities earn less than the supplemental living level (SLL), which is set at 35 per cent of the poverty line. Africans, young people aged 15 to 24, women and rural inhabitants constitute 76, 67, 60 and 46 per cent, respectively, of the self-employed earning less than the SLL".

Source: Mercedes González de la Rocha and Alejandro Grinspun: "Private adjustments: Households, crisis and work", in *Choices for the poor* (UNDP, 2001), p. 59.

Figure 2. Wealthier household expenses before and during AIDS-related illness; Makueni, Kenya



Source: Famine Early Warning Systems Network (FEWS), 2002.

[17] G. Rugalema: "HIV/AIDS: Loss of household assets and household livelihood in Bukoba District, Tanzania", Paper presented at the East and Southern African Regional Conference on Responding to HIV/AIDS: Development Needs of African Smallholders in Agriculture, Harare, June 1998.

[18] A. Williams and G. Tumwekwase: "Multiple impacts of the HIV/AIDS epidemic on the aged in rural Uganda", in *Journal of Cross-cultural Gerontology*, Vol. 16, 2001.

These economic conditions keep people in situations of poverty and constrain national efforts to improve services. The effects of poverty are evident in several areas. In Zambia, for example, nearly half of the children, regardless of orphan status, are unenrolled in primary school, largely due to enrolment and supplies fees imposed on parents and learners.[19] Malnutrition is pervasive in Zambian children, moreover, and has been for several decades, with more than half of orphaned children stunted as a result.[20] In South Africa, HIV/AIDS-affected households spend nearly a quarter less on food than do non-affected households, with serious nutritional implications for children.[21]

Based on a field study in southern Zambia, Waller found that more people became impoverished; among people already embedded in poverty, their distress intensified. As he noted:

> The poorest households with no or a few heads of cattle are unable to buy a coffin and rely on kin support networks to help feed the mourners. … [F]emale headed households had the greatest difficulties. They lacked the kin support and were forced to burry [sic] their relatives, usually a son or daughter, in a blanket, and were only able to feed the mourners maize.[22]

Zimbabwe's RA team reports a similar situation for female-headed households in that country.[23] Simulation modeling in Botswana indicates a fall of 18 per cent in "the average income of households in the lowest quartile. This is nearly double the income loss in the population as a whole".[24]

Similarly, modeling of the pandemic in Burkina Faso predicted that "with a stabilized [HIV] prevalence rate of 10 per cent in 2005, the incidence of poverty would increase from 45 to 52 per cent in nine years (from 1997 through 2005) and from 45 to 53 per cent after 14 years (from 1997 through 2010)".[25]

[19] M.J. Kelly: "What HIV/AIDS can do to education and what education can do to HIV/AIDS", Paper presented at the All Sub-Saharan Africa Conference Education for All, Johannesburg, Dec. 1999.

[20] K.D. Manda, M.J. Kelly and M. Loudon: *Situation analysis of orphans and vulnerable children in Zambia summary report* (Lusaka, UNICEF and others, 1999), p. 9. For trends in childhood nutritional status, see results from a demographic and health survey found in http://www.zamstats.gov.zm/statistics/zdhs/2002zdhsprovisionalresultsfinalpresentation.pdf

[21] F. le R. Booysen and M. Bachmann: "HIV/AIDS, poverty and growth: Evidence from a household impact study conducted in the Free State Province, South Africa", Paper presented at the Annual Conference of the Centre for Study of African Economies, St. Catherine's College, Oxford, 18-19 Mar. 2002, p. 12.

[22] K. Waller: "The impact of HIV/AIDS on farming households in the Monze District of Zambia", Research paper (UK, University of Bath, 1998).

[23] J. Kaliyati et al.: *HIV/AIDS and child labour in Zimbabwe: A rapid assessment*, Paper No. 2 (Geneva and Hararer, ILO/IPEC and the Institute of Development Studies, University of Zimbabwe, 2002), p. 10.

[24] R. Greener: *Impacts of HIV/AIDS on poverty and income inequality in Botswana* (Gaborone, Botswana Institute for Development Policy Analysis, 2000).

[25] UNDP: *Human Development Report: Burkina Faso*, 2001.

2.2. Gender relations and male values

The RAs all clearly indicate that unequal gender relations play an important role in driving the HIV/AIDS pandemic and in exposing labouring girls and boys to sexual harassment and exploitation. The South African report describes how children are socialized to fulfil different work roles. It also notes how the HIV/AIDS pandemic distorts such socialization by intensifying work burdens for both boys and girls. Further, the pandemic exacerbates gender disparities by:

- removing girls from school first, since they are often expected to assume adult roles as caregivers for sick relatives; and
- exposing them to greater sexual risks within the workplace.[26]

Gender inequalities have long been seen as critical to understanding the dynamics of the HIV/AIDS pandemic. In terms of access to education and health care, girls and women tend to have fewer advantages than do boys and men. For example, girls tend to be withdrawn from school before boys, where financial need exists or caregiving at home is necessary. Overall literacy levels for females, moreover, tend to be lower than among males, and – although unemployment among all youth is extremely high – young women have fewer opportunities than young men for waged employment.

- Using a conservative assessment based on the 1997 Namibia labour force survey, one study showed that over one-third of youth aged 15-24 years were unemployed. Women in that age group had a 20 to 25 per cent greater chance of being unemployed than men.[27] The lack of employment options increases the likelihood that girls and young women will be coerced into sexual relationships to survive.
- A 1999 survey of working children in Uganda noted that orphaned girls often were "married off" by guardians if the household was too stressed, or if the girl was felt to enjoy better opportunities because the suitor was considered rich.[28]
- A study in Nairobi, Kenya, found that over one-third of orphaned children ended up as street children, commercial sex workers, casual labourers, or married as girl children.[29] The ability to resist sexual harassment and exploitation is difficult, evidenced by the fact that, "[i]n major urban areas of eastern and southern Africa, epidemiological studies have shown that 17 to 22 per cent of girls aged 15 to 19 are already HIV infected compared with 3 to 7 per cent of boys of similar age".[30]

[26] For further analysis of the gender dimension of HIV/AIDS, see the several elements of the *Resource packet on gender and AIDS* (Geneva, UNAIDS, 2001). Also available on the UNAIDS web site.

[27] Fluitman: *Working, but not well*, op. cit., p. 28.

[28] J. Tumushabe: "Situational analysis of AIDS-induced child labour in Uganda and experience of community empowerment to manage the crisis", Paper presented at ILO/IPEC Technical Workshop on HIV/AIDS and Child Labour, Lusaka, May 2003.

[29] M. Njoroge, E. Ngugi and A. Waweru: "AIDS orphans multi-prolonged problem in Kenya: A case study", XII International Conference on AIDS, 1998, Abstract No. 60116.

[30] UNICEF, UNAIDS, WHO: *Young people and HIV/AIDS opportunity in crisis* (Geneva, 2002), p. 17.

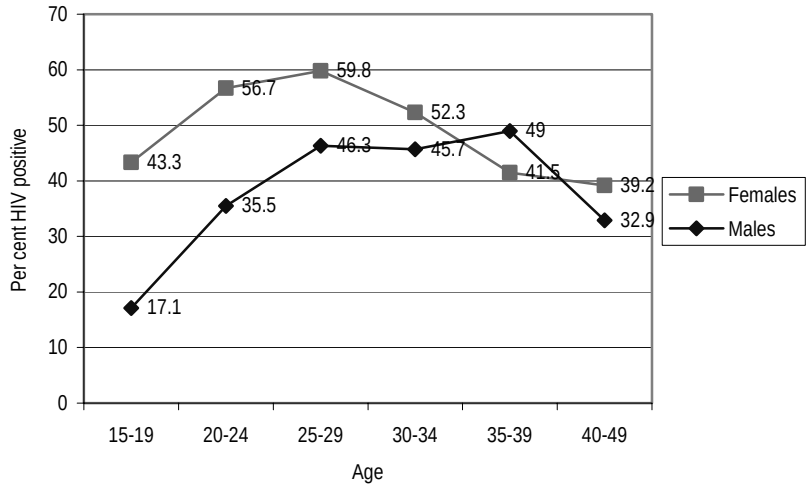
- A 2000 survey in Bobo-Dioulasso, Burkina Faso, showed that infection rates among young girls aged 13 to 24 were five to eight times higher than those among boys of the same age. [31]

- Figure 3 illustrates the gender and age differences in HIV infection rates for people tested at sites in KwaZulu-Natal Province, South Africa. It is clear from other studies across sub-Saharan Africa that women, especially younger women, suffer disproportionately higher HIV/AIDS rates than do men of the same age. [32]

Access to appropriate health care, especially for sexually transmitted infections (STIs), is often difficult for both girls and boys.

Socio-economic inequalities play out in cultural and social patterns that define male prerogatives. Added to these are the prerogatives that come with having income to spend on sex. Children – whether exploited for commercial sex or secondary-school girls enticed by consumer goods – are subject to the wealth that men can use to gain sexual advantage. A study in Kenya found that the most important reason for high infection rates among girls is the frequency of sexual intercourse with older men. [33] "Sugar daddies", as they are known around the world, seduce naïve and impressionable girls with offers of cash, consumer goods and supposed status.

Figure 3. Gender distribution of HIV-positive people at voluntary testing sites, Durban and Pietermaritzburg, South Africa, 1999



Source : Prof. A. Smith, Virology Department, University of Natal, Durban.

[31] ibid.

[32] The demographic analyses of the US Bureau of Census demonstrates the vulnerability of girls and young women to high HIV infection rates. See, for example, K. Stanecki: "The AIDS pandemic in the twenty-first century", Draft report for the XIV International Conference on AIDS, Barcelona, July 2002.

[33] G. Odipo: "Adolescent AIDS epidemic in Kenya: Lessons from child abuse proportion", Paper presented at East Cape Training Centre, Port Elizabeth, South Africa, Oct. 2000, p. 8.

Certain professions enable men, in many instances, to display their wealth, power or position. In the oil-rich Niger Delta region of Nigeria, regular wages provide oil workers with great wealth in contrast to the deep poverty of the population. Oil workers, especially in the remote production locations, regularly buy sex from young women and girls. [34] Male teachers use their status and income to procure sex with school children and women of less secure means in surrounding communities – which may explain why teachers have higher HIV/AIDS prevalence rates, on average, than the general population.

Male sexual norms have helped to shape and sustain socio-economic inequalities. Those norms also mark the clearest intersection of HIV/AIDS and child labour. The intersection begins at the broadest levels, with approaches to economic development that have been shaped and fostered by men. Male norms and male-dominated socio-economic systems include the inequalities in wealth and wages that men use to buy sexual pleasure for themselves. Gender inequalities are seen in the predominately male ownership of businesses within the sex industry. Girls especially, but some boys also in need of work or coerced into work, are susceptible to sexual exploitation in these male-dominated structures. [35]

2.3. Family arrangements and conditions

In exploring the links between child labour and HIV/AIDS, researchers have found that three issues stand out as important contextual factors:

- the important social security role of families for children;
- the failure of some families to provide the care, support and security for children; and
- social and economic change and concomitant stresses faced by members of extended families in caring for orphans.

As the authors of the South African report note, "Family links, relations, and interactions … play a key role in the dynamics of child labour." [36] Implicitly, where those family links are weakened by HIV/AIDS, orphanhood, family poverty and other factors, children are more likely to be involved in the workforce. In South Africa, it was found that residence in rural areas and small towns (including peri-urban townships surrounding Durban) contributed to stronger family ties. Adult presence and support were apparent even when living conditions in those households were difficult. By contrast, "many working children [in Durban] reported that they stayed on their own, and were responsible for themselves". [37]

[34] B.L. Faleyimu, et al.: "Sexual networking and AIDS education in the workplace and the community: The case of oil locations in Nigeria", Abstract prepared for the National HIV Prevention Conference, 1999. The authors argue, contrary to the conclusions set forth in this review, that oil workers are at risk of HIV/AIDS because of the economic/sexual survival strategy of community women.

[35] For an overview of the situation in West African countries, see *Child trafficking in West Africa: Policy responses* (Florence, Italy, UNICEF Innocenti Centre, 2002).

[36] A. Mturi: *HIV/AIDS and child labour in South Africa: A rapid assessment,* Paper No. 4 (Geneva and Natal, ILO/IPEC and the School of Development Studies, University of Natal, 2003), p. 2.

[37] ibid., pp. 20 and 21.

Factors that break up families and contribute to a loosening of household support include the stress of unemployment; the absence of one parent for long periods of time while away at work; family illness or death; and abandonment. In each of the four RAs, many children spoke of the fragility of household living arrangements and security. As one 13-year-old in South Africa reported, "I stay with my sister, who has a baby. We live with another sister who is now pregnant, and she treats me badly and sometimes does not want to buy food."[38] The South African researchers concluded that some orphans, abused or ignored, could not cope staying with members of the extended family.[39]

In the precarious world of work for children, some connections with family members usually remain a source of stability and security. At the same time, the families of working children experienced difficult economic and social situations that left them vulnerable to breaking up and a loss of support for the children. Of the 44 parents interviewed as key informants for Tanzanian RA, for example, 47 per cent, even though unmarried, were raising children.

Physical and psychological violence within households also has an impact on children. Research in Zambia has identified high levels of such violence toward women and girls within households.[40] Not the major reasons for children leaving home, they nevertheless remain important contributing factors. For example, a study by the ILO and KIWOHEDE, a Tanzanian non-governmental organization (NGO), identified 14 types of physical/emotional sexual violence against girls, including rape, refusal of partners to use condoms, exposure to STI/HIV and harassment.[41] A survey in Ghana found that 3 per cent of children living on the street reported leaving home because of sexual abuse, and another 3 per cent because of physical abuse. These and other reasons are presented in figure 4.

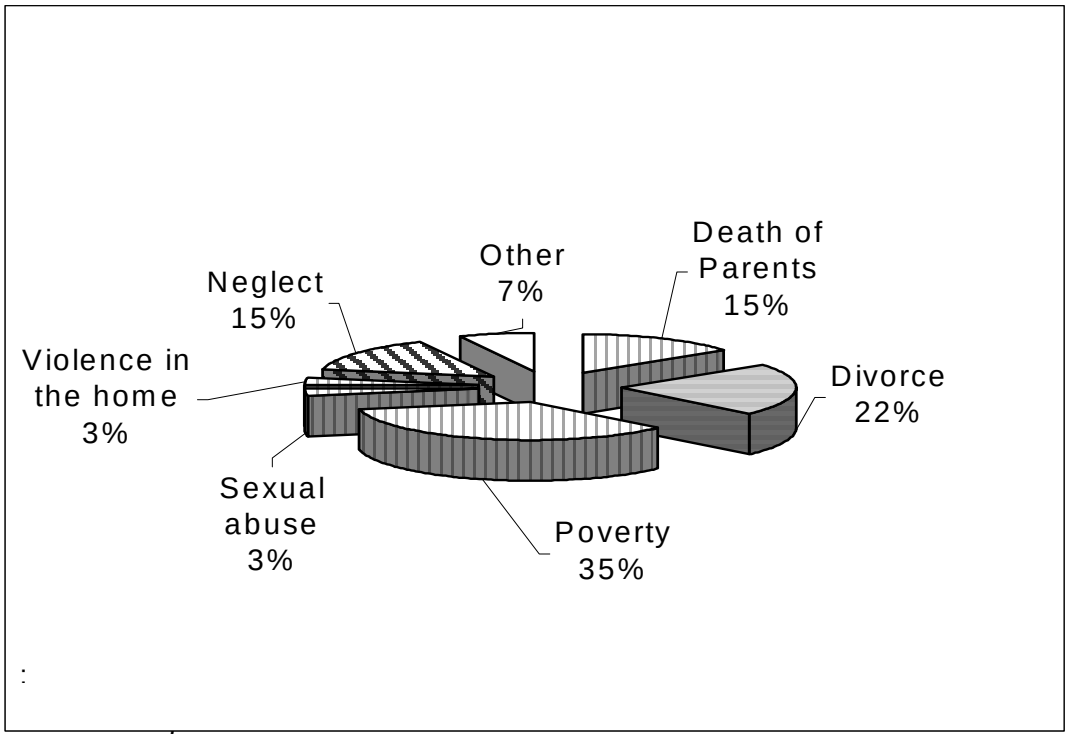
[38] ibid., p. 21.

[39] ibid., p. 20.

[40] Human Rights Watch: *Suffering in silence: The links between human rights abuses and HIV transmission to girls in Zambia* (New York, 2002).

[41] E. Kamala et. al.: *Children in prostitution in Tanzania: A rapid assessment* (Dar es Salaam, ILO, 2002).

Figure 4. Street children's reasons for leaving home, Ghana



Source: *The exodus: The migration of children from Ghana's rural areas to the urban.*

In discussing care for orphaned children in extended families, people commonly hold the following assumptions:

- the extended family is the traditional safety net in Africa, and family members are ready and able to assist others in need (this has been the prevailing view of many national officials and international agencies); and

- extended families are having a difficult time coping with the multiple burdens of contemporary society, including caring for sick relatives and orphaned children and, in many instances, are unable to provide adequate care and support for the rapidly growing number of orphaned children.

The second of these assumptions directly contradicts the first.

As is discussed further in section 3.5 (below), the RA teams in each of the four countries felt that the second situation was either the prevailing norm or else was becoming far more common, especially under the pressures created by HIV/AIDS. Foster makes the point that, despite increasing social and economic stresses, extended family care in rural Zimbabwe is seeing greater involvement from community members in supporting caregivers.[42] Rugalema, meanwhile, adds a cautionary note regarding the importance of family and community. He suggests that "investments" by children, grandparents and other relatives in family care also carry costs – in financial outlays; in substituting childcare for other productive work; and in greater burdens on grandparents and other extended families,

[42] G. Foster: "Understanding community responses to the situation of children affected by AIDS: Lessons for external agencies" (Geneva, UNRISD, 2002), www.unrisd.org.

who are likely to be already stressed by prevailing economic conditions.[43] A household study in the Free State Province of South Africa found that, overwhelmingly, caregiving was provided by female family members who were not otherwise employed or whose labour was primarily directed to family subsistence.[44]

The burden of caregiving on immediate and extended family members, grandparents and many children themselves is of growing concern. A study in Zimbabwe found that most people caring for children orphaned by HIV/AIDS were over 50 years of age. Of those, over 70 per cent were 60 years or older. The stress of caregiving was clear. Respondents reported regular concerns about adequate food and clothing, the high cost of medical fees and inability to pay school fees for orphans. Indeed, the health of the older caregivers had deteriorated as a result of the physical and emotional stress of assisting the children.[45]

2.4. Existing legal and policy safeguards

All four countries involved in the RAs are signatories to the ILO's Worst Forms of Child Labour Convention, 1999 (No. 182), and the ILO's Minimum Age Convention, 1973 (No. 138). National ratification of these Conventions obliges a country to take active measures to bring legislation into compliance and to enforce such legislation. The Conventions provide a framework for addressing child labour issues through national legislation, regulations, and programmes. Each country has minimum age legislation, but, as the RAs demonstrate, practices have yet to fully follow policy. Likewise, there is legislation protecting girls from sexual abuse, but enforcement remains problematic.

Both local groups and NGOs engage in advocacy to strengthen protection for children, especially girls. For example, Molo Songololo, the South African NGO, has conducted research on the sexual abuse of girls and used the findings to advocate greater legal protection and enforcement.

2.5. Existing HIV/AIDS prevention and care programmes

Each of the four countries covered by the RAs has central government-managed HIV/AIDS programmes, as well as many NGO and community-based programmes to promote prevention and to offer care and support to PLWHA and affected families. Apart from inclusion in extended family structures, orphan support initiatives have existed for several years, most of them informal arrangements within communities, although some receive support from faith-based groups, NGOs, and international donor agencies. None of the prevention programmes and projects are of sufficient intensity or scale to have slowed the national epidemics.

[43] G. Rugalema: "Coping or struggling? A journey into the impact of HIV/AIDS in southern Africa", in *Review of African Political Economy* (2000), Vol. 28, No. 86, pp. 537-545.

[44] F. Le R. Booysen and M. Bachmann: "HIV/AIDS, poverty and growth: Evidence from a household impact study conducted in the Free State Province, South Africa", Paper presented at the Annual Conference of the Centre for Study of African Economies, St. Catherine's College, Oxford, 18-19 Mar. 2002, pp. 8-9.

[45] WHO: *Impact of AIDS on older people in Africa: Zimbabwe case study* (Geneva, 2002).

On the other hand, solid models of prevention, home-based care and orphan support have evolved. One such programme was developed over several years in southern Zambia. Facilitated by Chikankata Mission of the Salvation Army, the programme mobilizes community skills and resources to provide care and support to PLWHA and affected households and orphaned children.[46] In Zimbabwe, the FOCUS programme benefits some 4,000 orphans, mobilizing volunteers to visit orphans, monitoring their situation and responding to their various needs with community resources. Urgent problems are referred to government authorities. Programme cost is modest, at about US$3 annually per child visited.[47] With adequate attention and support, it is likely that these models can be adapted and expanded in other areas.[48]

To date, little attention has been given to mitigating the devastating social and economic impact of HIV/AIDS. As household members become ill, they are unable to work, and families often sell assets to pay for treatment and withdraw members from school or productive activities to provide care. This disinvestment by households has led to "the rapid transition from relative wealth to relative poverty", in the words of one Zambian analyst.[49] The speed with which families are impoverished makes it difficult to manage changes, and has left both most governmental and most non-governmental institutions unable to cope with the number of people needing assistance and thus to respond effectively. In addition, HIV/AIDS affects the delivery of public services, as teachers, health workers, agricultural extension agents and others become ill and die.

2.6. HIV/AIDS prevalence and children orphaned by HIV/AIDS

As noted in table 1, HIV/AIDS prevalence among adults – usually defined as 15-49 years old, as people in this age range are usually most susceptible to HIV/AIDS infection due to sexual activity – in the four countries where RAs were conducted range from nearly 8 per cent in the United Republic of Tanzania to over 33 per cent in Zimbabwe. It is expected that HIV infection rates have increased in each of the countries since these data were reported.[50]

Regional and local variations in these national average data are found in each of the countries. For example, over 35 per cent of pregnant women in KwaZulu-Natal Province,

[46] W. Silomba: "HIV/AIDS and development – The Chikankata experience: One step further", *SIDA Studies*, No. 7 (2002), pp. 76-90.

[47] S.N. Phiri, G. Foster and M. Nzima: *Expanding and strengthening community action: A study of ways to scale up community mobilization interventions to mitigate the effects of HIV/AIDS on children and families* (Washington, DC, USAID, 2001).

[48] These programmes are reviewed by Rau in *Combating child labour and HIV/AIDS in sub-Saharan Africa*, op. cit. See also the UNAIDS best practices doc. *Investing in our future: Psychosocial support for children affected by HIV/AIDS – A case study in Zimbabwe and the United Republic of Tanzania* (Geneva, 2001).

[49] N. Namposya-Serpell: "Social and economic risk factors for HIV/AIDS-affected families in Zambia", Paper presented at the AIDS and Economist Symposium, IAEN, Durban, South Africa, 2000. A household-level survey in the Free State Province, South Africa, found HIV/AIDS-affected households had monthly incomes over 50 per cent below those of non-affected households. Booysen and Machmann: "HIV/AIDS, poverty and growth", op. cit., p. 10.

[50] Some initial evidence suggests a decline in HIV infection rates among young people in urban Zambia. UNAIDS: *Zambia: Epidemiological fact sheet*, update, 2002.

the RA focus in South Africa, were HIV/AIDS infected as of early 2002. (The HIV serostatus of women attending antenatal clinics, in lieu of full population-based samples, is used to estimate the prevailing HIV rate.) These were the highest rates in the country. Pregnant women in Dar es Salaam had HIV/AIDS rates more than twice the national average. In one of the study areas in Zambia, pregnant women had HIV infection rates 30 per cent higher than the national average.

In Gweru urban area – one of the sites for the Zimbabwean study – an enumeration identified over 4,000 orphaned children. Nearly 30 per cent of the children had lost both parents. More distressing than the number of orphaned children is the speed at which those numbers have grown over the past decade. As figure 1 shows, by 2010 sub-Saharan African countries can expect a dramatic increase in the number of children orphaned by HIV/AIDS. Across sub-Saharan Africa, by 2010, it is estimated that over 20 million children will be orphaned by HIV/AIDS. [51]

[51] *Children on the brink, 2002*, p. 28.

3. The evidence

3.1. What are the links

The links between HIV/AIDS and child labour can be subsumed under two broad categories.

- First, the linkage has been established for children who, through their involvement in the labour force, are at risk (or greater risk) of becoming HIV infected and to suffer from AIDS and related illnesses. The reasons for the susceptibility of children to HIV/AIDS include these:
  - once in the workforce, the children may find life so precarious that survival sex – i.e. exchanging sex for food, clothing, or small amounts of money – becomes an option;
  - girls, and some boys, may be drawn into sex work;
  - children may be exploited because of their vulnerability due to age, location or gender;
  - if HIV-infected, children are less likely (or able) to have access to proper nutrition, health care and drug treatments for opportunistic infections and AIDS.
- Second, children who are from households affected by HIV/AIDS often must enter the labour force because families cannot meet their basic needs without contributions from the children. As a result, children may be subjected to harsh and exploitative conditions and sexual abuse. These effects occur under the following conditions:
  - children are withdrawn from school to reduce family expenses, and then seek work;
  - children are placed with extended family members, but are expected/forced to work;
  - children flee new family arrangements because of depression, neglect or exploitation, and have to work.

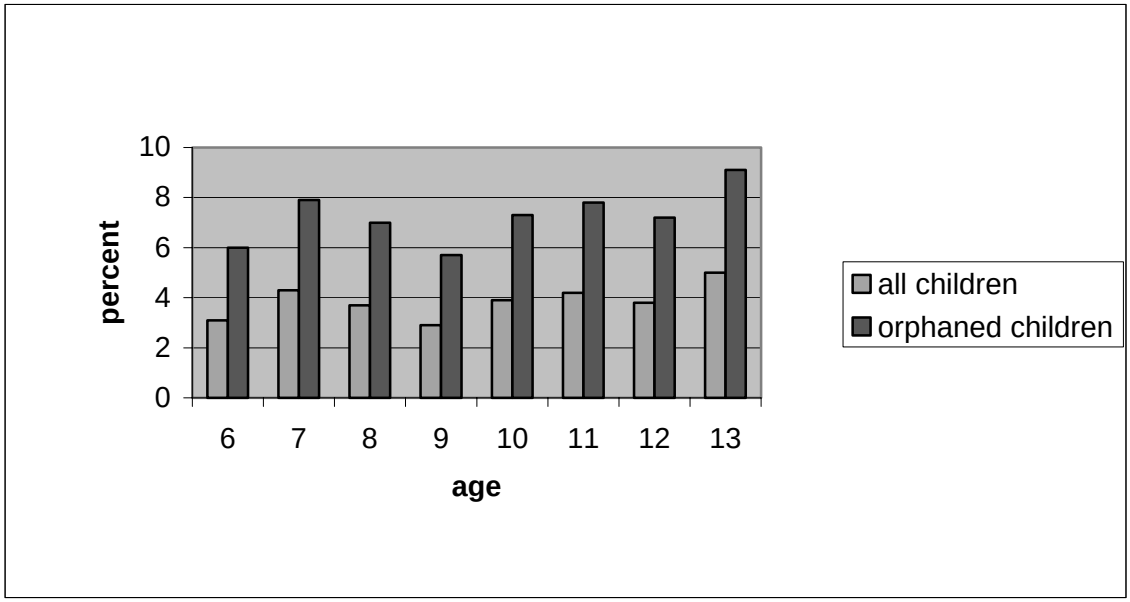
Given these connections, the HIV/AIDS pandemic compounds the challenge of reducing child labour by increasing:

- the number of children in the labour force and vulnerable to exploitation;
- the pressure on both households and the children themselves to have the children earn income instead of attending school;
- the demands on public and private services, notably the delivery of effective health care for children and adolescents and, in the case of South Africa, grants for children and caretakers;
- the burdens on community groups and institutions assisting caregivers and vulnerable children; and
- the risk that vulnerable children will engage in survival sex, thereby increasing their risk of HIV infection.

These links appear in all the RAs, clearly illustrating how HIV/AIDS exacerbates child labour, including child labour in its worst forms. The Zambian study is most explicit, concluding that HIV/AIDS has added 23 to 30 per cent to the child labour force.[1] The South African research team reports that nearly one-third of the working children they interviewed had been orphaned by HIV/AIDS.[2] All the research teams found clear and direct links between the AIDS epidemics and child labour, even if statistically significant data were not fully available to support the argument.[3]

An analysis of data from the Zambia Child Labour Survey for 1999 provides further statistical confirmation of the linkages between HIV/AIDS and child labour. Figure 5 shows that orphaned children are, in general, twice as likely to be working as non-orphaned children.

Figure 5. Effect of children's orphan status on working status, Zambia



Source: Lorenzo Guarcello and Furio Camillo Rosati, "Orphans and child labour", Presentation at the ILO/IPEC Workshop on HIV/AIDS and Child Labour, Lusaka, May 2003.

A study in Uganda stressed the changes in degree of work performed by children affected by HIV/AIDS. While the children involved in the survey had done basic household chores, prior to the family becoming affected by HIV/AIDS, once a household member became ill the children's "participation in domestic and farm work has increased,

[1] A.C.S. Mushingeh, et al.: *HIV/AIDS and child labour in Zambia: A rapid assessment on the case of the Lusaka, Copperbelt and eastern provinces* (Geneva and Lusaka, ILO, 2002), p. 23.

[2] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., p. 19.

[3] Without biological surveys, it is not possible to know with certainty whether working children have higher, similar or lower HIV rates than non-working children – or whether any of the children may be HIV-infected. Two generalizations are possible, however. First, working children can be assumed to be about as sexually active as non-working children (i.e. children in school and school leavers). Numerous studies address the relatively early age (14-17 years) at which sexual relations are initiated among adolescents. The second generalization holds that working places at least a portion of children at greater risk of sexual exploitation and abuse; therefore, other factors being equal, they are more likely to have higher HIV rates than non-working children.

often interferes with schooling and is detrimental to health. [In addition], AIDS orphans shoulder a big portion of the household and farm chores in foster homes". Other orphaned children worked outside the household to earn money to help support siblings and to contribute to the maintenance of the guardians' households. [4]

3.2. HIV/AIDS, impoverishment and child labour

Underlying most analyses of child labour are statements about poverty as the primary cause of child labour and an important factor behind forms of child labour that put children at risk of HIV infection. Little analysis, however, aims at understanding the bi-directional relationships, where poverty contributes to HIV/AIDS risk and HIV/AIDS contributes to poverty. There are two major reasons for this.

- Poverty tends to be seen as a given condition from which escape may not be possible. As much as anything, this seems to be because people involved in HIV/AIDS work have had little experience with addressing poverty, on the one hand; and, on the other, because they are bound by project and programme parameters to neglect economic and social dimensions of the HIV/AIDS pandemic.

- The second reason relates to the first. Too little attention is given to the concerns and opinions of people affected by HIV/AIDS, including PLWHA. People affected by the epidemics live with the reality of poverty. Reporters and analysts tend to take these statements at face value, however, rarely seeking to understand the socio-economic changes entailed as a household member shows symptoms of HIV/AIDS. "Poverty" has tended to become a rhetorical flourish added to explanations about the causes of HIV/AIDS. But HIV/AIDS programmes are not set up to deal with the poverty dimensions of the pandemic. In the fragmented world of development, "poverty" is a separate programme, as is HIV/AIDS. As such, dealing with the underlying socio-economic causes of HIV/AIDS becomes someone else's problem, as though HIV/AIDS responses existed in a world of their own. The rhetoric includes an element of fatalism – despite decades of development efforts, poverty remains, suggesting that little can be done to diminish it. Indeed, this has been the prevailing approach to HIV/AIDS, treating it as both a health and individual behavioural problem sealed off from the wider society. The RAs encourage readers to go beyond the rhetoric and better understand some of the relationships between poverty and HIV/AIDS. They do this both conceptually and concretely, with examples offered by the children involved in the surveys.

The children's responses to questions about why they work and about their living conditions offer insights into the dynamic nature of the poverty-HIV/AIDS relationship. They speak to processes of *impoverishment* – the how and why of the way in which a person, family or group becomes poor. HIV/AIDS can lead to impoverishment as well as exacerbate prevailing hardships. The children explain why they are working and the nature of family arrangements that push them into the labour force. The major reasons given include these:

- the death of a parent, or the disappearance of the main income earner;

- the increased burden on the extended family of caring for children of households affected by HIV/AIDS;

[4] J. Tumushabe: "Situational analysis of AIDS-induced child labour in Uganda", op. cit.

- worsening economic conditions, nationally or locally;
- new poverty;
- the need to meet basic needs, especially that of food;
- providing support for themselves or siblings; and
- paying school fees.

Other children mentioned the desire for financial independence and consumer goods. Obviously, not all the reasons reported for working are related to HIV/AIDS. Given the interwoven threads of impoverishment, however, HIV/AIDS has nevertheless become a critical factor contributing to child labour, where it does not actually cause it.

Profound economic reforms and constraints were among other relevant hardships faced during the last two decades of the twentieth century. The RAs show that the HIV/AIDS spread rapidly through the United Republic of Tanzania, Zambia and Zimbabwe during a period in the 1980s and 1990s when those countries were undergoing major economic and social programme reforms. During the same era, South Africa was bringing the neglect and exploitation of apartheid to an end, working to build new institutions and reform those that had not served the majority of the people. Given the history of apartheid, some of the reforms initiated by the democratic Government resulted in high unemployment and rising prices. In the other three countries, changes arising from reform included increasing unemployment; rapidly rising costs of living; new or increased fees for education, health care, and other social programmes; and a neglect of public health infrastructure. Often promoted as important means to stimulating economic growth and development, many of the reforms actually curtailed – even undermined – the development advances of previous years.[5] At least during the 1980s and the first half of the 1990s, national authorities paid far greater attention to managing these reforms than to addressing the consequences of the reforms for citizens or the emerging HIV/AIDS epidemics.

We thus see families and entire social groups moving into poverty – becoming impoverished – due to the economic and social changes. To be sure, some people moved out of poverty or fluctuated between levels of economic security. But what was striking about the 1980s and 1990s was the growing poverty and disparity between socio-economic groups.

HIV/AIDS emerged in the midst of these complex socio-economic conditions. The pandemic took advantage of prevailing hardships and existing gender and socio-economic fractures to gain a foothold, spreading rapidly throughout eastern and southern Africa.[6] Among infected individuals and affected households, HIV/AIDS worsened economic conditions.[7] Some people found no way to cope with the added burden of HIV/AIDS-related expenses and lost income, when incomes were already marginal and services costly. Individuals lost jobs, retired because of illness, or, especially among the vast majority in the informal sector, were no longer able to work. In some instances – and this is one area where child labour is linked to HIV/AIDS – other household members stepped

[5] T. Mkandawire and V. Rodriguez: *Globalization and social development after Copenhagen: Premises, promises and policies* (Geneva, UNRISD, 2002).

[6] J. Collins and B. Rau: *AIDS in the context of development* (Geneva, UNRISD/UNAIDS, 2000).

[7] For a recent review of the literature on the impact of HIV/AIDS on household well-being, see Barnett and Whiteside, in *AIDS in the 21st century*, op. cit.

in to compensate for the lost income. In other cases, households have neglected agricultural activities, and production has fallen.[8] In still other instances, efforts were made, as medical costs increased, to cut back on household expenses. Reducing school costs was another area in which families sought savings.

To supplement these economic losses, children may be withdrawn from school and/or told to work. The situation in Uganda is not atypical in many other parts of Africa, where "[g]uardians and parents faced with extreme situations of poverty as under AIDS and armed conflict often put in place conditions that force … girls into early marriage or the search for work at a vulnerable age".[9] In an era where Western concepts of economic opportunity are expressed (and too often repeated) in terms of individual choices and abilities, it is important to remember that these ideas derive from conditions very different from those prevailing for the vast majority of people – including children – in sub-Saharan Africa. Circumstances, rather than selected opportunities, push children into labouring conditions that enhance their risks from HIV/AIDS. The authors of Tanzanian RA express the situation well:

> These orphans are … forced by socio-economic circumstances rather than by their economic choices to enter the labour market early. A bad situation is then exacerbated by the fact that many of these children wind up in the worst forms of child labour. Most working orphans complained of a whole complex of problems, among them going without food, forced initiation to commercial sex work and failure to receive wages.[10]

Poverty is not an individual choice, but it limits individual choices.[11] Thus, it is unsurprising that many HIV/AIDS prevention initiatives that focus on awareness raising and behaviour change have little impact among working children or other groups. The ability of children in the world of work to exercise choices, either to reduce the immediate risk of HIV/AIDS infection or to alter their socio-economic environment, is very limited.

In some instances, the reports make it clear that long-term poverty has affected households. For example, some child informants noted that others in their households had been withdrawn from school before them. It is well documented that female-headed households are among the poorest, and have little opportunity to escape from poverty. That is, many of the households from which the children came were recently poor or had been disadvantaged over a number of years, if not generations.

Out of this already complex mix of factors emerges the need to distinguish between conditions of poverty and out-right destitution. The heavy financial burden of medical care and a funeral, the loss of household income during a lengthy illness and a period of caregiving can quickly rob families of existing savings and assets. Loss of a house and household goods and assets after the death of a male head of household adds to the impoverishment of the surviving spouse and children. While the extended family may be able to provide a buffer, that does not always happen. Several children described living conditions that indicate they were destitute – living without a house and household goods,

[8] This was a finding described in *The impact of HIV/AIDS on the different farming sectors in Namibia* (University Central Consultancy Bureau, University of Namibia and FAO Regional Office for Africa, 2001).

[9] Tumushaba: "Armed conflict, HIV/AIDS and child labour in Uganda", op. cit., para. 4.1.

[10] H.H. Semkiwa et al.: *HIV/AIDS and child labour in the United Republic of Tanzania: A rapid assessment – A case study of Dar es Salaam and Arusha*, Paper No. 3 (ILO/IPEC, 2003), p. 40.

[11] The UNDP defines human development as "a process of enlarging people's choices" *(Human Development Report, 1999).*

with an uncertain daily income that could not provide an adequate diet or other basics of daily life. According to one South African girl who lived by prostitution: "The problem is that I was living in the bush. I was also eating food drawn from the dustbin. Food from the dustbin is unhealthy. So I am working to support myself. I have no parents." As a 12-year-old South African boy said: "We are a family of five and my mother supports us. We all live … under a bridge." [12]

Looking at the conditions and processes that cause poverty makes it then possible to identify interventions that can mitigate the impact of poverty and, hopefully, remove the factors that led to impoverishment. Rather than treating poverty as a static condition, it is possible to focus planning or target specific assistance. Only by breaking down abstract notions of "poverty" into real-life conditions and situations can mitigation programmes and policies be designed and implemented that will protect children from entering the labour force or from exploitation if they are in the labour force. An example of a focused policy – with adequate resources for implementation – is to remove school fees or regulatory constraints to obtaining grants or exemptions from payment of fees.

3.3. Child workers at risk of infection

Once in the labour force, children are vulnerable to HIV infection or the consequences of infection in several ways. The RA reports reveal that work environment and type of work are factors in the degree of vulnerability children suffer. Children working alongside a parent appear least likely to be sexually exploited. At the other extreme, girls (and a small number of boys) in commercial sex work ran the highest risk of becoming HIV infected. Between these extremes lie working conditions where physical threats and harassment were common, particularly for girls and younger children, with an over-arching potential for sexual assault or manipulation. The work most children performed offered no economic security or escape from poverty. It only perpetuated their situation while, especially in the era of HIV/AIDS, carrying health and livelihood risks.

Whether children simply work on the street or both work and live in the street is another work condition-related factor placing children at risk of HIV/AIDS. The Zambian RA team draws this distinction and explains the differences (see also "Definitions of child and child labour", see page 54).

- Children on the street are those engaged in some kind of economic activity, ranging from begging to vending manufactured commodities or food. Most go home at the end of the day and contribute part of their earnings for the economic survival of the family unit. They may be attending school and retain a sense of belonging to a family or household. Because of the economic fragility of their families, these children may eventually opt for a permanent life on the streets.

- Children of the street actually live on the street. Family ties may exist, but are tenuous and maintained only casually or occasionally. Most of these children have no permanent residence, moving from place to place and from town to town. [13]

Many children who work on the street reported they tried to avoid working at night to reduce risks of violence. Children without homes, however, had to make do with whatever was available. Given their precarious living conditions, they were more likely to be

[12] Mturi and N. Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., pp. 16 and 22.

[13] The distinction is drawn from M. Lemba: *Rapid assessment of street children in Lusaka*, a study for Project Concern International, Lusaka, 2002.

harassed and sexually assaulted. The probability of having unprotected sex increases as children seek a degree of comfort or protection from relations with other children or older youth. Although young people tended to form groups, there remained the ever-present threat of attack by other children, young people or law-enforcement authorities. In Zimbabwe, 4 per cent slept on the streets – in shop verandas, in the open or in drains. Others lived in informal settlements in dwellings made of paper and other available materials. In the absence of blankets, plastic bags were used for warmth. Some children were subsisting on one meal a day, while others collected leftovers from restaurants.[14] Further, the Zimbabwean team heard from children that forced homosexual sex regularly occurred among children of the street. "At night, the older boys who shared sleeping space with the younger often raped the latter with impunity. Allegedly … police officers also participated in the homosexual abuse."[15] Despite the threat of HIV/AIDS, the children could not defend themselves against such assaults. A study in Kenya found that "28 per cent of boys and 22 per cent of girls reported that forced sex was attempted with them. In addition, 31 per cent of boys and 27 per cent of girls reported having been pressured to have sex", usually by older peers or adult men.[16] Boys then face the double stigma of homosexual rape.

Almost all of children living on the street in Zambia were not in school (and may have had little if any schooling prior to moving to the street), were not exposed to formal HIV/AIDS prevention programmes, and learned about HIV/AIDS from peers. Often, their knowledge of the disease and protection methods were inadequate and incorrect.[17] Thus, their ability to avoid HIV infection was even further reduced.

Migration has long been recognized as an important risk factor for HIV/AIDS transmission in many parts of sub-Saharan Africa.[18] The various RAs encountered very different situations involving children and migration. In the United Republic of Tanzania, nearly half of the children interviewed had come from outside the area where they worked, and over three-quarters of those had migrated to seek work.[19] By contrast, in Zambia about 80 per cent of interviewed children lived in the area of their birth.[20] It is not clear whether migration placed the Tanzanian children at greater risk. Some lived with relatives, but others had fewer options and less security. Migration by girls for domestic work was especially common, with nearly half of all domestic workers in the United Republic of

[14] Kaliyati et al. : *HIV/AIDS and child labour in Zimbabwe*, op. cit., p. ix.

[15] ibid., p. 28.

[16] WHO: *What about boys: A literature review on the health and development of adolescent boys* (Geneva, 2000), p. 45.

[17] Mushingeh et al. : *HIV/AIDS and child labour in Zambia*, op. cit., pp. 18-20.

[18] For example, M. Wambura: "Population mobility and the spread of HIV in rural villages in Mwanza region, Tanzania", an abstract for the 2002 International HIV/AIDS Conference; J. Decosas and A. Adrien: "Migration and HIV", *AIDS*, 11 supp. A (1997): S78; G. Pison et al.: "Seasonal migration: A risk factor for HIV infection in rural Senegal", *Acquired Immune Deficiency Syndrome* 6 (1993): 196-200.

[19] Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., p. 19 and table 4 (p. 21).

[20] Mushingeh et al.: *HIV/AIDS and child labour in Zambia*, op. cit., p. 11.

Tanzania being children.[21] Over 22 per cent of children working in domestic work reported, in one survey, of having been sexually abused.[22] Access to medical care for sexually transmitted infections, pregnancy, and basic health care is difficult for most of these children, in part because their work allows little time for attending a clinic, in part because of limited incomes. It has also been reported that some children move from domestic work into prostitution with promises of more lucrative work.

For most children, working conditions were often difficult – long hours, risk of injury, and the potential for physical abuse were frequently cited by the children involved in the RAs. Ill-health was part of the work and living conditions. Self-treatment or no treatment at all was common in Zambia because the children did not have the money to attend a health clinic, and often could not spare the time away from work to seek medical attention.[23] Day-to-day survival took precedence over longer-term well-being, a common situation among the impoverished.

In South Africa, the children's rights group Molo Songololo has documented an increase in the trafficking of children for sexual exploitation as a result of increased demand, in part from growing numbers of tourists in Cape Town.[24] In other large South African cities, the child sex industry has become increasingly organized, with children either being forced into prostitution or exploited by their parents to earn money for the family. According to a report by the information and advocacy group Global March, "[a]n increase in the number of children living on the streets has contributed to the growing number of child prostitutes".[25] In the United Republic of Tanzania, too, trafficking of children for sex work or domestic work has been documented.[26]

> What brought me here is that my mother disappeared in 1999. I was coming from church at Nongoma. My friends and I got a lift from a white man who was coming here [to Durban]. I realized later that my friend had set me up, because she was also not staying in her home. She was running away from home, and wanted to take me with her dirty tricks. We went as if we were going to church, and the white man bought nice things for us on the way. I later realized that we were in Durban. When I ask my friend what was going on, she started to behave badly. I lived on the street for about a year and I saw other girls who were doing this job. A certain gentleman who was called Rosta told me to do this job too. I did the job for one day and I left it because I did not like it. I decided to sit down and thought about this job. After two months, I joined it because I needed money ... It is very dangerous here – sometimes the boys try to rape us on the streets and try to take our money.
>
> Source: *Girl engaged in prostitution, Stanford Hill, Durban, South Africa.*

[21] ILO Gender Promotion Programme: *National report for promoting the linkages between womens [sic] employment and the reduction of child labour* (Dar es Salaam, ILO, 2001), p. 25.

[22] ibid., p. 43. By contrast, none of the children in domestic work in the South African study reported incidences of sexual exploitation. The reason appears to be that the children worked with their mothers or in households familiar to the family.

[23] Mushingeh et al.: *HIV/AIDS and child labour in Zambia*, op. cit., p. 15.

[24] *The trafficking of children for purposes of sexual exploitation – South Africa* (Cape Town, Molo Songololo, 2000).

[25] *Out of the shadows*, op. cit.

[26] ILO Gender Promotion Programme: *National report for promoting the linkages between womens [sic] employment and the reduction of child labour*, p. 19.

It should be noted that the RAs did not apply any test to determine the HIV sero-status of working children. Nor did the RAs administer HIV tests to living parents or guardians. However, the researchers were familiar with symptoms of HIV/AIDS and of opportunistic infections. Descriptions by orphaned children of parental symptoms were used to make rough yet credible assessments of the cause of illness/death of one or both parents (or guardians) of the children. Thus, it is not possible to say with demonstrable certainty from these qualitative surveys that orphaned children were working because of the death of a parent to HIV/AIDS, or that an opportunistic infection or the work of children was directly linked to HIV-infection.

3.4. Impact on children's education

One 2001 study examined enrolment, school completion, and other educational data for primary school students in a number of African countries over the decade of the 1990s. The research showed a correlation between high national HIV/AIDS prevalence (more than 11 per cent) and decreases in school enrolment. Girl's gross enrolment ratio (used as a measure of access to, or availability of, educational facilities) decreased in nine of 14 countries; among boys, it decreased in seven of the 14 countries. Of these, decreases in girl enrolment exceeded that of boys in three of the countries, indicating both national differences and a stronger likelihood that girls' education will be more adversely affected by high HIV/AIDS patterns than that of boys.[27] By comparison, in countries with prevalence below 11 per cent (n = 20), girls' gross enrolment decreased in five countries and in four for boys. The study concludes that: "As HIV prevalence increases, the total number of girls of all ages enrolled in primary school decreases. The correlation … for boys [is] also negative but [not] statistically significant." Put another way: "As HIV prevalence goes up, the demand for education goes down, and girls appear to be affected negatively more than boys."[28]

The study also found that, once in school, children continued to move ahead from grade to grade at rates similar to those prevailing before the 1990s. The implication is that children are not dropping out or being withdrawn from school at higher rates during the era of AIDS than they were in the era of major economic reforms, although it is important to recognize that in many African countries, drop-out rates were high in the 1980s and remained so into the 1990s.[29]

The RAs add dimensions to this broad overview. Again, it is useful to see the differences, and the similarities, between the children in the four countries. In South Africa and Zimbabwe, school attendance for working children remains relatively high – two to three times the levels in the United Republic of Tanzania and Zambia (see table 3). The figures for South Africa and Zimbabwe suggest the continued importance of formal schooling for many of the children and parents, as well as the availability of places for children. Both the United Republic of Tanzania and Zambia imposed school fees early in the 1990s and, along with other financial costs, many families could not afford to pay the fees. It is interesting to note that many of the working children in South Africa do so after school and on weekends, rather than during the school day.

[27] R. Chesterfield, K.I. Enge and P. Martínez-Enge: *Girls' education and crises* (Washington, DC, USAID, 2001).

[28] ibid., pp. 54 and 55.

[29] ibid., p. 58.

Table 3. Educational status of children in rapid assessments

Country	National net primary school enrolment rates (UNESCO data)	Children involved in Ras		
		Currently in school (%)	Once attended, but no longer attend school (%)	Never attended school (%)
South Africa	88.9	60.0	N/A	N/A
Tanzania, United Rep. of	46.7	37.7	37.7	23.6
Zambia	65.5	25.8	58.2	16.0
Zimbabwe	79.6	72.2	27.8	N/A

At the same time, nearly 60 per cent of the children interviewed during the study in Zambia had dropped out of school. Even in Zimbabwe, over one-quarter of the children had dropped out of school. In all cases, children who have to leave school, either because of pressures related to HIV/AIDS or economic conditions, face fewer opportunities for gainful employment and a satisfactory future life than children who remain in school. The results point to the differentiation occurring across societies as a result of HIV/AIDS and other factors.

It is widely reported that children from families where one or more adults are HIV-infected are more likely than children in non-affected households to be withdrawn from school because families:

- cannot afford the school costs;
- need the children to help supplement household income; or
- need them to help care for sick relatives. [30]

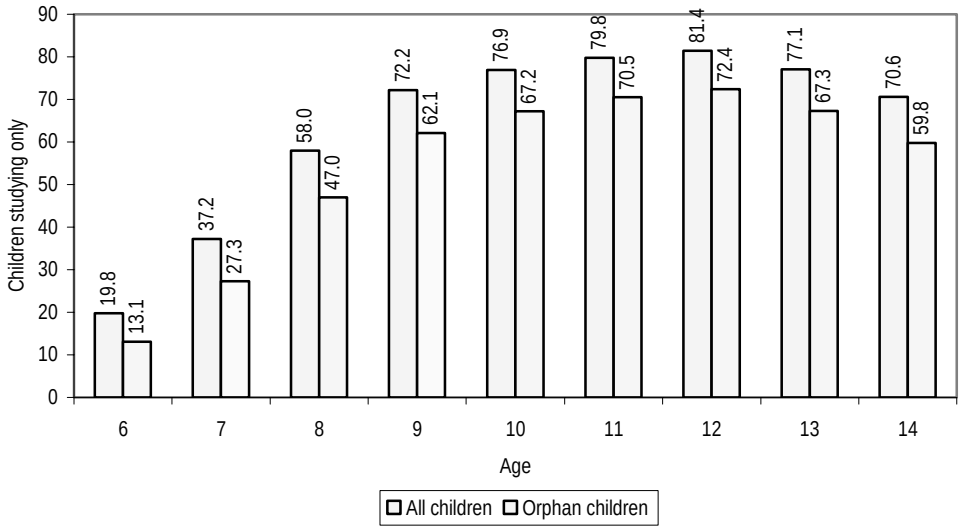
These trends are especially evident in countries with high HIV/AIDS rates. In western Kenya, 20 per cent of households with orphaned children do not have children in school, primarily due to lack of money. [31] In Zambia, rural orphaned children have a 20 per cent higher rate of non-school attendance than non-orphaned children. [32] Other data from Zambia show a consistently lower school attendance rate for orphaned children (figure 6).

[30] M.J. Kelley: "The encounter between HIV/AIDS and education" (Harare, UNESCO, 2000).

[31] M. Ayieko: *From single parents to child-headed households: The case of children orphaned by AIDS in Kisumu and Siaya districts in Kenya*, Study paper No. 7 (New York, UNDP, 1997).

[32] ibid.

Figure 6. Effect of orphanhood on school attendance, Zambia



Source: L. Guarcello and F.C. Rosati: "Orphans and child labour", Presentation at the ILO/IPEC Workshop on HIV/AIDS and Child Labour, Lusaka, May 2003.

As the pandemic spreads and its impact becomes more intense, the education of children in affected households is influenced in one of several ways, where families:

- delay school entry;
- withdraw girls first;
- send children only sporadically; or
- fully withdraw children from school.

In one study area in the United Republic of Tanzania, delaying school enrolment to postpone the costs was the most common response. The socio-economic status of affected households also has a significant bearing on school attendance, further affirming that HIV/AIDS perpetuates – and in some instances creates – household poverty. Following a 1991-94 longitudinal study in the Kagera region of the United Republic of Tanzania, researchers concluded that: "The most disadvantaged group is orphans in poor households. Household wealth raises the enrolment rate of orphans, though their enrolment is still lower than that of non-orphans. Orphans in non-poor households have higher enrolment rates than non-orphans in poor households." [33]

All the RAs confirmed these conclusions. Numerous children are quoted as saying that they were working because they were not in school or because they were trying to earn money to pay for school fees for themselves or other family members. "My mother could not pay fees since she was seriously ill", a child in Zimbabwe told the researchers. "When she died, that was the end of the road for me." [34] Orphanhood and family finances were key

[33] M. Ainsworth, K. Beegle and G. Koda: *The impact of adult mortality on primary school enrolment in northwestern Tanzania* (Washington, DC, World Bank, 2002); M. Ainsworth and D. Filmer: *Poverty, AIDS and children's schooling: A targeting dilemma*, Policy Research Working Paper 2885 (Washington DC, World Bank, 2002).

[34] Kaliyati et al. : *HIV/AIDS and child labour in Zimbabwe*, op. cit., p. 27.

factors in school attendance and, again, socio-economic differentiation is apparent in the survey analyses. As the Tanzanian RA notes, "double orphans were the leading category among unenroled children of school-going age. Orphans also represented the smallest percentage of those currently attending school". [35] Even where orphaned children were in school, the stigma associated with HIV/AIDS could affect their relationships with teachers and other students. The added stigma of poverty led some students in Zimbabwe to attend night school. [36]

Some families are less able to cope with significant economic changes (including those caused by HIV/AIDS) than others, leading to disruptions in schooling. Children of farm workers in Zimbabwe are one example. News reports cite instances of children and teachers being harassed by occupiers, farm schools closing, and farm workers' children dropping out of school because they were afraid of strangers as they walked along the road to school. Particularly vulnerable were HIV/AIDS orphans, especially girls, who had higher drop-out rates, generally leaving school within three years of being orphaned. [37] Zimbabwe's Basic Education Assistance Module is designed to assure that all children receive some education. (Zambia and the United Republic of Tanzania have similar supplemental education programmes.) However, even this supplemental programme – which did not impose school fees – did not adequately cover all areas or reach all potential students. As a child who sold goods on the street told the South African researchers:

> My mother is unemployed and my grandmother pays my school fees. I have not been in school the whole of this year. By the time my grandfather died, I was doing Sub A. He then passed away. I continued with Sub B, then this year I was supposed to do Standard One, but I did not go back to school. There was no money.

The quality of education is affected by disruptions in attendance, not only among students, but teachers as well. The ability of school systems to deliver quality education is affected by HIV/AIDS in several ways. Disruptions take the following forms:

- loss of trained teachers to HIV/AIDS;
- reduced productivity among sick teachers;
- larger classes when teachers are not readily replaced, and fewer inspectors and administrators to keep the systems running efficiently; and
- the closure of classes or entire schools if population decline leads to declining enrolment. [38]

The loss of teaching staff as well as administrators and supervisors is rapidly increasing. In some countries, this loss is overwhelming. In Nyanza Province, Kenya, it is reported that 20 to 30 teachers die each month from AIDS. In Botswana, death rates among primary school teachers increased tenfold. [39] Learning time is lost, classes double up and

[35] Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., p. 26.

[36] Kaliyati et al.: *HIV/AIDS and child labour in Zimbabwe*, op. cit., p. 27.

[37] "Children victims of land crisis, AIDS in Zimbabwe" (Associated Press, 2000).

[38] Kelly, op. cit.

[39] D. Gachuhi: "The impact of HIV/AIDS on education systems in the eastern and southern African region" (UNICEF, 1999); Loewenson and Whiteside: *HIV/AIDS: Implications for poverty reduction*, op. cit.

the quality of teaching and learning decreases. Teacher morale is affected by both the loss of colleagues and the stress of working under increasingly demanding conditions. Children affected by HIV/AIDS bring their worries and fears to school, creating a new dimension of responsibility for teachers and administrators. School systems such as the United Republic of Tanzania's are training teachers to provide counselling services.

The era of HIV/AIDS has many implications for the well-being of children. Children lose key opportunities for creating a more secure economic future for themselves and their families. In search of economic opportunity, young people migrate to urban areas, adding to the problem of unemployed youth. Exposure to HIV/AIDS-prevention education is likely to be minimal. The stigma and discrimination suffered because of being both "uneducated" and from a family affected by HIV/AIDS can have long-term psychological implications. Hope, too, is lost. In the United Republic of Tanzania, "some [orphaned children] become severely depressed, avoiding social contact and losing hope of a happy life".[40] A study from South Africa on sexual and social attitudes among children 12 to 17 years of age argues that: "Young people who are poor, yet have a sense of optimism, engage in less risky sexual behaviour. Young people who are poor and feel trapped in a poverty spiral feel pessimistic. Their response to HIV is that it is something that is almost inevitable. This attitude correlates strongly with risky sexual behaviour."[41]

3.5. Child-headed households

Lack of inherited assets is an important variable among orphaned children – especially since there appears to be a growing trend among orphans, notably in eastern and southern Africa, to care for themselves and their siblings. It is estimated that over 7 per cent of Zambia's nearly 2 million households are without any adult member, and are headed by a boy or a girl aged 14 or younger.[42] The Zambian RA team identified 15 child-headed households during its research. Zimbabwe's RA team cites evidence that nearly 2 per cent of the 6,525 children in the Gweru urban area were in child-headed households. Zimbabwe's RA, however, identified over twice that percentage as being children-heading households or caring for themselves.[43] In the United Republic of Tanzania, over 9 per cent of children in the survey lived on their own, essentially heading a household – at least where a house and living arrangements actually existed.

While they represent only a small proportion of all households, child-headed households do exist, and they present an especially important challenge for policy-makers, programme planners, and service agencies alike.[44] There is insufficient data regarding child-headed households, but their very existence is a new phenomenon within Africa, suggesting yet one more manifestation of growing inequalities in society and the ongoing socio-economic differentiation occurring as a result of the HIV/AIDS pandemic. Child-headed households exist because no relatives are left to care for the children, or else the surviving relatives are already too burdened to adequately care for the children they have

[40] Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., p. 40.

[41] S. Valentine: "Hope and optimism affect safer sex choices", 1 Mar. 2002 www.health-e.org.za/view.php3?id=20020302).

[42] GRZ-UNICEF 1997, p. 2.

[43] Kaliyati et al. : *HIV/AIDS and child labour in Zimbabwe*, op. cit., pp. 21 and 27-28.

[44] Nelson Mandela Children's Fund: "Report: A study into the situation and special needs of children in child-headed households" (Johannesburg, June 2001).

inherited. Many children who become household heads have little option but to seek work to support themselves and their siblings. Stories exist of older children earning the cash to keep younger siblings in school; however, continued schooling for any of the children in these households is problematic.

An 18-year old Zimbabwean girl heading a household

She lost both parents, her father in 1992 and her mother in 2001. When the mother was alive, they rented a room at a plot in Gumtree, Gweru. She is the fifth-born of a family of ten children. When the father died, she was in Grade 4. Thereafter, none of her siblings went to school because the mother could not afford it.

During her mother's protracted illness, they sold all the assets; they had to pay for her health care. She worked as a domestic worker to assist with her mother's expenses. The white couple she worked for went to Canada, leaving her kitchen utensils which she then sold to pay for her mother's visit to a private doctor. They were expelled from the house they were renting, and moved to an informal settlement to live in a plastic shack, where the mother subsequently died. Her relatives came to collect the body, leaving the children because their father had not paid bride wealth. One of her elder sisters, born in 1977, died in 2001, and her husband died five months later leaving a two-year-old child. Her elder brother, born in 1971, also died of TB in 1995, and she has one surviving elder brother, who is a street vendor.

She lives in the shack left by her mother with four male siblings, one of whom is mentally retarded, and a two-year-old nephew left by her sister. She works as an egg vendor at the main bus terminus. She misses work to care for her mentally retarded young brother, who is unwell. One of the younger brothers begs in the street to supplement household needs. He sniffs glue, and she has no control over him. She had a boyfriend who wanted to marry her, but left her because of her family responsibilities. Like all her siblings, she has no birth certificate, so the Government Social Welfare Department provides no assistance.

Source: *Zimbabwe rapid assessment report*, p. 35.

3.6. A gender perspective

The situation of girls requires special attention in the context of HIV/AIDS and child labour. Girls are more likely than are boys not to be in school, and thus working in some form. They are more likely to be withdrawn from school before boys; more subject to sexual harassment, manipulation and exploitation; and far more likely to be drawn or forced into prostitution. Once sexually active, whether by choice or through coercion, girls are also far more susceptible to HIV/AIDS infection.

The RAs provide further insights into the situation of girls. It is often assumed in secondary accounts that girls play a major role in the care of sick relatives. The RAs confirm that girls are withdrawn from school – whether for shorter or longer periods or permanently – to care for younger siblings and sick relatives, especially when an adult female relative is unable to provide that care. For example, as one girl now working in domestic work told the South African researchers, "I was doing Sub A when I was 8 years old. My grandmother became sick and they asked me to look after her until she died." The team reported that a "surprising low percentage" of children (8-22 per cent) were involved in care for the elderly, the sick, and other children, the majority of them being girls.[45] While team members may have been surprised that more girls were not in caregiving roles, the percentage nonetheless is very significant.

It appears, however – the qualitative data do not permit full confirmation – that caregiving by children (notably girls) is less frequent, or involves fewer children, than is often assumed. At the same time, caregiving, while important, also has what economists term as "opportunity costs" and, for many children, it is disruptive. In Zimbabwe, fully

[45] Kaliyati et al.: *HIV/AIDS and child labour in Zimbabwe*, op. cit., p. 33.

17.5 per cent of the children who went to school (mostly girls) also reported missing classes to care for a sick parent or relative. [46]

Similarly, the relationship between orphan status among girls and their involvement in prostitution/commercial sexual exploitation [47] is indicative. Zambia's RA establishes the link most clearly. It found that, of the 17 children (15 girls and two boys) who were in prostitution and interviewed in-depth, eight had lost both parents and four others had lost one parent. [48] All of the country surveys found that girls in prostitution came from difficult social and economic backgrounds, that HIV/AIDS exacerbated those difficulties, and orphan status weakened any social and family support systems that might otherwise have protected the girls. A Zambian girl in prostitution described her own situation in this way:

> We were suffering a lot in the household. Most of the time we were hungry, and neighbours would start laughing at us. They would be eating while we starved, as if we didn't want to eat. … You know, in our household we are three families, including my mother's sister and her children.

A relatively low proportion of working girls are in prostitution. Zimbabwe's RA identified 10 per cent of their informants (23 of 230, all of them girls) as being in prostitution. (Two boys, both in urban Zambia, described themselves as being in prostitution.) Although two-thirds of these girls reported using condoms consistently, the vast majority had not had a medical examination, and nearly 40 per cent reported having had a sexually transmitted infection. [49] The Tanzanian RA determined that 4.7 per cent of their child informants were in prostitution – and over half of these had been orphaned. Of course, the children who acknowledged during the RA research that they were commercially sexually exploited does not include girls (or boys) who have occasional sexual relations against their wishes to gain food, shelter, protection or other basic needs.

It was noted that girls in prostitution "often suffer from low self-esteem, and are often inclined to accept abuse they encounter at work as part of the job". [50] It is well documented that children often internalize abuse and adult censure, blaming themselves for situations that in fact are not of their own making, and over which they have no control. [51] Especially when dealing with male adults, girls are at a major disadvantage. Men regularly blame women and girls for transmitting HIV/AIDS infections, when, in fact, women and girls

[46] ibid., p. 27.

[47] There are numerous problems with terms used in dealing with children who are sexually exploited in what is normally called prostitution or commercial sex work. Both of the latter expressions convey a sense of intentionality or choice. In the case of children, no such intent or choice to engage in commercial sexual relations can reasonably be attributed. Manipulation, false inducement or the use of force trap children in such situations. With this in mind, the ILO uses the terms "children in prostitution" or "children in commercial sexual exploitation".

[48] Mushingeh, et al.: *HIV/AIDS and child labour in Zambia*, op. cit., pp. 16-18.

[49] Kaliyati et al.: *HIV/AIDS and child labour in Zimbabwe*, op. cit., pp. 33-34.

[50] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., pp. 36-37.

[51] A good place to start is with the work of James Garbarino. His books include *Let's talk about living in a world with violence* (Chicago, Erikson Institute, 1996) and *Children in danger: Coping with the consequences of community violence* (San Francisco, Jossey-Bass, 1992). More specific to Africa is V. Makame et al.: "Psychological well-being of orphans in Dar es Saleem, Tanzania", *Acta Paediatrica (2002)*, Vol. 91, No. 4, pp. 459-465.

have only limited control over sexual relationships.[52] The power imbalances leading to child sexual abuse and manipulation are based on social norms largely developed over generations in favour of males and adults. Legal and political systems uphold many of those norms. The *Human Development Report* for Botswana reports that "acts of violence against women and children persist in part because the socio-economic conditions in Botswana and the justice delivery system create conditions that are ripe for such abuse. … Amongst children aged 5-15 … sexual abuse by older males may well account for the majority of, if not all new [HIV/AIDS] infections".[53]

The demand side of sexual exploitation deserves far more attention than it has been given to date. Girls, in particular – whether they are in school, working as domestic servants, trying to earn cash by hawking, or working in overt prostitution – are subject to sexual coercion, manipulation, and harassment by men. The gender dimensions of the HIV/AIDS pandemic, particularly the greater vulnerability of girls and young women to infection and its impact, are manifest in the sexual exploitation by men of girls.

The quotes by girls cited in the RA reports make it clear that male demands for sexual relations – through prostitution or manipulation – are a regular part of the girls' existence. This is most obvious for girls who are in prostitution, but includes many girls affected by HIV/AIDS and/or in child labour.

3.7. Social support networks and policies and programmes to protect children

The most important social support system for child labourers is a caring, protective and supportive family. The RA reports make it clear that the impoverishment of many families, and the multiple stresses faced by extended families, leave many children in less than ideal circumstances. A good portion of the interviewed children were living with grandparents, uncles, or aunts.

In the United Republic of Tanzania, 40 per cent of adults interviewed were caring for at least one dependent child. According to the RA report, where nieces/nephews or grandsons/daughters were being taken care of, in most cases they were orphans. Further, a quarter of the interviewed adults said they had cared for non-relative children, half of whom had lost their parents. At the extreme, 20 children were living with one grandmother, the mothers being away working and the fathers having abandoned the families or being unknown.[54] As one South African girl in prostitution reported, "My grandmother earns a pension. We are a big family, and she can't support us all. This is why I am doing this job ..." Or as a boy who works in gardening said, "My grandmother and I are poor. My mother passed away, and I do not know my father. I leave the house without eating even if food is available. I do not eat so that my other brothers and sisters can have food."[55]

[52] D. Topouzis with G. Hemrich, *The socio-economic impact of HIV and AIDS on rural families in Uganda: An emphasis on youth*, Study Paper No. 2 (New York, UNDP, 1994).

[53] UNDP: *Botswana human development report, 2000: Towards an AIDS-free generation* (Gaborone, UNDP, 2000), p. 29.

[54] Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., pp. 21-22.

[55] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., pp. 15 and 25.

In Zimbabwe, nearly 45 per cent of the children in the survey (all orphans) were living with a grandparent (30 per cent) or aunt or uncle (14.8 per cent). South Africa is the only one of the four countries reviewed here that provided an old-age stipend. Even there it was noted that, in most instances, where grandparents were caring for children, they did not have the resources to meet all of the children's needs. The guardians, moreover, had difficulty negotiating bureaucratic channels to access support.

The ability of the extended family and foster arrangements to offer adequate care and support to orphaned children appears to be declining. Zimbabwe's RA team, for example, suggests that the "family-based kinship system … has been eroded by urbanization and socio-economic change, and, where it still exists, it has been stretched to the limit by the AIDS pandemic. Poverty … means the extended family is finding it difficult to provide … orphans with clothing, shelter, and education." In Zimbabwe, 30 per cent of the children interviewed were living with a grandparent, and nearly 15 per cent with an aunt or uncle. Over half of the children had moved from one household to another, an indicator of both stress on households and instability in the lives of orphaned children. [56]

If, as the RAs suggest, extended families are unable to cope with the dramatic increase in the number of orphaned children due to the HIV/AIDS epidemics in the region, changes in the policies and programmes of national governments and international donor agencies must change to reflect this reality. Some of that is happening, albeit slowly. One of the most significant changes in the United Republic of Tanzania and Zambia, for example, has been the abolition of school fees, in part because of the patent difficulties faced by orphaned children. The return to no-fee schools is an important development for these countries, but efforts are needed to speed implementation of the process to where full access to school places is assured for each student.

At the same time, the complex linkages between child labour and HIV/AIDS make national responses more difficult. As the South African team notes: "More children leaving school [due to the combination of poverty and HIV/AIDS] and taking up work will challenge poverty alleviation programmes …" [57] Indeed, conditions of poverty are likely to deepen and widen, making hollow shells of some existing social welfare and social security programmes and plans. Zambia, for one, does recognize how HIV/AIDS contributes to impoverishment. This is made explicit in its poverty alleviation strategy:

> The foremost barrier to moving out of poverty in Zambia is the lack of sustained levels of positive growth. This has been exacerbated by increased income inequality, the persistence of discrimination against women and the girl child, insufficient investment in economic and social infrastructure to keep pace with requirements for rapid growth, and the HIV/AIDS pandemic". [58]

In the absence of new resources, or new priorities for using resources, it seems unlikely that this challenge will be met in time to benefit the hundreds of thousands of orphaned and labouring children. The heavy burden that HIV/AIDS places on national economies, on public services and on businesses limits the ability, even among well-meaning governments, to take major action to curtail child labour. In several countries teachers are being lost, for example, faster than new ones can be trained and brought into

[56] Kaliyati et al.: *HIV/AIDS and child labour in Zimbabwe*, op. cit., pp. 38 and ix.

[57] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., p. 41.

[58] Zambia, Ministry of Finance and National Planning: *Poverty reduction strategy paper 2002-2004* (Lusaka, 2002).

service.[59] Thus, children in school are finding their educations compromised by teacher absenteeism, larger classes, and reduced administrative supervision and support for teachers. The public health facilities that labouring children might use, meanwhile, are heavily strained by HIV/AIDS cases. Resources that might go towards improving education, health and welfare systems are being diverted to deal with HIV/AIDS. Finally, as the number of working adults falls, personal income tax revenues and business profit taxes are also likely to fall.[60]

National policies go some way toward protecting children caught in the nexus of child labour and HIV/AIDS. But on-the-ground programmes are equally important. Most countries, including the four covered by the RAs, have many such schemes, which take three forms: NGOs; formal community-based organizations (CBOs) such as faith-based groups; and non-formal CBOs.[61] The latter include neighbourhood support groups – often created for and run by women – to assist in the care of widows, the elderly and orphaned children, and to extend assistance to families providing home-based care. Many of these informal groups arise spontaneously. Some are unable to sustain themselves for long; others are transformed into more organized structures that attract new resources. Many NGOs are providing direct service to orphaned and vulnerable children (OVC), but, because of the magnitude of the problem and related costs, these services reach only a few of the children in need. Other NGOs offer training to local groups in providing home-based care. The degree to which children benefit from such training is unknown.

The RA teams note that national, provincial and local governments all provide support to community and NGO initiatives. The level of support depends on current priorities and resources. In KwaZulu-Natal Province of South Africa, the Department of Welfare maintains a budget line item to support projects and volunteers that provide community and home-based care for children infected with and affected by HIV.[62] In all the four countries under review, government ministries provide varying levels of resource and policy support to orphaned and vulnerable children and to HIV/AIDS prevention and care programmes. In some cases, however, these systems are already weak and unable to cope with the added burden of hundreds of thousands of orphaned children and tens of thousands of child labourers.

3.8. The impact of HIV/AIDS on child well-being: Future scenarios

What does the future hold for the nexus of child labour and HIV/AIDS? The RAs do not directly address this question, but the report summaries and conclusions suggest likely scenarios for the next ten to 15 years. First, given the rates of HIV infection in each of the four countries, the associated adult mortality will remain high. Orphaned children will increase in number – a trend confirmed by computer modeling (see figure 1).[63] At the same time child labour, including its worst and most hazardous forms, will grow. And the link with HIV/AIDS will become ever more evident.

[59] Loewenson and Whiteside: *HIV/AIDS: Implications for poverty reduction*, op. cit.

[60] UNICEF/ESARO: *Child workers in the shadow of AIDS* (Nairobi, 2001).

[61] For a review of some of those programmes, together with their strengths and weaknesses, see the ILO/IPEC report by Rau: *Combating child labour and HIV/AIDS in sub-Saharan Africa*, op. cit.

[62] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., p. 44.

[63] *Children on the brink, 2002*, op. cit.

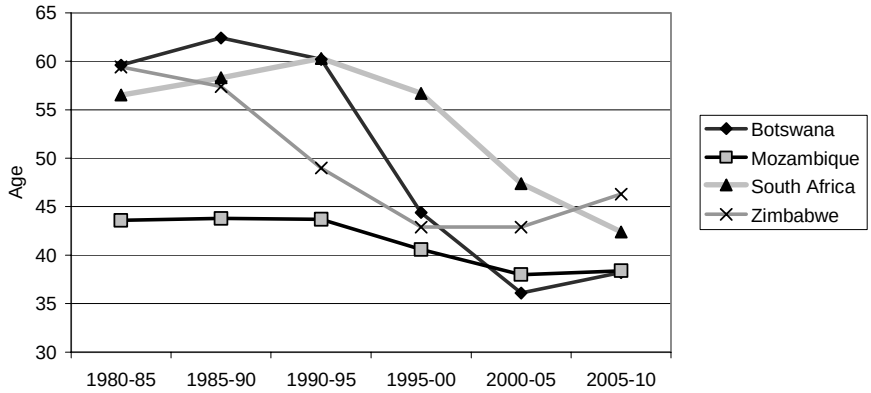
The ability of extended families and government departments and agencies to cope with the swelling number of HIV/AIDS orphans is already strained. The South African RA team suggests that these pressures will lead to changes in the responsibilities of government agencies, including a further decentralization of services and resources to better meet local demands. The Tanzanian team also implies this, suggesting the need to develop new national policies in line with social realities. Further, it foresees changes within society addressing the immense impacts of HIV/AIDS and child labour. Indeed, it is hard not to envision changes in societies, as they seek to deal with the complex and interrelated issues of HIV/AIDS, child labour, and growing impoverishment. [64]

Among changes likely to occur:

- Life expectancy will decline dramatically, as illustrated in figure 7, and population growth will slow. Demographic changes due to HIV/AIDS, already evident, will, in indirect ways, affect the well-being of children, including the increased likelihood that children will have to work. There will be fewer adults in the 25-50 age range to produce more children, to care for dependent and orphaned children or to fill jobs.

- Household structures will change. As noted, there will be many more orphans, and a growing proportion of these will be orphaned by HIV/AIDS. Many will be taken care of, but tens of thousands – if not hundreds of thousands – will be displaced or forced to fend for themselves. All will suffer the trauma of losing one or both parents (and possibly their subsequent guardians), feel the stress of household impoverishment, and experience the difficult choices of how to prioritize the use of family labour and earn income. Projections done in Botswana suggest that nearly 7 per cent of all households – particularly small households – will disappear by 2008. [65] Ever more children will have to be supported by relatives, the community or the State, or else support themselves. As all the RA teams point out, however, the ability of extended families to care for orphaned children has already declined significantly from earlier decades. Without significant outside support, those families will be even less able to offer the care and support that children need. As that burden increases, even well-intentioned guardians may not be able to meet the needs of children in their care.

Figure 7. Changes in life expectancy due to HIV/AIDS: Select southern African countries



Source: UN Population Division, World Population Prospects: 2001 Revision.

[64] Mturi and Nzimande: *HIV/AIDS and child labour in South Africa*, op. cit., p. 41; Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., p. 43.

[65] R. Greener: *Impacts of HIV/AIDS on poverty and income inequality in Botswana* (Gaborone, Botswana Institute for Development Policy Analysis, 2000).

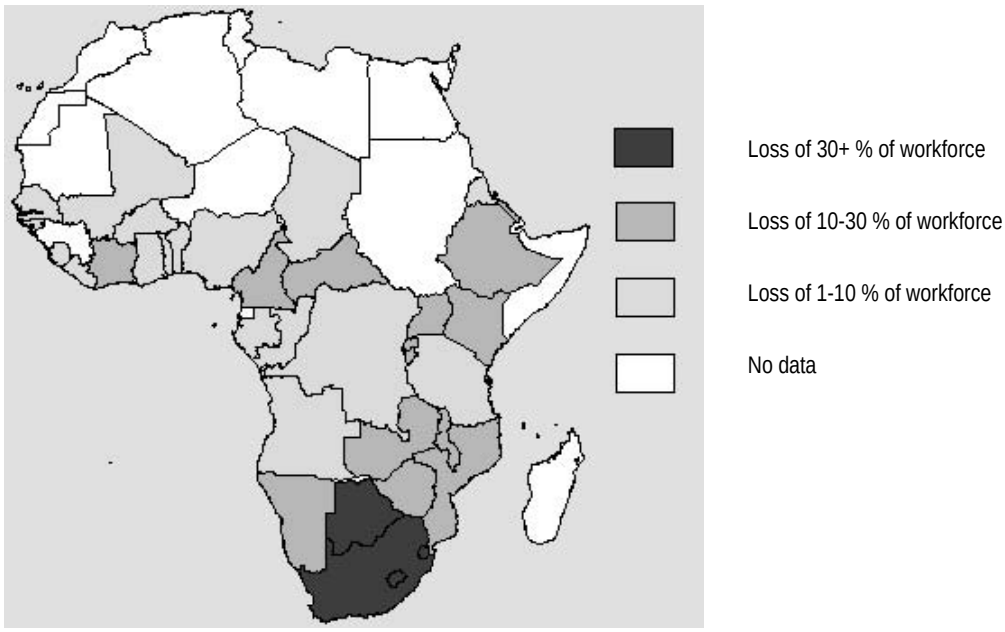
- Workforce changes will have implications for child labour. As the map in figure 8 illustrates, the ILO forecasts, due to the impact of HIV/AIDS over the coming years, significant decreases in the size of the workforce. As people in their 20s and 30s die, many of them due to HIV/AIDS, two broad scenarios affecting child labour are possible:

  – New opportunities may arise for the children who become adults, and who might otherwise have been forced into marginal jobs. Such new work opportunities tend to assume that new workers will have had at least a basic education – again, not always an assured prospect for many children in the era of HIV/AIDS.

  – New work opportunities also assume an expanding economy, one that creates new jobs. Alternatively, companies – large and small, formal and informal – might exploit the large number of children seeking work as a way to contain labour costs. It also seems likely that class disparities will continue to widen, as affected and unaffected children experience unequal access to education, health, and family support, thereby shaping their respective future opportunities. Children orphaned by HIV/AIDS, disadvantaged by HIV/AIDS and poverty and marginalized by society may end up working for children whose families have escaped the worst impacts of the epidemics.

These and other changes will depend on the willingness and ability of all governmental and social institutions to recognize the problems and to offer creative solutions. In addition, the lessons from South Africa, the United Republic of Tanzania, Zambia and Zimbabwe can guide other countries, such as those in West Africa, in providing more effective prevention, care, and mitigation programmes in addressing both HIV/AIDS and child labour.

Figure 8. Projected per cent of labour force lost to HIV/AIDS by 2020



Source: ILO (used for PowerPoint presentation, Lusaka 2003).

4. Recommendations and conclusions

Close review of the RA reports highlights the importance of understanding the nexus of child labour and HIV/AIDS. Clearly, the link between the HIV/AIDS pandemic and increases in child labour, including in its worst forms, does exist. This connection is intensifying, moreover, as ever-increasing numbers of children are forced into the labour force. The reports also make it clear that other factors are exacerbating both child labour and HIV/AIDS. Most importantly among these are the deep and extensive poverty that affects millions of families in the four countries and the pervasive gender inequalities.

At the same time, it is important to distinguish between the various categories of affected children, and the reports help in that regard. While millions of children are affected by HIV/AIDS because of the death of one or both parents, many will remain with the other parent or find care with a member of the extended family. As affected families grow in number, however, some children will have to work, will be withdrawn from school or have their studies disrupted. Girls will face greater bias than boys, and some girls (as well as a very small number of boys) will be drawn into prostitution. The chances of sexual abuse, manipulation and exploitation for girls (and some boys) will grow as their numbers in the workforce grow. In turn, the risk of becoming infected with HIV increases.

While the linkage between HIV/AIDS and child labour is very real, the reports also reveal areas in which our knowledge is incomplete. More quantitative data are needed.

- For example, we have a sense of the scale of the problem, but understanding and monitoring how these numbers are growing and needs are changing will require more and better numerical assessments.

- We have numerous reports from focus group discussions (FGDs), interviews, etc. of changes in extended families, particularly regarding their inability to assume traditional caregiving roles for orphaned children. A more dynamic view of changes in family and household structures is needed in order to design programmes that will assist those families and the affected children.[1]

- We know far too little about the willingness and ability of governments, businesses, unions, NGOs and communities to confront male sexual exploitation of children. Assessments of how male norms drive the HIV/AIDS epidemics, followed by clear commentary by men of male attitudes and norms, are rare.

4.1. Summary of rapid assessment findings

Before moving on to a discussion of good practices and recommendations suggested by the RAs, we will re-examine the key RA findings. The following extracts are taken from the country reports. (Emphasis has been added to key phrases for this synthesis report.)

[1] The leader of the South African RA team will be involved in a study on changes in household structures in that country. Similar research is needed in other countries to understand specific changes and dynamics.

South Africa

- The majority of the *children said they were working because of poverty*. They volunteered to find work in view of deteriorating situations in their households. Their contributions were either the only income or supplementary household income to support themselves and their families.

- Many children were working because one or both of their parents were dead. Thirty-seven per cent of the children interviewed had lost at least one parent. Some children reported that their parents were very ill. *AIDS-related illness, it was estimated, was the cause of death among the parents of 85 per cent of those children. This suggests a direct link between HIV/AIDS and child labour*. Judging by the interviews with the working children, most would not have been working had their parents still been alive. The death of the parent(s) left these children with limited options. Some stayed together in the home with an elder child assuming responsibility as head of household. Others joined members of their extended families.

- The major surprise in this study related to education. *About 60 per cent of the participating children were enrolled in school.* Most were only working part-time during weekends and school holidays. Interruption of schooling among these working children appeared to be minimal.

- *Girls are especially vulnerable to sexually abusive forms of child labour*. Child sexual abuse in said to be increasing in the country, and there is only weak enforcement of existing laws to protect children from sexual assault, prostitution and other forms of sexual abuse.

- Given that girl children engage in prostitution more commonly than do boys, and that they conduct business mainly on the streets of Durban, we can conclude that *vulnerability to risk varies between girls and boys* and between occupational types.

United Republic of Tanzania

- The study revealed that *more than 60 per cent of children working in the informal sector were either single or double orphans*. (Most of the dead parents had succumbed to HIV/AIDS-related complications.) About 70 per cent of the children involved in the self-employed sector, 60 per cent of those in domestic work and 55 per cent of those in prostitution were either single or double orphans.

- *Most of these children had either dropped out of or never attended school*. More than 65 per cent of the children involved in self-employment and 77 per cent of those in prostitution had dropped out of school.

- *Among those children engaged in prostitution, nearly 60 per cent were aged 15 years or younger*.[2] In domestic work, this was true of about 30 per cent of the children, and of those in self-employment about 40 per cent.

[2] This study provides further evidence in support of the findings of an earlier RA on children in prostitution. See E. Kamala, et al., *Tanzania children in prostitution: A rapid assessment* (Geneva, ILO/IPEC, 2001).

Zambia

- In Zambia, *poverty and HIV/AIDS are mutually reinforcing, and together they create fertile conditions for child labour*. Merely counselling boy and girl labourers regarding the hazardous nature of their activities will be ineffective as long as their families remain in poverty.

- *HIV/AIDS has worsened the situation, creating a self-perpetuating cycle of suffering* for many children. As long as poverty continues to afflict 80 per cent of Zambia's population, children will be involved in child labour, and they will continue to be affected, and infected, by HIV/AIDS.

Zimbabwe

- *High prevalence of HIV/AIDS is associated with high rates of orphanhood, and hence with child labour*. Attacking the root causes of HIV/AIDS and its spread would therefore have a significant effect on child labour levels.

4.2. Identified good practices

The RAs and their subsequent reports, supported by ILO/IPEC, help identify several good practices useful for subsequent work on HIV/AIDS and child labour.[3] The RAs reflect some of the best features of action research. Especially noteworthy is that a multi-country study such as this one provides points for comparison and contrast. At the same time, it offers ideas, approaches and examples that can be shared between countries in adopting more effective responses to child labour and HIV/AIDS.

Several other aspects of the RAs represent good practices. In the area of research methodologies:

- the multidisciplinary researchers worked well in teams, adding significant value to the process of contacting and interviewing children on sensitive topics and analysing the findings;

- the teams were further strengthened through the participation of academics and NGO representatives with field contacts in either child labour or HIV/AIDS;

- the researchers reached the target populations with the help of local informants and the mapping of locales where children, including girls in prostitution, were engaged in work;

- referring to the words and insights of children and key informants recorded in the reports assured a focus on the daily realities of children who experienced HIV/AIDS and child labour;

- the methodology can be readily replicated, given the common questionnaire template used by all the teams;

[3] The good practices noted here derive specifically from the RA reports. Another set of lists can be found in Rau: *Combating child labour and HIV/AIDS in Sub-Saharan Africa*, op. cit.

- more quantitative research may be obtained by adding a few questions to the SIMPOC national and baseline surveys in Africa – the findings will complement the qualitative analysis of the RAs.

Good practices are also seen in the linking of research to potential programmatic responses. For example:

- all the country reports made it clear that child labour and HIV/AIDS cannot be separated from prevailing economic and social conditions, which affect both children and their families and communities;

- the children's own words offer a means to move beyond abstract notions of poverty to the real causes of impoverishment;

- the research findings can be used to inform government, business and union policy-makers as well as programme planners. The South African team was most explicit in stating that recommendations had policy and programme implications;

- the RAs are models for identifying useful materials (such as NGO materials in South Africa for teachers on the sexual abuse of children) and approaches (such as the budgetary support provided by the KwaZulu-Natal Provincial Department of Welfare for home-based care);

- the research identified what is really working, especially for children. In the United Republic of Tanzania, that includes home-based care; in South Africa and Zimbabwe, it includes child and family commitment to education; in Zambia, it includes community mobilization to support households and orphaned children in need.

4.3. Recommendations from the rapid assessments

The RA teams offered the following recommendations for ways of addressing HIV/AIDS and child labour. Some of the recommendations are specific to the respective countries, but many can be applied, with appropriate adaptations, to other countries. The recommendations listed under each of the following sub-heading are not fully specific to one country, and include some noted by two or more RA teams.

Further research

- It is necessary to understand changes occurring in family structures, especially under the impact of HIV/AIDS, and the effect of these changes on the well-being of orphaned children. This is a theme that runs across all four countries, and it stands out as a topic requiring further study – not only to address the nexus of HIV/AIDS and child labour, but also to comprehend important aspects of social relations. In this context, the South African team noted an "increase in skipped-generation families – household structures comprising an older and a younger generation, but where, often because of AIDS, the middle, parental generation is missing".[4] Are there certain household configurations that are better able to care for affected children? What support systems – from other extended family members, from communities or from government institutions – can best assist extended-family caregivers to provide appropriate and adequate support to affected children?

[4] Mturi and Nzimande, *HIV/AIDS and child labour in South Africa*, op. cit., p. 41.

- The Tanzanian team adds a further dimension to the situation of families when it notes: "The majority of the families surveyed were too poor to meet the demands, including schooling, of supporting the extra children."[5] Questions about family structure, coping and capabilities obviously follow.

- In the same context, it is important to recognize and understand changes in the social safety nets often provided by extended families. Which households are coping with the impact of HIV/AIDS, i.e. increased numbers of orphaned children? What features distinguish coping from partially or non-coping households? What percentage of households are collapsing and dissolving under the pressure of HIV/AIDS and the demands of increased child care?

- How many orphaned children are there in local areas? The Gweru Urban District of Zimbabwe has conducted such an enumeration; other areas and countries need to maintain regular censuses on this and related issues.

- How many children are heading households?

- Some initial research has been done on the risks to girls of sexual exploitation in different work environments. Further research can suggest means to minimize those risks, especially for girls in domestic work and those working in the informal economy in the absence of a parent/guardian.

- How are school systems dealing with the needs of HIV/AIDS-affected students? This question arises in all four country studies.

Policy development and changes

- Enforcement of existing policies to ensure that children attend school.

- Development of clear, practicable child labour policies that are both multi-sectoral and multi-layered.

- Development and dissemination of guidelines on operating shelters and "safe houses" for street children, and on how to move children back into the school system.

- Development or refinement of policies and legislation to strengthen anti-child labour enforcement with employers.

- Enforcement of existing legislation that protects girls, including those in prostitution, from sexual abuse.

- Mounting nationwide awareness and information campaigns to inform low-income parents of their rights. For example, the right to waive school fees.

- Reintroduction of policies and programmes that serve people, including local government provision of welfare and supplementary feeding programmes for children.

- New legislation to protect the inheritance rights of orphaned children.

[5] Semkiwa: *HIV/AIDS and child labour in the United Republic of Tanzania*, op. cit., p. 42.

Programmes

- Orient HIV/AIDS and child labour programmes to support and build upon community strengths and resources more effectively. This will involve devolving many programmes and resources to more local and community levels.

- Expand poverty alleviation programmes, targeting the most affected households.

- Create new job creation and job training programmes for children, and renew existing ones. As the Zambian team suggests, "Although the root cause of child labour is household poverty, the Government cannot wait until it salvages the economy to focus on children who are being economically exploited. Legislation alone is not sufficient – tangible programmes are needed."

- Renew HIV/AIDS prevention and destigmatization campaigns, while involving street children in peer education.

- Develop or strengthen programmes that increase access to help with school fees and programmes that help prevent children from dropping out of school.

- HIV/AIDS concerns should be mainstreamed into child-labour programmes, in particular the "time bound programmes" for the elimination of child labour.

- Programme planners dealing with AIDS prevention should be made aware of the reality of child labour linked to the pandemic, and be encouraged to add a "child labour module" to their work.

4.4. Putting the recommendations into practice

All of the recommendations from the country RA teams are relevant and important. But it is essential that they be prioritized. Otherwise, it is too easy to agree in principle to a long list of recommendations, but to do little or nothing to take effective measures to addressing them. The five following items are offered as a step toward encouraging the national and organizational prioritizing of recommendations for action.

- Conceptually, adopt the term "impoverishment" as a means to analysing linkages between child labour and HIV/AIDS. This framework encompasses the socio-economic factors that contribute to child labour and HIV/AIDS risk conditions. Similarly, such a conceptual framework permits fuller understanding of the impacts of HIV/AIDS on children, households and communities. The framework also permits identification of focused responses to the causes of impoverishment.

- Confront the male roles and attitudes primarily responsible for the risks of sexual exploitation among girls (and some boys) and of HIV/AIDS infection. This measure may take a number of forms, but should include the discussion and implementation of programmes addressing children's rights – defining, in detail, appropriate and acceptable male norms and behaviours towards girls and women and high-profile enforcement of existing or new laws to prevent sexual exploitation of children.

- Over a ten to 20-year period, focus national and international resources on job training, job creation, and social welfare reconstruction.

- ILO/IPEC should support research on the ability of households, extended families, and communities to protect and provide sustained care and support for children affected by HIV/AIDS.

- The ILO and other international agencies should support the regular sharing of experiences, through multiple forms and mechanisms, among CBOs, NGOs and other social partners in creatively addressing the needs of children affected by HIV/AIDS, the worst forms of child labour and sexual exploitation.

An ILO/IPEC technical workshop in Lusaka, Zambia, in May 2003, offered suggestions for tangible action to address the priority recommendations. Proposed actions for dealing with the sexual exploitation by men of girls (and women) included these:

- sensitizing men, male adolescents and boys regarding the implications of current male sexual norms related to the spread of HIV-AIDS and the sexual exploitation of girls and boys (on a lesser scale, the same applies for women);

- including sex education for children in the classroom curricula and non-formal educational settings and child-rights education for teachers and parents provided through teachers committees, parents and teacher associations, teacher training and teacher refresher courses;

- adopting new policies and laws addressing the sexual exploitation of children, adequately implementing the policies and enforcing the laws; and

- mounting or expanding information campaigns regarding the worst forms of child labour (which includes sexual exploitation), targeting communities and tourists and working through faith-based organizations, NGOs and the media.

In the area of research, workshop participants urged countries to build upon and complement the ground-breaking RAs in addressing HIV/AIDS and child labour. The following recommendations were proposed.

- National databases on HIV/AIDS and child labour should be prepared, and repository centres and archiving methods created with the assistance of IPEC's statistical and monitoring programme (SIMPOC).

- With the financial assistance of donors, national research institutions should produce gender-disaggregated quantitative statistics and qualitative research on the links between AIDS orphanhood, socio-economic circumstances and child labour.

- The concept of poverty as a main cause of HIV/AIDS prevalence and child labour in sub-Saharan African countries needs disaggregation in terms of gender, ethnicity, class and age.

- Further good practices ought to be compiled and disseminated with a view to replicating and scaling up the pilot interventions on HIV/AIDS and child labour from district to national level, as well as with a view to influencing national policies.

- HIV/AIDS indicators should be included in the impact assessment of programmes and policies targeting the elimination of child labour.

On the issue of addressing the socio-economic causes and impacts of HIV/AIDS and child labour, participants argued for:

- expanding vocational training for children and youth, including preparation or replication of curriculum materials aimed at the prevention of HIV/AIDS and child labour;

- reprioritizing the use of national resources to expand education facilities for all children;

- understanding the cost-benefit implications of proposed initiatives as one means of ensuring adequate funding; and

- seeing HIV/AIDS and child labour issues as multisectoral and multi-layered issues, more practicably focusing community, district and national resources on infrastructure.

Finally, the international community was encouraged to become more fully involved in HIV/AIDS and child labour issues by:

- intensifying, through ILO/IPEC and other international agencies, information and dissemination campaigns publicizing the joint problem of HIV/AIDS and child labour, particularly in coordination with community-based organizations and NGOs;

- sharing information on HIV/AIDS and child labour among the tripartite partners of the ILO (governments, workers' organizations, and employers' organizations) and supporting the expansion of partner activities (i.e. advocacy and media campaigns) in addressing the implications of HIV/AIDS for child labour; and

- advocating for reduction in the cost – or for free provision – of antiretroviral drugs for PLWHA.

Moving the HIV/AIDS and child labour agenda forward

In May 2003, ILO/IPEC sponsored a technical workshop in Lusaka, Zambia, on the links between HIV/AIDS and child labour. Representatives from the ILO social partners, the RA teams, other UN agencies and NGOs were involved. The workshop presentations and discussions confirmed and gave further evidence of the links between HIV/AIDS and child labour and the implications for future policy and programme development.

Among key issues raised during the technical workshop:

- the number of children affected by the HIV/AIDS pandemic will continue to grow for at least another decade;
- the magnitude of the problems experienced by orphaned children and the communities in which they live will expand;
- already, HIV/AIDS-related child labour, including child labour in its worst forms, is evident in urban and rural communities across sub-Saharan Africa;
- national responses – policies, programmes, resource mobilization—will need to be greatly accelerated to keep pace with the impacts of the pandemic;
- already active, unions, employers, local communities, and NGOs are prepared to be more fully engaged in the prevention of child labour and in addressing the impacts of HIV/AIDS;
- numerous good practices, in the form of projects and programmes, can provide models for scaling up effective responses to the linked problems of HIV/AIDS and child labour.

Workshop participants developed an action-oriented strategy to create greater awareness of and action aimed at the entwined issues of HIV/AIDS and child labour. The strategy includes four broad action areas, with specific action items to guide the respective organizations represented at the workshop. A fuller report of issues raised during the workshop is found in Appendix 3, and the strategy paper adopted by the participants appears in Appendix 4.

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Appendix 1

Methodologies of the four country rapid assessments on HIV/AIDS and child labour

The country rapid assessments (RAs) were conducted between the last quarter of 2001 and the first quarter of 2002. Each study included a literature review and collection of secondary information on social and economic conditions in the country.

RA field study locales

The research combined a rich mix of urban, peri-urban and rural locales. In most instances, selected RA sites were areas of known high HIV prevalence and/or a large number of documented orphaned children. The sites offered optimal opportunity to interview children in the workforce and key informants familiar with the child labour and HIV/AIDS situation. The sites assured that findings reflected current – and potential future – realities.

In South Africa, KwaZulu-Natal (KZN) Province was the geographic focus. It had the highest HIV prevalence in the country and it was easier there to locate children working in different occupational categories. In KwaZulu-Natal Province, two sites were chosen: the Durban Metropolitan area and Empangeni, a town about 200 kilometres north of Durban. Several interviews were also conducted in rural areas and small towns between Durban and Empangeni. All occupational groups were found there aside from "children working on farms".

The Tanzanian research team selected districts and localities in Dar es Salaam and Arusha regions. This was because of the large number of children immigrants to these regions, and the opportunity to balance urban and rural sites within each. With the help of district, ward and street-level authorities, specific urban and rural-district locales were chosen within each region.

In Zambia the study was conducted in Lusaka, the Copperbelt, and Eastern provinces. In the Copperbelt Province, the research was conducted in the cities of Kitwe, Luanshya and Ndola. In the Eastern Province, the study was done in the district towns of Chipata, Petauke, Katete and their surroundings. Lusaka and the Copperbelt cities have among the highest HIV/AIDS rates in the country, are large urban centres, and, according to the Zambian report, are severely affected by unemployment, street children, AIDS morbidity and mortality and a concentration of orphans. The Eastern Province was chosen partly because of generally high HIV infection rates and the assumed potential for child labour in small mines in the province.

Zimbabwe's RA focused on the Gweru and Shurugwi areas of Midlands Province. These farming and mining areas were known to have the highest concentration of economically active children between the ages of 5 and 17. Provincial officials, moreover, had data on the total number of registered orphaned children. The 17 wards in Gweru provided an urban setting for the research, while Shurugwi offered access to rural children in two secondary and two primary schools. As in the United Republic of Tanzania, local authorities played an important role in identifying target population sites and assisting with contacts.

The RA teams

The country teams were multidisciplinary, with team members selected for their practical experience in fields such as children's and orphans' issues, gender, labour economics, social welfare or sociology, policy and HIV/AIDS. Ensuring diverse research perspectives, contacts and sensitivities, each team included both women and men, younger researchers and at least one person with demographic and research design experience.

All of the research team members were well qualified academically, and each team was led by a person with a current academic appointment. The Tanzanian team also included the head of an NGO. Her work brought her into regular and direct contact with children orphaned by HIV/AIDS and working in the informal economy. The presence of an NGO on the team seems to have more surely permitted close consultations with street-level authorities in exploring living conditions among the children and in making contacts with working children. This is not to suggest that the other country research teams did not make such contacts, but only to argue that the mix of

researchers and direct providers in the Tanzanian team helped remove possible initial suspicions regarding outsiders, especially among one of its target groups – children who had migrated to urban centres for work. At the same time, it is worth noting that the findings from the United Republic of Tanzania differ little from those of the other countries.

Conceptual framework

ILO/IPEC commissioned the RAs to demonstrate that there were links between child labour and the HIV/AIDS pandemic moving through sub-Saharan Africa. The research was expected to provide qualitative information clarifying that linkage and to stimulate appropriate and effective policy and programme responses.

Each team addressed the issue in similar but distinctive ways. The Tanzanian RA, for example, included migrant children in the study, since many children were moving from towns to larger urban areas in search of work and were, in the process, vulnerable to sexual exploitation and HIV. The Zambian team found that the closure of a copper mine in the Copperbelt city of Luanshya greatly intensified economic hardship for all residents, with implications for children. Zimbabwe's RA focused on one province known to have the largest number of economically active children.

None of the studies involved HIV testing of children. Neither did most of these children consider taking an HIV test on their own. Thus, it was not possible to make a direct link between children's working status and conditions and their HIV status. The research did investigate children's awareness of HIV/AIDS and prevention methods. In addition, while investigating children's relationships with parents/guardians, the attempt was made to assess qualitatively whether an ill or dead parent showed HIV/AIDS symptoms.

Conceptually, the RAs were able to trace the linkages between children affected (as opposed to being infected) by HIV/AIDS and children entering the workforce. In this case, "affected children" refers to children whose parents or other family members were (assumed to be) infected with HIV/AIDS, thereby –

- placing a financial and emotional burden on other family members, which in turn could involve children in contributing to new income;
- exposing children to the consequences of cutting household expenses, including, in some cases, withdrawal from school;
- adding new household tasks, mainly caregiving or additional chores, while another family member seeks work; or
- subjecting the children to a combination of these pressures.

The RAs established these linkages, revealing even more ramifications than had been anticipated.

Research methodology

Nearly all children in the labour force work in the informal sector, where statistics are notoriously weak and relatively little is known about the smallest components of that sector – activities such as petty trading, domestic work, car washing and prostitution.

These studies sought to delve into that sector, with the focus on working children, a topic even more obscure than that of the informal sector itself.

The informal sector is primarily a response to weaknesses in the formal sector – limited manufacturing and services to provide jobs for all who want them. Incomes tend to be lower than they are in formal sector work; benefits are usually not offered; and legal safeguards are lacking. People working in the informal sector usually do so out of need rather than desire (although some participants cite the flexibility and independence of the informal economy as advantages). Gaining access to workers in the informal sector is a challenge, and access to working children presents an even greater challenge. These studies have shown, however, that it is possible to acquire substantial information from children who work in the informal sector. Of course, we always want to know more, but the studies represent important insights into marginal and sensitive topics such as HIV/AIDS, informal sector work and children's well-being.

The RAs all used a similar investigative instrument, one adapted by ILO/IPEC from RA guidelines developed by UNICEF and the ILO. [1] That instrument incorporated three methods of data collection:

- in-depth interviews with children;
- focus group discussion (FGD) with children; and
- key informant interviews with formal and informal authorities aware of the situation of working children, including parents.

In all four countries, the instrument was adapted to local realities and situations. The Zimbabwean team developed its own instrument for conducting in-depth interviews with children. The Tanzanian team engaged children in a mapping exercise to identify areas where child labour was concentrated. As with any large group, an open-ended format was applied in conducting the FDAs, allowing for a range of responses and changes of direction with questions.

While no problems with the instruments were reported, arranging interviews and FGDs was often time-consuming and problematic. Working children were reluctant to take time away from opportunities to earn cash, or they depended upon permission from employers or supervisors. Focus groups sometimes had to be cancelled because the children did not show up. The need to establish a rapport with children took time and often was not compatible with standardized questionnaires and the time constraints faced by the researchers.

Sample size and composition

A total of 945 children were involved in the four surveys. The following table breaks the group down by country, gender and form of interview. Blanks indicate the unavailable data.

Country	In-depth interviews			Focus group discussions			Total		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
South Africa	70	58	128	47	43	90	117	101	218
United Republic of Tanzania		[not identified]			[not identified]		81	110	191
Zambia	91	65	156	120	30	150	211	95	306
Zimbabwe		[not identified]			[not identified]		124	106	230
Total							533	412	945

In identifying candidates for the sample, the country teams were guided by ILO/IPEC parameters to children –

- orphaned by HIV/AIDS;
- living with HIV/AIDS, or who suffered a high risk of becoming infected with HIV due to the nature of their work; or
- affected by HIV/AIDS and/or forced to drop out of school and enter the labour market due to the pandemic.

Children in the labour force worked on commercial farms and were engaged in street hawking and petty trade, petty services (e.g., car washing), or domestic work. Some of the girls worked in the commercial sex industry. The children in the sample ranged in age from 8 to 18 years.

In addition to the children involved in the sample, interviewees included key informants, including parents/guardians, among them HIV/AIDS counsellors, police officers, health and social workers, staff of NGOs providing direct services to working and/or orphaned children, teachers, employers and others aware of the situations among working children and children affected by HIV/AIDS.

[1] *Investigating child labour: Guidelines for rapid assessment – A field manual*, draft (January 2001), www.ilo.org/public/english/standards/ipec/simpoc.

Definitions of child and child labour

One of the challenges was agreeing on age parameters for children. In South Africa, the researchers defined a child as a person who was 15 years old or younger, the country's legally defined minimum age for employment. In the United Republic of Tanzania, the RA involved children under the age of 18 years, although the national minimum age for work is 14 years. The Zambian team used 16 as the upper age for selecting children for interviews, although national legislation decreed 15 as the minimum age for children to work. Finally, in Zimbabwe, where 15 is the legal minimum age for child employment, children up to the age of 18 were engaged in the survey.

The research teams were sensitive to the reality that most children work within their home. This is part of the socialization process, with the respective roles for girls and boys usually prescribed. Thus, the teams made a distinction between working children and child labour. In general, the criteria set by Zimbabwe's Ministry of Public Service Labour and Social Welfare were reflected in all the reports. The following situations involved "child labour".

- A child working more than three hours per day is considered "economically active" – i.e. involved in the labour market.
- A child is engaged in domestic duties for more than five hours per day.
- Work interferes with schooling and other opportunities for growth considered a part of childhood.

Street children are a common phenomenon in Zambia. Many engage in petty trade and services, their lives can be both precarious and dangerous. The team made a distinction between children on the street, children of the street and abandoned children. Citing a recent study, Zambia's RA described the differences:

> Children on the street are those engaged in some kind of economic activity, ranging from begging to vending of manufactured commodities or food. Most go home at the end of the day and contribute part of their earnings for the economic survival of the family unit. They may be attending school and retain a sense of belonging to a family or household. Because of the economic fragility of their families, these children may eventually opt for a permanent life on the streets. Children of the street actually live on the street. Family ties may exist but are tenuous and maintained only casually or occasionally. Most of these children have no permanent residence and move from place to place and from town to town. Abandoned children are entirely without a home and have no contact whatsoever with their families.[2]

[2] Citing Musonda Lemba: *Rapid assessment of street children in Lusaka*, a study conducted for Project Concern International (PCI), Lusaka, March 2002, p. 5. See also above (3.3 Child workers at risk of infection), p. 22.

Appendix 2

Demographic profiles of children in the research samples

The common criterion for selecting child interviewees (through questionnaires, in-depth interviews and focus group discussions (FGDs) was whether the children were working. The research teams were inconsistent in reporting basic demographic data. The following tables provide some of that data as they are available in the country reports. Cumulatively, more boys than girls were involved in the RAs. Children aged from 8 to 18 years were represented, with a concentration of children in the 13 to 17-year age group; and a high proportion of the children had lost one parent or both. Only the South African team attempted, on the basis of symptoms reported by respondents, to determine whether a parent had died of HIV/AIDS. There, of the 82 identified instances of a dead parent, the team determined that 70 of the dead parents (85 per cent) had shown symptoms of HIV/AIDS.

Number of male and female children respondents

Country	Males	Per cent	Females	Per cent	Total respondents
South Africa	120	55	98	45	218
United Republic of Tanzania	81	42	110	58	191
Zambia	211	69	95	31	306
Zimbabwe	124	54	106	46	230
Total	536	57	409	43	945

Where data are available, the following two tables describe the age and parental status of the children surveyed.

Age of children respondents, in years, as a percentage of all respondents in the United Republic of Tanzania's and Zimbabwe's RAs*

	8-9	10-12	13-15	16-17	18
United Republic of Tanzania		11.5	30.9	57.6	
Zimbabwe	4.3	22.6	37.4	27.0	8.7

* The age of interviewed children was not identified by the team in South Africa and Zambia; the upper age in all cases was 18.

Parental status obviously is an important factor in the welfare and work status of children. However, as the RAs found, many children are working even though one or both parents are alive. Family economic status was as much a factor determining whether a child was in the workforce as was the status of parents.

Parental status of interviewed children

Parental status	United Republic of Tanzania		South Africa	
	T	%	T	%
Both parents living	74	38.7	127	58.3
Mother living	47	24.6	[at least one parent dead] 70	32.1
Father living	20	10.5		
Both parents dead	50	26.2	12	5.5
	191	100.0	218	100.0

Appendix 3

Issues and themes arising during the technical workshop

The ILO/IPEC technical workshop on the linkages between HIV/AIDS and child labour was held in Lusaka, Zambia, in May 2003. The workshop included representatives from governments, trade unions, employers' organizations and NGOs in South Africa, United Republic of Tanzania, Zambia and Zimbabwe. Other UN agencies and international experts were also involved. A list of workshop participants and a report on the individual presentations are available from ILO/IPEC.

This report focuses on the issues and themes that emerged during workshop presentations and discussions. There was much agreement regarding several issues, and frequent overlap between issues. This points to the participants' evident desire to proceed in creative and effective ways to reduce the impact of HIV/AIDS and eliminate child labour, especially in its worst forms. While there was agreement on many issues, participants referred to their own different experiences in raising questions about the most effective and appropriate approaches to dealing with the issues. Identifying and discussing these differences was an important outcome of the workshop, as neither HIV/AIDS nor child labour (nor the two combined) lend themselves to generic or standard solutions.

Issues and themes

1. Magnitude and dimensions of the HIV/AIDS pandemic and child labour

The magnitude of the linked problems, it was generally agreed, was greater than many decision-makers and programme planners were aware. Given that this was a relatively new set of linked issues, available information and data needed organization before presenting it to key decision-makers in governments, unions and workers' groups, employers' organizations, international organizations, NGOs, faith-based organizations and community groups.

The magnitude of the impact of HIV/AIDS on children, it was argued, suggested that recommended responses had to be costed out to assess their financial viability. Not all programme decisions would or could be made on this basis, but it was futile to ignore costs of building facilities (such as orphanages) or starting or expanding programmes (such as subsidies for school children). It was necessary to determine whether they were affordable and whether they promised to deliver benefits at a socially acceptable cost.

2. HIV/AIDS and child labour are linked

Recent qualitative research commissioned by ILO/IPEC in South Africa, United Republic of Tanzania, Zambia and Zimbabwe firmly establish the link. Each of the RAs found that child labour is exacerbated by the HIV/AIDS pandemic, and the two problems mutually reinforce one another. In addition, analysis of child labour quantitative data from Zambia, for example, shows that, with both parents dead, more children work and fewer attend schools than if one or both parents are alive. Further, child labour participation varies according to whether the mother or father has died. The importance of parents/adult guardians in preventing child labour, including its worst forms, was repeatedly stressed during the workshop.

The RAs all noted the strain on extended families in caring for the dramatically increasing number of orphaned children. The issue emerged on several occasions, and it was noted that further research was needed to understand the changes occurring in families under the pressure of HIV/AIDS.

Research on child labour, including its linkage with HIV/AIDS, can be used to promote changes in national policy. Examples were offered of where this had happened. Research by CHIN in Zambia, for example, resulted in refinements to child labour legislation and the inclusion of a budget line item to address child labour within the Ministry of Labour. An important part of the

process in changing policies is building networks and mounting sensitizing campaigns targeting key stakeholders.

3. HIV/AIDS and child labour are development issues

Both HIV/AIDS and child labour arise from and exist within a socio-economic context of impoverishment, neglect and gender and income inequalities. Thus, responses to the constellation of related issues must come from development perspectives. It was noted on more than one occasion, for instance, that demand by waged employees and wealthy individuals and companies for child labourers and the goods they helped produce were important factors in perpetuating child labour. One important step in addressing the problem was knowing who the employers were. Enforcement of existing or new regulations and laws was essential; toward that end, monitoring of policies and laws was needed.

Poverty was frequently cited as a major cause of both HIV/AIDS risk conditions and child labour. It was argued, however, that the term "poverty" is too broad, failing to provide adequate insights into how families and children become and remain poor. The term "impoverishment" was offered as an alternative, and several examples were cited of how the term can be used to disaggregate the reasons children are working and at risk of HIV/AIDS.

4. Responses must be multi-sectoral and multi-layered

Most countries had developed multi-sectoral responses to HIV/AIDS, with governments playing a facilitating role with all the various actors. But implementation of such responses remained incomplete. It was agreed that, with the added dimension of child labour, multi-sectoral programmes were ever-more necessary.

Opinions varied regarding the most appropriate response: nationwide policies and programmes, or numerous smaller programmes at the local level. A general consensus prevailed, however, over the need to mainstream HIV/AIDS and child labour issues. Effective mainstreaming would involved a focus on both girls and boys, as well as on women and men. To move beyond mere rhetoric in this regard, it was urged that child labour awareness-raising be conducted at all levels and through networking with all social partners. A recommendation was offered to develop guidelines for planners on mainstreaming HIV/AIDS and child labour issues into programmes, as has already been done for gender and HIV/AIDS. Another suggestion was to include child labour issues within poverty reduction strategy papers (PRSPs) and development plans, among other things using child labour as an indicator of movement toward poverty reduction goals.

5. Link between HIV/AIDS and child labour increases stigma

Children from families where a person is sick with or has died of HIV/AIDS often face social stigma. That stigma may apply with even greater force to orphaned children, and many children forced to work are treated as second-class citizens. Thus, children affected by the pandemic and involved in child labour experience severe human rights abuses, with implications for the children and society as a whole.

6. Gender dimensions to both HIV/AIDS and child labour

South Africa's RA noted that girls were more involved in risky work than boys, and were more vulnerable to HIV/AIDS infection. Further, girls dropped out of school more frequently and in greater proportion than boys. It was remarked that men may not be fully aware of the damage they cause in sexually exploiting children. On the other hand, it was noted that male attitudes and behaviours are important factors in spreading HIV/AIDS and putting children at risk of sexual exploitation. The issue of male behaviours was raised on several occasions, but did not become a topic for in-depth discussion and analysis. The media and male peers were cited as an important avenue to expanding awareness and affecting changes in social norms. The major role of women in caregiving with PLWHA was noted on several occasions.

7. Access to education and child labour

The South African RA team representative reported that 60 per cent of interviewed working children were still in school. They were working to pay school fees and supplement family incomes.

In other countries, access to education was constrained by costs, as well as by whether one or both parents were living. In the context of HIV/AIDS, many families and guardian families had difficulty paying all the costs of sending children to school. The inclusion of HIV/AIDS-prevention education in school curricula was emphasized, as was the inclusion of components on children's rights, especially for girls.

A question was raised about households that were reluctant to send their children to school: When children are in school, to what extent do households feel they are gaining value and not losing income? That is, do families see children's time spent in school, rather than working, as an opportunity cost they cannot afford? Families greatly needed money. An example from the United Republic of Tanzania was given of some children who were removed from work on plantations, only to have them go on to find other, perhaps more hazardous, work elsewhere.

Another issue was whether – and, if so, how – educational systems could be more flexible in accommodating children who, because of family commitments, cannot attend regularly or within normal school hours. Some participants felt that such flexibility was important, given the pressures on low-income households, and that more flexible school systems were a way to reduce child labour. Others believed that parents/guardians needed to be held accountable to keep children in school – that flexibility implied accepting the fact that children worked and, to these participants, that was unacceptable.

A related situation was described by the South African team. In that country, the Government provides grants to families with children under 7 years of age (recently raised to 14). It was suggested that, in some instances, when the grants ended children had to work to make up for the lost income. It was also noted that child-headed households are unable to access such grants, since they are provided only to adults.

8. Policy guidance and direction for local programmes incomplete

Several countries are reviewing, revising or developing HIV/AIDS and/or child labour policies that offer opportunities for assuring that the linkages are identified in policies. The new information on HIV/AIDS and child labour and the links between them needs to be incorporated into all policy changes. At the same time, means are needed to monitor and enforce both existing and new policies. Cases where lawyers were engaged in the enforcement of existing laws were offered as one means to expand effective policy implementation.

9. Community responses and projects

Community action was described as the key to reducing the impact of HIV/AIDS on child labour.

Numerous examples of local programmes and projects were offered. Despite some concern regarding the sustainability and impact of local projects, strong support was expressed for promoting community-based initiatives to deal with HIV/AIDS prevention and care and reductions in child labour. An example from an NGO in the United Republic of Tanzania stressed that community ownership was an important factor in sustainability and effectiveness. In answer to concerns about how to assess and strengthen local ownership, examples of indicators were cited, including community material contributions to PLWHA and affected families, caregiving and guardianship for orphaned children.

Community-based projects frequently rely on volunteers. But differing experiences were reported regarding the value of working with volunteers. On the one hand, they were close to the problems and communities; they helped generate resources and kept project costs manageable. On the other hand, some participants felt that volunteers retained only a short-term interest and commitment. Where this was true, they could cost projects valuable time in training and organization when they dropped out. Nevertheless, cases in the United Republic of Tanzania were described where volunteer commitment had been maintained and they had made valuable contributions.

Concerns were raised about the ability of civil society organizations to manage the vast problems generated by the HIV/AIDS pandemic, including its impact on child labour. Examples of contributions by governments, unions, and employers' organizations were cited. But the need for greater government involvement and commitment of financial resources was stressed. The

discussions frequently emphasized advocacy by civil society groups for prioritizing government budgeting and programmes.

It was essential, participants agreed, that communities be allowed adequate time to engage in problem analysis to identify responses they could manage and own. Many projects fail to allow the time for these processes to move forward, resulting in a lack of community control and ownership.

10. Programme and project responses often very effective

Experiences with given programmes and approaches differed according to where and when they were conducted. For example, varying opinions were voiced about the value of orphanages versus community/extended family care for orphaned children.

South Africa's RA suggested a need for more orphanages, as well as more training to providers of home-based care. Other participants indicated that many existing orphanages were overcrowded, in poor condition and unable to provide effective services. A programme in eastern Zambia was offered as one example. This scheme aimed to withdraw children from child labour and provide rehabilitation with special schools, counselling, and material, nutritional and medical assistance. Like orphanages, such programmes reach only some children. The cost of the programme was discussed, especially in terms of replication and sustainability without external funding.

Similarly, different experiences and views were expressed regarding the value of small income-generating activities (IGAs). Some participants suggested that IGAs were an important coping mechanism for impoverished individuals, households and small groups. Others said they believed that IGAs were not working and were unsustainable. In Zimbabwe, it was reported, most women who received financial support to begin IGAs left their homes to operate the activity. This left girls to provide for caregiving and other household chores. Some of the girls, furthermore, were withdrawn from school to perform those household tasks. It was felt that many IGAs did not work, in some cases even increased the burden on girls. If IGAs were not working, it was observed, it was necessary to look at how they were structured and managed. Perhaps they were being imposed on groups, rather than growing out of local interests and organizational methods.

Different experiences and views were also voiced regarding various forms of financial support – e.g. childcare grants, subsidies for school fees, IGA loans/grants – and whether these should go directly to children or to families/guardians. The Zimbabwean team noted that about 40 per cent of families who got financial support from the national AIDS Trust Fund used the money to buy food, and about 20 per cent used the money to pay school fees – the point being that money intended to support PLWHA went instead to family needs. It was suggested that alternative forms of support for orphaned children be considered – e.g. subsidizing school fees (a common initiative among some NGOs across southern and eastern Africa), vocational and technical training for youth, group forms of income-generating activities, and village allocations of land for use by and for orphaned children.

According to the consensus, there was a need to expand programmes that provided information to parents about the legal rights of children, including the right to education. Some of the information could be disseminated by working with and through the media.

One element enhancing the effectiveness of programmes was assigning focal point persons with responsibility for monitoring and guiding implementation of national and organizational policies and reporting to ministerial or association managers. The educational system in the United Republic of Tanzania and the Zambia Federation of Employers have found that focal point persons make important contributions to implementing and guiding their HIV/AIDS and child labour programmes.

Local/village/community committees were seen as important in addressing child labour and the needs of orphaned and other vulnerable children. It was noted that in Zimbabwe and Uganda, among other countries, village committees maintain registers of orphaned children and vulnerable households in order to direct assistance.

The importance of parents/guardians for children's well-being was noted throughout. Programme responses in practice included psycho-social counselling, spiritual counselling, training of teachers to identify symptoms of stress in children and refer them to counsellors and community awareness-raising.

11. Resource mobilization for both HIV/AIDS and child labour

These issues received extensive attention, especially during discussion of planning for the future. It was broadly agreed that funding at all levels and from all sources remains inadequate for effective HIV/AIDS and child labour prevention. Strong emphasis was placed on advocacy in gaining support for government budget line items for both HIV/AIDS and child labour initiatives.

Working toward effective actions

In attempting to address some of the complex issues surrounding HIV/AIDS and child labour, participants argued for:

- gaining and disseminating a fuller understanding of effective programmes and projects that deal with both components of the linked problem; and
- identifying and strengthening the most important support services, while conceiving care for orphaned and vulnerable children (including children affected by HIV/AIDS) as falling upon a continuum:
  - from nuclear to extended families;
  - from community support systems to public and private institutions;
  - from local and district to national programmes and policies; and
  - from using locally generated resources to leveraging the private sector to expanding government and international donor commitments.

Within that context, there was general agreement that successful models and experiences of community-based and other local programmes first needed to be absorbed into government and donor planning, and then scaled up and replicated on a broad scale. Thus, the often repeated observation that lessons from the field should guide programming was reiterated for addressing the linked issues of HIV/AIDS and child labour. To make it possible to scale up and replicate effective programmes, organizations running such programmes and projects had to more fully document and disseminate their community-oriented experiences. In turn, information had to be combined with well-planned advocacy through NGOs, workers' and employers' organizations, and multi-sectoral networks, where feasible.

An underlying theme throughout the workshop was understanding changes in households. The Zambian NGO, CHIN, offered a conceptual framework to assess factors leading to breakdowns in household coping ability. HIV/AIDS was one such factor, and this framework makes a useful starting point for further analysis of changes in families under pressures of the impact of HIV/AIDS. In turn, the analysis can contribute to the targeting of families in special need or those likely to need assistance in preventing children from having to work.

Given the range of issues raised during the technical workshop, and given the limited resources at hand, participants agreed that it was necessary to prioritize actions. Which ones were practicable and which ones could be effectively achieved? One direction was to focus on the worst forms of child labour. Another was to target support for those children where both parents have died.

On the issue of targeting responses, it was noted that working children were not a homogenous group: they differed according to age, gender, type of work, when and where that work was performed and household situation. A question was also raised about opportunity costs, where some households with children in school had to forego any income a child might earn. In this light, it seemed reasonable to target very vulnerable and destitute households with financial and material support. Targeting as a strategy also arose within discussions about how to channel assistance to orphaned and vulnerable children:

- through the children themselves (especially relevant for child-headed households or households where child abuse was apparent);
- through households;
- through schools; or
- through orphanages and rehabilitation institutions.

With each option, it was agreed that monitoring and accountability were important.

The workshop concluded with the drafting of a strategy plan on addressing HIV/AIDS and child labour. Through the country teams, numerous ideas for practical action were offered for application by the organizations represented at the workshop. The strategy plan is available from ILO/IPEC.

Appendix 4

ILO/IPEC Tripartite Workshop on the Impact of HIV/AIDS on Child Labour in sub-Saharan Africa
(Lusaka, 6-8 May 2003)

Participants' strategy paper

Introduction

In sub-Saharan Africa more than 11 million children are AIDS orphans,[1] and by 2010 an estimated 20 million boys and girls will be either single or double orphans. The research findings from community-based and advocacy organizations, universities and international organizations such as the ILO, UNICEF, UNAIDS, World Bank, UCW,[2] on HIV/AIDS, child labour and child protection, confirm the link between child labour and HIV/AIDS. In fact, for a child, the loss of the mother or the father (or both) has a strong link to her/his economic exploitation, as orphans are twice as likely to work than non-orphans.

The HIV/AIDS-induced child labour problem poses a significant threat to the successful fulfilment of obligations and commitments created by international Conventions and agreements. Current strategies aiming to combat child labour do not adequately account for this new problem; therefore, ILO/IPEC should assist member States, in coordination with different social partners and other international organizations, to pursue a strategy[3] which:

- reinforces national and international commitments to combating HIV/AIDS-related child labour;
- identifies key areas of intervention and stimulates time-bound action from a gender perspective;
- fosters cooperation and communication between social partners, communities and NGOs;
- raises awareness of HIV/AIDS-related child labour through formal and non-formal education and sharing of information;
- reduces the risk of child labourers contracting HIV/AIDS.

The participants in the Tripartite Workshop on the Impact of HIV/AIDS on Child Labour in Lusaka (6-8 May 2003) called for further and intensified action on the following prioritized areas in order to achieve a number of objectives and policy options.

[1] UNAIDS, UNICEF, USAID: *Children on the brink: A joint report on orphan estimates and programme strategies*, 2002.

[2] ILO, World Bank and UNICEF inter-agency research project on "Understanding children's work".

[3] Bearing in mind the "Education for All Goals", the UNGASS commitments from the United Nations Special Session of the General Assembly on Children (2002) and on the United Nations Special Session on HIV/AIDS (2001), the Fourth World Conference on Women (Beijing, 1995), as well as the relevant ILO Conventions (i.e. Nos. 138, 182); the Convention on the Rights of the Child; the United Nations Millennium Goals, and the ILO Code of practice on HIV/AIDS and the world of work.

1. Education, information and awareness-raising

> **Objective 1**
>
> Awareness and understanding of the problem of HIV/AIDS-induced child labour, as well as issues related to prevention, are increased through an enhanced communication flow within families, communities and educational institutions.

- Sex education for children, as well as teachers is provided through teachers committees, parents and teacher associations, teacher training and teacher refresher courses.
- Schools and teachers' unions are involved as catalysts in AIDS and child labour prevention.
- Non-formal and informal channels of education, including peer education, on HIV/AIDS and child labour are effectively used to reach out for boys and girls who are not in the formal system of education.
- HIV/AIDS and child labour prevention issues are incorporated in the current networks dealing with child protection in sub-Saharan Africa.
- Boys, girls, youth parliaments and councils, parents' and teachers' associations, etc. are mobilized in order to disseminate information on the negative impact that the HIV/AIDS pandemic creates, including increased child labour and its worst forms.
- The International Programme on the Elimination of Child Labour (IPEC) and other international agencies, in coordination with community-based organizations, intensifies information and dissemination campaigns on the joint problem of HIV/AIDS and child labour.
- In the framework of the combat against commercial sexual exploitation of boys and girls (CSEC), campaigns against sexual tourism in countries affected by HIV/AIDS are intensified.
- Books and school material for boys and girls and adolescents are prepared and adapted, as appropriate, on the topic of AIDS and child labour.
- Formal and non-formal education systems, including vocational training programmes, assist in building knowledge of teachers, children on HIV/AIDS and child labour issues, including the importance of using condoms, avoiding sexual intercourse with multiple partners, the health risks of certain traditional practices,[4] and the importance of changing prevailing male sexual norms.
- The network of HIV/AIDS and child labour practitioners created by the Lusaka Workshop on the Impact of HIV/AIDS on Child Labour in sub-Saharan Africa (6-8 May 2003) is maintained and reinforced.

> **Objective 2**
>
> Community and faith-based organizations, as well as grassroots associations, are mobilized in order to ensure appropriate and sustainable responses and increased awareness on the problem of HIV/AID-induced child labour.

- Information seminars and training of trainers sessions (TOT), with community and faith-based organizations, parliamentarians, mayors and local leaders, on the theme of AIDS orphans and child labour are organized to ensure sustained advocacy.
- Men, male adolescents, and boys are sensitized on the implications of current male sexual norms on HIV/AIDS spread and sexual exploitation of girls and boys. The same applies for women on a smaller scale.
- Women, men, girls and boys at the grassroots level (including the informal sector associations) are engaged to develop concrete initiatives for preventing child labour and HIV/AIDS.
- Support and training on child rights is provided to HIV/AIDS orphans' foster families.

[4] Such as female genital mutilation (FGM), using the same blades for circumcision, body beauty marks, shaving the dead and his/her family members in funerals, etc.

- Orphanages capacity to deal with the growing number of AIDS orphans is enhanced.
- Traditional healers and faith-based organizations are sensitized regarding the risks of campaigning against adolescents' decisions to use condoms.

Objective 3

The media play a key role in combating child labour related to HIV/AIDS.

- A training course and accompanying training packages for journalists and the media on how to portray the complex problem of "HIV/AIDS-induced child labour" is undertaken.
- A media network on HIV/AIDS and child labour for sub-Saharan Africa is created.
- All possible means such as TV, radio, artists, musicians and soap operas are applied as mobilizing tools.
- Materials for the press are prepared (brochures, pamphlets, CD-ROMS, photo libraries, fact sheets, web pages, etc.).
- The media are used as a means to improve intra-family communication on the topic of HIV/AIDS and child labour.
- The media are used to increase global awareness on the issue of HIV/AIDS and child labour.

2. Policy, programme, and research

Objective 4

The ILO's tripartite constituents, in coordination with IPEC and other partners, target responses to the AIDS orphan and child labour crisis and raise funds to combat it.

- Information is shared among the tripartite partners of the ILO on HIV/AIDS and child labour.
- Training materials for trade unions and employers on HIV/AIDS and child labour are made available.
- The ILO's tripartite constituents and other stakeholders[5] are encouraged to take part in coordination and networking of activities targeted at the elimination of "HIV/AIDS-induced child labour".
- Bipartite mechanisms, such as collective bargaining agreements and employment codes are used in order to introduce the question of HIV/AIDS and child labour.
- Workers' and employers' organizations, as well as civil society, and other relevant groups apply pressure to different ministries, national AIDS councils and funds in order to ensure sustainable funding for HIV/AIDS and child labour action and research.
- National authorities, with the assistance of its social partners, identify legislation that needs to be revised or adopted in order to combat child labour in the framework of the HIV/AIDS crisis.
- National authorities, in coordination with the ILO social partners, take deliberate measures to facilitate the distribution, through the workplace, of anti-retroviral drugs (ARVs) for workers, employers and the community at large.

Objective 5

Time-bound programmes for the elimination of child labour mainstream HIV/AIDS concerns into national planning processes, legislation, research and resources.

- Local resource mobilization is undertaken through existing mechanisms such as the national AIDS councils, funds for children, ministries.

[5] Community-based organizations, civil society, NGOs, faith-based associations, boys and girls, the private sector, families, pressure groups, women's organizations, youth organizations.

- Indicators on HIV/AIDS are included in the impact assessment of programmes and policies targeted at the elimination of child labour.
- HIV/AIDS concerns are mainstreamed in current projects dealing with hazardous child labour, commercial sexual exploitation of children and domestic work.
- The Poverty Reduction Strategy Paper (PRSP) process is used as an entry point for HIV/AIDS and child labour consideration.
- National AIDS Councils and AIDS focal points in ministries of health and education, include child labour components in their work.
- Ministries of finance, planning, labour, health, education, women/gender, secretariats and national AIDS commissions are involved in the planning process and activities dealing with AIDS and child labour to ensure enhanced funding for the needed interventions.
- District-level resources and leadership are used in the fight against HIV/AIDS and child labour.
- Political parties are involved in the integration of HIV/AIDS and child labour issues in decision-making.
- Existing national funds allocated for HIV/AIDS prevention progressively integrate the child labour dimension in a gender-sensitive manner.

Objective 6

Existing national and international research institutions encourage research and programmes on HIV/AIDS and child labour, as well as the development of standardized guidelines.

- Stakeholder workshops, organized at the national level on the topic of the impact of HIV/AIDS on child labour, are held in different sub-Saharan African countries in order to establish detailed action plans.
- National databases, repository centres and archiving methods are created with the assistance of IPEC's statistical and monitoring programme (SIMPOC), on HIV/AIDS and child labour, ensuring the confidentiality of the information.
- National research institutions produce, with the financial assistance of donors, gender-disaggregated quantitative statistics and qualitative research on the links of AIDS orphanhood, socio-economic circumstances and child labour.
- Goals, indicators and targets are set, and monitoring mechanisms are identified, for the prevention/combat of the HIV/AIDS-induced child labour problem from a gender perspective.
- A comprehensive inventory of "Who is doing what?" in the field of HIV/AIDS and child labour, including an inventory of all research and programmes done in the area of HIV/AIDS and child labour, is drawn up.
- The concept of poverty as a main cause of HIV/AIDS prevalence and child labour perpetration in sub-Saharan African countries is disaggregated in terms of gender, ethnicity, class and age in order to find tangible and short/medium-term solutions to the problem.
- Good practices are further compiled and disseminated widely with a view to replicating and scaling up the pilot interventions on HIV/AIDS and child labour from district to national level, as well as influencing national policies on the subject.
- A supplement to the ILO Code of practice on HIV/AIDS and the world of work is drafted and adopted by the ILO tripartite constituents in order to fully reflect HIV/AIDS and child labour concerns.