

Unto the Thousandth Generation? The Reproduction of Risk Among Thai Youth Affected by HIV/AIDS

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Abstract:

It has been suggested that vulnerability to HIV-infection may be transmitted inter-generationally, that youth who experience a parent's AIDS-related death may as a consequence fall into marginal social and economic circumstances, which increase their risk of becoming HIV-infected. While the epidemic is still too recent and the incidence of orphanhood too rare to evaluate the long-term impact of AIDS on affected children in Thailand, it is possible to begin to examine the types of environmental risks to which Thai AIDS orphans are being exposed and the actions taken by their guardians to protect the children from these risks. This study examines the circumstances of Thai youth who have lost one or both parents to AIDS-related causes. Using data collected through interviews and focus group discussions in peri-urban and rural communities in Chiang Mai province, it examines the caregiving arrangements for AIDS orphans, the problems experienced by households caring for AIDS-affected children and the strategies which these families have devised for coping with these problems.

Introduction

As the global AIDS pandemic matures, increasing attention is being focused on its broader social and economic ramifications. Of particular concern in this respect is the impact which AIDS-related morbidity and mortality will have on children whose family members suffer from the disease. Children are generally more vulnerable than adults to the effects of family crises since they lack the resources to distance themselves from problems in the home. Furthermore, familial disruptions have particularly profound consequences for children, since they are engaged in time-dependent developmental tasks which have significant implications for their life chances in years to come (Lyons, 1997; Pierce, Sarason and Sarason, 1996; Hunter and Williamson, 1998). Children's welfare is an especially focal concern in the context of HIV/AIDS since the disease strikes disproportionately at adults in their prime years of family formation. This means that a large share of the households in which AIDS deaths occur contain at least one child of dependent age. Furthermore, since the disease is sexually transmitted, it is common for more than one adult in the household to be HIV-infected.

In Thailand where more than 600,000 people have already succumbed to AIDS and 600,000 to 800,000 are presently HIV-infected, there are estimated to be between 75,000 and 100,000 children under fifteen years of age who have lost at least one parent to AIDS-related causes (Save the Children, 1998; Centers for Disease Control, 2001). Furthermore, for every child who has been orphaned by the disease there are as many as twelve others who are living with a mother who is HIV-infected (Brown and Sittitrai, 1995). Despite the potential scope and gravity of the orphan crisis, our present knowledge of these children and the circumstances under which they are living is quite limited. There have been only sporadic efforts to gather information on such basic questions as the children's custodial arrangements, the socio-economic status of the households in which they reside, the composition of these households, and the problems which they and their caregivers are experiencing.

To address this gap in the knowledge base and to provide a grounded basis for policy development and intervention planning, the author is undertaking a longitudinal study of the welfare of Thai AIDS orphans and their informal care providers. Preliminary data for this study gathered through semi-structured interviews and focus group discussions form the basis for this conference paper which discusses the challenges faced by AIDS orphans and their familial caregivers as well as the strategies which families are employing to minimize the disadvantage which AIDS-affected children face by comparison to unaffected peers.

Drawing Lessons from the International Literature on AIDS Orphans

It is useful when considering the effects of AIDS on children in Thailand, a context in which this issue has been little studied, to draw insights from related inquiries carried out in other parts of the world. Of particular interest is the small but growing body of research on HIV/AIDS and children in sub-Saharan Africa, a region of the world which has close parallels to Thailand in terms of the duration of the epidemic and the (predominantly heterosexual) pattern of disease transmission (Mann, et al., 1992).

Custodial/Fostering Arrangements

One of the broadest concerns relating to the impact of AIDS on children in low- and middle-income countries relates to the availability of appropriate care and support for young people who are left orphaned. Early studies of AIDS' impact on African social systems suggested that there could be widespread child abandonment (Hunter, 1990; Preble, 1990), and indeed, studies in Eastern and Southern Africa have documented a rise in the number of child-headed households, especially in communities which have borne an extremely heavy burden of disease (Foster, et al., 1997; Urassa, et al., 1997).

The experiences of these children notwithstanding, the general consensus in the literature is that the majority of the AIDS-affected children in Africa are being provided for by family members or, less commonly, neighbors (Foster and Williamson, 2000). Investigations of the patterns of child fostering in sub-Saharan Africa, both in the context of AIDS and more broadly, suggest that children tend to be fostered by members of their extended family or clan with the probability of a child being placed with a specific relation (or alternatively, the perceived desirability of that kinsperson as a foster caregiver) being determined by a constellation of factors including: the relative's geographic proximity, occupation, economic status, social linkages to the child's parents/nuclear family and their kinship relationship to the child him- or herself (e.g., there might be a norm of fostering children with maternal relatives) (Aspaas, 1997). These preferences are culturally specific and vary within as well as across countries.

To date there has been little written about child fostering practices in Thailand, although there are at least two forms of child fostering mentioned in the literature. Richter and colleagues (1992, 1996) have described a fostering arrangement which appears to be widespread among young mothers from rural communities in the Northeastern region. During the dry season when agricultural (and other) employment is hard to come by at home, women from these communities leave their children behind in the care of the children's (typically, maternal) grandparents and travel with their husbands to the city (Bangkok) in search of wage labor. In some parts of the Northeast, this practice is said to be so common that in the dry season the village is populated exclusively by elderly persons and young children.

A second form of fostering, which has been observed in Thailand but remarked upon only indirectly in the literature (see, for example, the discussion of *buun khun* in Mulder, 1996), is the de facto adoption of a child by a maiden aunt, typically a maternal relative. By contrast to children left temporarily with their grandparents, who are still supported economically by their parents, children placed in the care of never-married aunts appear to be raised within any regular inputs or contributions from their biological parents (apart from such contact which these adults would normally have with a niece or nephew).

Economic Marginality

Arising in conjunction with and compounding the other forms of disruption and displacement associated with becoming an orphan is a change in a child's economic circumstances. The economic insult associated with AIDS typically begins while the child's parent is still alive but already sick with AIDS-related illnesses (Ainsworth, 1997; Cross, 2001; deGuzman, 2001). During this period family wage earners' absence from the workforce and costs associated with the patient's medical care begin to erode the household's standard of living, and the damage is often cumulative with the household sustaining multiple illnesses and/or deaths with an insufficient gap between these events to allow for their recovery. Mtika (2001) refers to this progression as a weakening of the household's "social immunity" and demonstrates that in Malawi it has implications for household food security.

In Thailand, the cost to a household of a single AIDS case has been estimated at between \$30,000 and \$50,000 (US). This estimate includes not only direct medical and funeral expenses but also lost labor, travel expenses and other indirect costs (Pitayanon, et al., 1997). The variation in this figure is attributable in large part to the nature of the household members' participation in the formal economy with households composed of more working members suffering a greater economic loss than those with fewer wage earners. As the authors hasten to point out, however, the burden which AIDS creates on a household follows an inverse relationship with poorer households - typically those with more dependents and fewer persons formally employed - suffering greater hardship in conjunction with the AIDS death. This is because they have fewer resources upon which to draw during times of crisis and so are more dependent on maladaptive responses such as the sale of productive assets and reductions in the consumption of high quality foods, educational and health services, all of which build the household's earning potential and resilience to crisis over the long term.

Among the poorest households the most common means of making up for shortfalls in income and/or savings was to borrow money from extended family members and in this way even members of the extended family are financially taxed by an AIDS death. This means that the households taking in AIDS orphans as foster children are likely to have suffered a significant drain on resources just prior to or coinciding with the child's/children's arrival. Where these households are headed by elderly grandparents, who may have been dependent on the deceased adult for some or all of their own upkeep, the situation is dramatically more severe, and surveys of the Thai elderly suggest that as many as half receive regular assistance from their children (Chayovan and Knodel, 1997).

Elder-headed households – especially those in which there are no working aged adults present – are also significantly more likely than younger households to be living in poverty and have lower per capita incomes on average than do the younger households. A family economic

survey in Thailand confirms that 17.9% households headed by persons over 70 years of age are impoverished (UNDP, 2000) as compared to less than 1% of all households (Ahuja, et al., 1997). Furthermore, household incomes decline as the age of the head of household exceeds the prime working age (Campbell, et al., 1993).

So, it is likely that many AIDS-orphans will be moving into homes that are significantly less affluent than those into which they were born or that the households in which they continue living become impoverished in the wake of their parent's death. It is not known how effectively fostering families can stave off these effects by sending retired or otherwise economically inactive members back into the paid workforce, shifting resources among members of the extended household, changing patterns of production or consumption, or other coping mechanisms.

Not all children face comparable circumstances within a given family configuration. Research in Africa suggests that the plight of children - even siblings - can vary significantly based on the children's age and gender. Younger orphans are, of course, the most vulnerable in terms of their dependence on the care of others. However, they are also most likely to be taken in by members of their extended family who can raise them as their own children. On the other hand, these children who will remain in a dependent status for a longer period of time following their parents' death will be more likely than their older siblings to suffer a second disruption (such as the death of a second parent or elderly caregiver) during their period of custodial placement. They may thus face multiple disruptions over the course of their development.

Older children are both more of a burden and more of a contribution to the family who takes them in. In an agricultural setting and/or a low skilled economy, pre-teens and teens may have the necessary credentials to contribute to or even sustain entirely a household's economy. So, rather than investing scarce capital in high school enrollment costs, foster care providers may encourage these youngsters to leave school in order to join the subsistence economy or paid labor force. This tendency has been confirmed by studies in rural Africa which have shown a pronounced decline in the rates of school enrollment linked to the spread of HIV/AIDS. However, data shortfalls in these areas have made it difficult to attribute these declines specifically to the absence of AIDS orphans from the classroom (Foster and Williamson, 2000). In more skilled labor environments in Africa (i.e., urban areas) and presumably in Thailand, the rising skill-base of the labor force has decreased both the earning potential of unskilled teens and their desirability as employees. In such settings, then, one might anticipate a higher school retention rate, although conversely the consequences for those who drop out of school in these settings would be much more severe.

Psychosocial Disruption and Adaptation in the Wake of a Parent's Death

Psychological disruption and re-adjustment are among the most direct effect of a parent's illness and subsequent AIDS death on a child. The loss of a parent is, under the best of circumstances, a very traumatic event for a child to endure, and when the death is AIDS-related the disruption is often exacerbated by the extended period of illness and anticipation preceding the death and the secrecy and stigma surrounding the disease (Dane, 1994). As is true with many mental and emotional health issues, the psychosocial dimensions of childhood AIDS bereavement have been better studied in the industrialized world than in developing countries. Studies of American children living with a mother who is HIV-infected reported problems

include feelings of helplessness, a sense of isolation, regressive dependency or alternatively parentification, and psychological disturbance (Reyland, et al., 2002; Siegel and Freund, 1994; Stein, et al., 1999). In addition, American adolescents who had lost a parent to AIDS have shown more emotional stress, conduct and problem behaviors and lower self-esteem than unaffected teens (Rotheram- Borus, et al., 2001).

Studies carried out in various settings in sub-Saharan Africa seem to confirm affective consequences of a parent's illness or death, but these reports do not associate these changes with behavioral problems. In Tanzania, for example, AIDS orphans demonstrated more internalized problems and chronic depression than non-orphans, although they were no more likely to be disciplined in school (Makame, et al., 2002). Pre-teens and teens in Luanda, Angola, also showed an increase in depressive symptoms which were not linked to problem behavior (Poulter, 1997 cited in Foster and Williamson, 2000).

Studies of Thai children and their responses to various life stressors have characterized them as tending more frequently towards problems of over-control (fears, feeling guilty, somatic concerns) – similar to those reported in African children – rather than under-control (arguing, disobedience, cruelty to others), which are characteristic of American children (Weisz, et al., 1993, 1988). It might therefore be anticipated that Thai youth will respond to a parent's AIDS death by internalizing stress rather than acting out.

Methods

Preliminary research for a longitudinal study of AIDS' impact on orphaned children and their caregivers was carried out in Sansai District, Chiang Mai Province from December 2001-January 2002. This district (roughly equivalent to an American county), which directly abuts Chiang Mai city, experienced very high rates of HIV-infection and large numbers of AIDS cases throughout the 1990s (MOPH, 1997). As a result a large proportion of the families residing in the district have lost one or more members to AIDS-related causes. The district's long and intense exposure to the AIDS epidemic and its socio-economic diversity (communities in the district range from peri-urban to rural and from moderately affluent to impoverished) were among the factors considered in selecting it as a research site as was the principal investigator's pre-existing relationship with members of the district public health office which facilitated access to local communities.

Given the presumed difficulties of defining and recruiting from a population of AIDS-affected households even in an area where exposure to the disease is high, the investigator employed a combined snowball-key informant approach, using local health personnel (para-professionals based at primary health stations in the communities) as an initial point of contact, and worked through these contacts to recruit (anonymously) AIDS-affected families who lived in the target communities. While this recruitment strategy proved a time-efficient and effective way of identifying large numbers of potential informants, it undoubtedly did not result in a sample which was representative of the population of AIDS-affected families in the area – much less on a regional or national scale – as will be discussed further in the results and analysis sections. The limitations of this recruitment strategy were accepted at this stage in the study design process, however, since the goals of this preliminary data collection effort were first to assess difficulties in identifying and enrolling study participants and secondly, to inform subsequent data collection efforts including the scope of qualitative interviews and the construction of a quantitative survey

instrument.

The initial research design called for two forms of qualitative data collection: semi-structured interviews with community-based health workers (key informants) and focus group discussions with caregivers for children who had lost at least one parent to AIDS. This strategy was later supplemented with additional unstructured interviews carried out with a group of caregivers whom it was found had been systematically excluded from the focus group discussions.

Semi-structured Interviews with Public Health Personnel

Semi-structured interviews were carried out with two types of informants, government health care workers (four para-professional working at community-based primary health stations and one visiting nurse from the provincial hospital who was providing additional services in several of the target communities). The interviews were conducted by the principal investigator in Thai in the back room of the community health centers or in the informants' private residences (on the grounds of the health center) and averaged between 45 minutes to an hour in length.

Topics of discussion included: a brief history of the AIDS epidemic as experienced in that community, trends in local attitudes towards persons with AIDS and their family members, AIDS-related interventions sponsored either by the government or non-governmental organizations, estimates of the number of AIDS-affected children living in the community and the health worker's perceptions of the problems faced by families caring for these children.

Focus Group Discussions with Caregivers for AIDS-Affected Children

Three focus groups consisting of six to eight persons each were convened at the primary health center in three different (non-adjacent) communities. In two cases these groups, whose composition was determined by a health worker based in the community, were composed entirely of grandmothers who were caring for pre- or primary-school aged grandchildren who had lost both parents to AIDS. In the third case, the group also included two parents (a couple) who were HIV-infected (the woman had AIDS) and were making plans for their children's long-term care.

The focus group discussions lasted between 60 and 90 minutes and were moderated by the principal investigator. They covered topics including: the perceived prevalence of HIV/AIDS in the community, the attitudes of local residents towards PWAs and their family members, the attitudes of local residents towards children affected by HIV/AIDS, the problems experienced by households caring for children affected by HIV/AIDS and the strategies used for addressing these problems.

Interviews with Caregivers for AIDS-Affected Children

Unstructured interviews were carried out with three informants who were caring for primary-school aged children who had lost one or both of their parents to AIDS. The informants were known to the investigator based on prior research in their communities but had not been approached by local health workers to participate in the focus groups convened in their communities. All three of the informants interviewed on this basis were the paternal aunts of the children in their charge, and all three were single (never married) and living with their surviving parents in the parents' home.

Discussions with these informants, which were not conducted as formal interviews but were carried out with the informants' knowledge that the information was being collected for the

purpose of a scientific investigation, covered topics which included: the process by which the orphaned child had come to reside with the informant, problems encountered in caring for the child and strategies for addressing these problems and perceptions of AIDS-affected children in the community.

Results

Assignment and Ordering of Preference among Potential Familial Caregivers

In the focus group discussions both parents and grandparents of AIDS-affected children expressed the view that grandparents were the most appropriate caregivers for children whose parents had died or were unable to provide care. Not only were grandparents described as experienced caregivers to young children, with most of the elder generation having raised several children to adulthood, but it was also believed that they shared the parents' interest in and affection for the children to a degree unmatched by other potential foster caregivers. Indeed, several respondents specifically contrasted the attitudes of a (hypothetical) grandparent with those of (an equally hypothetical) aunt or uncle, saying that the latter would favor their own (natal) children over the fostered child (*thaa mii arai ja tong hai luuk khong khow kon*).

Another reason given for preferring grandparents as caregivers was that they were seen as having fewer obligations which competed with child-rearing. Grandparents – and grandmothers, in particular, were described as being “at home” and available to provide childcare. However, this claim was often contradicted later in the discussion when grandparents who were caring for orphaned grandchildren described the need for them to resume economic activities outside of the house in order to meet their vastly inflated economic needs.

A small but noticeable difference was noted in the way in which the aunts who were caring for their orphaned nephews or nieces responded to questions regarding the choice of foster caregivers. By contrast to the parents, grandparents and health workers questioned, most of whom defined familial caregivers exclusively in terms of grandparents, caregiving aunts framed their responses more broadly, saying that children should be placed in the care of “someone who was a relative” (*khon pen yaat*) or of “a family member who could take care of them” (*samachik khrop khrua thii duu lae dek dai*). They did not dispute the fact that most families chose to place orphaned children in the care of a grandparent, but rather explained that in their own case such a placement was impractical given their parents' age or degree of infirmity, the amount of energy needed to keep up with a young child or in two instances, the nature of the child in question.

One woman explained, for example, that the 11 year-old boy whom she had been looking after since his father's (her brother's) death six years earlier was a particularly “naughty” boy (*son*) and that others would not put up with him. Another aunt commented that her niece “required a lot of help and attention” (*tong mii khon chuey luey duu lae talot*) which she was able to provide but her parents were not. Since these interviews were conducted after the focus groups had been convened, it was not possible to compare the aunts' responses to those of the grandparents or to compare the demographic characteristics of the extended families involved to see, for example, if the families who had placed children in their grandparents' care had younger relatives in the region who might instead have taken the child in.

Economic Burdens of Child-Rearing

Without exception the dominant concern of caregivers of AIDS-affected children were the costs associated with child-rearing in an increasingly market-based society. Both parents and grandparents bemoaned the costs they currently faced and predicted that their expenses would rise as the children ascended to secondary school. Yet continuation of formal education through the end of secondary school was viewed by both parents and grandparents as a necessity given prevailing trends in labor markets.

Caregivers estimated that the costs associated with a pre- or primary-school aged child's care and schooling, including school uniforms, shoes, books, supplies, lunches and/ or snacks (the cost of which was being subsidized by the community in many cases), and transportation to and from school¹ at approximately 3,000 baht/year. Pre-school aged children were said to have somewhat higher costs associated with their care (compared to primary school aged children) if they were enrolled in private daycare, but slightly lower costs if not. These estimates were exclusive of the cost of various extra-curricular activities (school trips, religious school, computer or English language instruction), which are becoming increasingly common even in rural areas and which were seen by both parents and grandparents as important supplements to the standard curriculum.

For several elderly caregivers who participated in these focus groups, the costs associated with childcare meant that they had to resume or increase their participation in the formal economy. The activities which they took on included (for men) planting an additional crop of rice or other field crops during the dry season² and (for women) preparing food for sale in the local marketplace, working as a domestic in another family's home (outside the village) or business, or laboring on a construction site or in an agricultural field. This last set of activities which were physically very taxing were viewed with particular distaste and concern as to their sustainability over time, given the caregivers' declining health and physical strength. In addition, participation in the formal economy often meant that would-be caregivers were away from the home for several hours a day, making it imperative that they arrange alternative childcare.

Younger foster caregivers (i.e., aunts), all of whom were economical active prior to taking on childcare responsibilities, reported fewer changes in their work activities as a result of fostering. However, they too commented that the costs associated with raising a child were considerable and in two of the three cases (the two less affluent households) informants reported taking on additional work (hiring out as an agricultural laborer, doing additional piecework or projects) and cutting back on their discretionary expenditures to free up resources for the child.

Access to Formal Child Care

Another difficulty identified by all family caregivers interviewed individually and by

¹Only one of the communities in which interviews were conducted had a primary school in close enough proximity to the children's homes to allow the children to walk.

²The norm in these communities was for all land-holding households to plant a single crop of rice which was used for household consumption. A second crop of rice or other marketable crops including garlic, beans, vegetables, chiles, or cut flowers would be produced on the land during the dry season only if the household was dependent on this planting as a source of cash income.

participants in each of the focus groups had to do with the availability of childcare for AIDS-affected children. This was particularly an issue for those whose charges were too young to enter primary school. The inaccessibility of child care stemmed from two causes. The first of these was, the cost associated with placing a child in formal daycare program, such as pre-school, were considerable, exceeding in many cases the cost of primary school (which is provided by the government and so does not charge tuition).

A second obstacle faced by caregivers seeking daycare for their AIDS-affected charges was the climate of fear which still surrounded the disease. Many persons caring for young orphans reported a great deal of resistance from both parents and teachers when they attempted to enroll the children who they were caring for in local preschools or daycare programs. In one community other parents with children enrolled in the local preschool threatened to withdraw their children if an AIDS-affected child was not barred from attending. In another community an aunt caring for a niece who had lost her father (but not her mother) to AIDS reported that she had had to contact several different daycare providers before finding one who had an opening for the child (it was not clear if the school which eventually took the child in knew of her family situation). As a result, the caregiver incurred considerable inconvenience and expense, having to transport the child to and from school each day and paying significantly more for tuition than she would have at the local school.

Asked to explain their communities' resistance to allowing AIDS-affected children to enroll in local schools – a trend which seemed to conflict with their almost unanimous opinion that AIDS-related stigma had declined in their communities – informants responded that local parents still had an exaggerated (though many said, understandable) fear of contagion. As one informant explained:

It is not that they [the other parents] hate/stigmatize (*rangiet*) my daughter (sic), it is just that they are afraid that she has AIDS. If she is playing with the other children and falls down and gets hurt, one of the children may contract AIDS from her blood.

Informants also noted that their neighbors did not trust them to truthfully reveal the serostatus of the children in their care (“Would you tell others that your grandchild was HIV-infected if she looked healthy?” one woman asked). So, local residents presumed all AIDS-affected children to be HIV-infected until such time (typically upon reaching first or second grade) as the child's

persistent good health dispelled their fears.³ Indeed, the aunt who had encountered such resis-

³In Thailand the natural history of pediatric HIV infection tends to follow one of two trajectories. Children born with a high viral load (believed to be those infected early in gestation) show signs of the disease such as failure to thrive and recurrent illnesses in early infancy. These children typically die before their second birthday. Children who are born with lower levels of the virus in their bodies (those infected later in gestation or during labor and delivery) tend to be symptom-free for several years and begin to show signs of declining immune function between the ages of four to six. These children can survive until age eight or ten (Lumbiganon, et al., 2000).

tance to enrolling her niece in the local pre-school reported that she had no problems when her daughter entered the local school in first grade.

Permanency/Long-term Stability of Childcare Arrangements

A final issue raised, often indirectly, by focus group participants were concerns about the longevity of fostering arrangements which placed young children in the care of elderly relatives. The physical strain of looking after toddlers, while juggling domestic tasks and often paid employment, was thought to tax the health of caregivers who were already suffering from fatigue and chronic illnesses such as diabetes and high blood pressure and it was unclear how long such arrangements could be sustained or what would be done should the grandparents pre-decease their charges.

Related to this were discussions (prompted by the moderator) about the possibility of older orphans maintaining child-headed households in the absence of adult providers. Indeed, one such household composed of a college-aged woman (in her early twenties) caring for her younger sister (still in high school) existed in one of the communities in which interviews were carried out. However, all respondents who were questioned about this possibility directly dismissed the possibility that children (even those of post-secondary age) could be left unsupervised. They instead suggested that arrangements would have to be made for the children to move in with distant relatives or neighbors.

Discussion

The results of this preliminary investigation both support and allay fears relating to the welfare and developmental trajectories of Thai AIDS orphans. On the positive side, caregivers for AIDS orphans expressed a strong commitment to this role despite the significant economic and physical hardship which it often entailed. They demonstrated their willingness to make significant sacrifices on behalf of the children in their care and were furthermore attentive to the children's needs, both currently and prospectively. Forward-thinking actions such as putting aside money in anticipation of future educational expenses or reduced household earning potential were reported as were actions aimed at alleviating acute crises.

Despite their efforts and intentions, however, caregivers for AIDS orphans reported problems which might significantly compromise the welfare and life chances of the children in their care. Chief among these were the economic hardships which caregiving families were experiencing. In the absence of quantitative data comparing the economic status of AIDS-affected households to that of their unaffected neighbors, it is impossible to say whether the conditions described by focus group participants were specific to that group or common to many residents of the communities in which they resided. There is, however, reason to believe that the economic status of AIDS-affected households might decline over time as these households age or as they make up for acute shortfalls in cash by selling off durable assets, and these trends should be monitored.

Deserving of particular attention as a possible effect of economic hardship are the implications of this condition for children's educational opportunities and achievements. While caregivers expressed their intentions to maintain fostered children in school through the completion of secondary school, it is unclear if they will be able to make good on this promise. It also seems likely that children from homes experiencing financial hardship – and possibly

those in homes where access to transportation or other forms of support is more limited – will have fewer opportunities than their peers to participate in discretionary activities which may enhance their prospects in the labor market in years to come.

Household stability and the longevity of caregiving relationships is another issue which should be studied over the long-term. With many caregiving households struggling to keep up with the financial and physical burdens of childcare it might be expected that some will be unable to sustain this responsibility indefinitely. What forms of support or alternatives are available if the original foster caregivers must share or relinquish this role? Will the children again be relocated or will they be asked to provide for themselves? Will family members who initially passed up (or were passed over) as custodians for the children become willing and involved caregivers at a later time? Furthermore, what are the psychological implications for the children of losing a second guardian?

Indeed, while neither caregivers nor key informants (health workers) identified psychosocial adjustment as a concern, this issue cannot yet be dismissed as a potential hazard of AIDS orphanhood, especially given the low level of awareness of and concern with mental and emotional health needs in Thai society. Again, this study's small sample size, qualitative methodology and reliance on the indirect reports of family caregivers as its sole source of information on child adjustment precluded more conclusive analysis of the children's adjustment and developmental progress. However, future research should look in greater detail at the impact which the traumatic experience of a parent's death and subsequent family hardships may be having on these children in order to identify if the "exceptional" characteristics enumerated by caregivers of some children were simply normal personality variations or symptoms of psychopathology.

A final insight gleaned from this study and deserving of attention in follow-up research concerns an apparent distinction which informants are making between elderly family members who are caring for their grandchildren and younger adults (women) who have assumed de facto custody of their nieces and nephews. This distinction was suggested both by the exclusion of younger caregivers from focus groups convened by community-based health workers and by the ways in which informants talked about caregiving candidates. While it is too early, on the basis of these data, to assert that this distinction exists, it could have significant implications if borne out, among these the need to investigate the availability of informal support for foster caregivers of different generations and the need to adapt research recruitment strategies to compensate for the (anticipated) under-representation of younger caregivers in samples built through the referrals of key informants.

Conclusions and Implications

Clearly a great deal more study is needed to determine how successful Thai families and communities have been and will continue to be at sheltering their youngest members from the disruptions which inevitably accompany a parent's death. The challenges which families caring for these children face are formidable, among these the high and rising costs associated with child-rearing in a modernizing society and the significant physical and economic constraints upon caregivers, especially members of the third generation who are returning to the role of provider and caregiver after what was presumed to be an indefinite hiatus.

The difficulties which caregivers face are in many cases intensified by lingering

resistance to the inclusion of AIDS-affected children in local preschools and daycare programs. To alleviate this needless tax on caregivers' resources and facilitate the children's integration in the educational system and their local communities, public health officials should take steps to assuage the public's exaggerated and often baseless fears about the dangers which these children – the vast majority of whom are *not* themselves HIV-infected – pose to their unaffected peers. Informational campaigns, like those launched in the mid-1990s to reduce fear and increase the acceptance of HIV-infected adults, could be effectively employed to increase compassion for and reduce the isolation of AIDS-affected children.

For such a campaign to be effective, though, community members must be assured that the safety of their children is not being compromised. It is therefore essential that public health officials work with members of the Ministry of Education to define a set of principals and practices which would bar from the classroom only those children whose health status poses an active risk to the peers but also guards against unsafe interactions between potentially infected/infectious youth and others. This program will likely need to include an outreach and training component directed at the teachers and administrators of pre- and primary schools as well as the numerous individuals providing informal childcare services in their homes.

The provision of some form of respite care, whether organized centrally by the state or by communities locally, could also help to alleviate the burden carried by relatives whose physical and economic resources are being stretched thin by their responsibilities as foster parents. These services, which have no precedent in Thailand, might also prove of value to other community members who face similar time and financial constraints as they attempt to juggle child-rearing with the new reality (for many) of participation in a wage labor economy. The integration of AIDS-affected and unaffected families as beneficiaries of these services might also lessen the stigma AIDS and/or orphanhood in these communities.

Finally, as the deaths of young adults rends holes in the safety nets of many families, leaving children in the care of elders with no intervening generation available to assume economic or custodial responsibilities should the grandparents die prematurely or be rendered incapable of caring for the youth, there is a need to consider the role which formal institutions might play in backstopping informal efforts. AIDS-affected families and communities in Thailand are already putting forth an earnest, sometimes heroic effort, to protect their children and their future, surely the society as a whole would be well advised to invest their resources to leverage these efforts.

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