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Orphans and Vulnerable Children Affected by Sexual Violence and HIV/AIDS in Two Local Government Areas in Anambra State Southeastern Nigeria

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Abstract: The National HIV/AIDS and Reproductive Health Survey indicated that Nigeria has one of the highest number of AIDS orphans in the world, with an orphan population of about 1.4 million children. According to the survey, the planning status of births in Nigeria showed that 10% of all pregnancies are unwanted while 22% are unplanned. Sexual violence is one of the leading risk factors for orphanhood and HIV/AIDS in Nigeria. The study is aimed at surveying orphans and vulnerable children affected by sexual violence and HIV/AIDS in two Local Government Areas in Anambra State Southeastern Nigeria. The survey took place between August 2007 to July 2008 on orphans and vulnerable children aged 0-18 years old, who were direct and/or indirect victims of sexual violence and affected by HIV/AIDS. Data were collected in two Local Government Areas (LGAs): Ekwusigo and Nnewi North LGAs by trained research assistants through focus group discussions, advocacy visits, home-based care visits and during HIV counseling and testing. A Chi-square test was conducted for data analysis. A total of 1192 respondents were interviewed, out of which 628 (52.8%) were males and 562 (47.2%) were females. 474 (39.8%) were paternal orphans, 67 (5.6%) were double orphans and 63 (5.3%) were maternal orphans. 110 (9.2%) children were positive for HIV while total number of 800 (67.2%) parents or primary caregivers were positive for HIV. 475 (39.9%) children were direct and/or indirect victims of sexual violence. There was a close correlation between the HIV status of parent or primary caregivers and victims of sexual violence ($P < 0.05$). Majority of children who were victims to sexual violence obtained such indirectly through their mothers. There was no significant difference ($P > 0.05$) in the HIV status of children between sexes. There is needed more evaluation and interventions to prevent or respond to sexual violence and its profound consequences for the victim's social well-being. Its correlation with risk factors as HIV infection, paternal and maternal orphanhood may result in dropping out of school, homelessness at an early age, as well as stigmatization and rejection by families and communities. Therefore, more attention is needed from researchers, policy-makers and programme designers in this area.

Key words: Sexual Violence · Orphans · Vulnerable Children and HIV/AIDS

INTRODUCTION

Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work"[1]. Sexual violence is both a public health problem and a violation to human rights. It is associated with an increased risk of a range of sexual and reproductive health problems such as unwanted pregnancy, unsafe abortion, STIs and HIV/AIDS, urinary tract infections, chronic pelvic pain, vaginal bleeding or infection. Mental health consequences are just as serious as physical injuries and may often confer increased risk of poor emotional health during the lifetime of the affected

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individual. Mental health disorders related to sexual violence often include depression, post-traumatic stress disorders and sleep difficulties [1]. Sexual violence is sometimes carried out by strangers but more likely by acquaintances, neighbors or relatives. Usually the abuser or violator resorts to scaring, alluring, pressuring or threatening the girl to keep quiet about the ugly incident [2].

Nigeria has a population of 140,003,542 [3], an estimated 900,000 AIDS orphans are currently in Nigeria [4]. The National HIV/AIDS and Reproductive Health Survey [5] indicated that Nigeria has one of the highest number of AIDS orphans in the world, with an orphan population of about 1.4 million children. According to the survey, the planning status of births in Nigeria showed that 10% of all pregnancies are unwanted while 22% are unplanned. Moreover the attitude of Nigerians towards family members living with HIV/AIDS is discriminative. According to the NARHS report, 40% of males and 52% of females in Nigerian do not care about Persons Living with HIV/AIDS. Worldwide, it is estimated that more than 15 million children under 18 years have been orphaned as a result of AIDS. Around 11.6 million of these children live in sub-Saharan Africa [6].

According to experts, 30% persons of the children infected by the virus globally die before their first birthday and 50% before age 2 [7]. AIDS is responsible for leaving vast numbers of children across Africa without one or both parents. In some countries like Nigeria, a greater proportion of orphans have lost their parents to AIDS than any other cause of death. AIDS epidemic has an impact on the quality of life of children and adolescents who suffer successive losses and can be deprived of their parents, occasionally of their relatives and of their own health. AIDS orphans have increased risk of malnutrition when compared to those children living with their parents and they can be stigmatized and discriminated of their or their parents' HIV status, among other unfavourable events [8, 9].

Orphaned children are highly traumatized by loss of parents. Many of them witness physical deterioration, even the deaths of their loved ones. After the trauma of death, many orphans face the disastrous lack of adult attention, guidance and social example. The risks associated with this deficit include; detachment, emotional withdrawal, instability, intimacy, lack of responsibility towards others, poor problem solving skills, tendencies towards angry, resentful and hopeless emotional states, inability to engage in relationships with peer or adults, depression and social marginalization [10]. Orphan-hood is by far the most long-lasting impact of HIV/AIDS pandemic and demands unprecedented efforts from government, civil society and the business sector to strengthen and support communities sa that they are able to meet the physical, emotional and psychosocial needs of all our children. Importantly, these efforts to mitigate this social crisis need to be sustainable into next decades, enabling the children to grow into productive adults.

The study was therefore carried out to assess orphans and vulnerable children affected by sexual violence and HIV/AIDS and to provide baseline data useful for the design of interventions, which will help address the needs of the children affected in Anambra State.

MATERIALS AND METHODS

Study Areas: Nnewi is the second largest city in Anambra State in southeastern Nigeria. Nnewi comprises of two LGAs – Nnewi North and Nnewi South LGAs. Together, nnewi and its satellite towns have a population of about 2.5 million (2005 estimates), with Nnewi itself having an estimated population of 204,252 (2007 estimates) [11]. Its coordinates are 6° 1[1] N, 6°55[1]E and shares boundary with Ekwusigo LGA. The towns that make up Ekwusigo LGA are Ozubulu, Oraifite, Ichi and Ihembosi.

In Nnewi, Afia-Olu festival is an annual event. It is a part of the people's culture that is very dear to them and affords them an opportunity to relax and enjoy themselves at year's end. The festivals are usually very colourful and feature a lot of cultural masquerades and dancers. It creates avenues for a lot of sexual misconduct, where a good number of participants and inhabitants under the influence of alcoholism carry out unsafe coital acts, most which are achieved through coercion.

The Subjects, Ethical Clearance and Advocacy: The Institutional Review Board of Anglican Diocese of Nnewi Health and Community Development Services (ADONHACDS), St' Andrews Church DCC, Nnewi approved the study and permission was obtained from the Anambra State Ministry of Health to get on the study. In each village in each LGA, the purpose of the study was explained to the chief and village elders and their permission to proceed was secured. A house-to-house census of the subjects aged 0-18years was conducted. Information pertaining to their level of orphan-hood was identified. Informed consent was sought and obtained prior to the study after explanation of the procedures and likely benefits from the study. The study was carried out between August 2007 and July 2008, inclusive.

Methods

Focus Group Discussion and Administration of Questionnaires: Focus group discussions were conducted in each of the sampled villages in the two LGAs to fill in the gaps in knowledge. Questionnaires were used to obtain more detailed information on the subject matters raised including whether paternal, maternal or double orphaned, at least one adult died in past 12 months or sick at least 3 months, at least on adult seriously ill for 3 months in the past 12 months, whether the child live outside of family care.

In-depth Interviews: In-depth interviews were conducted to obtain more detailed information on the issues under study. Parents and or primary care givers and orphaned children were interviewed to get a broad and clearer picture of the level of child's orphan-hood and those directly/indirectly affected by sexual violence and as associated with HIV/AIDS amongst the vulnerable children and parents or primary caregivers.

HIV Testing: HIV testing was conducted using the STAT PACK HIV 1 and 2 screening kit.

Statistical Analysis: Data were analyzed using Social Sciences (SPSS) Statistical Package (Version 13.0). Cross-tabulations were generated and *Chi*-square test was applied for this purpose.

RESULTS

A total of 1190 respondents were interviewed, out of which 628 (52.8%) were males and 562 (47.2%) were females. 474 (39.8%) were paternal orphans, 67 (5.6%) were double orphans and 63 (5.3%) were maternal orphans. 110 (9.2%) children were positive for HIV while total number of 800 (67.2%) parents or primary caregivers were positive for HIV. 475 (39.9%) children were direct and/or indirect victims of sexual violence. There was a close correlation betwen the HIV status of parent or primary caregivers and victims of sexual violence ($P < 0.05$). Majority of children who were victims to sexual violence obtained such indirectly through their mothers. There was no significant difference ($P > 0.05$) in the HIV status of children between sexes.

In-depth interviews yielded some striking thematic responses. The responses showed a marked variation in perception as it relates to experience of sexual violence level of orphan-hood, the degree of stigmatization and psychosocial impact on the respondents. The responses also indicated the risk associated with malnutrition when compared to those children living with their parents, while they can be stigmatized and discriminated of their or their parent's HIV status:

"I lost my father at the age of 12 years and then my mother was just a peasant farmer. One day, when I was 17 years old, I was sick and my mother confided in one of my uncles to take care of me. He took advantage of me and raped me. I felt like committing suicide, but he threatened to kill me if in any way I reveal it to my mother" – a 35 years old mother explained.

The impact of coercive sexual advancements on the psychosocial behavior of the affected usually leads to resentful and hopeless emotional states, tendency towards angry and inability to engage in relationships with peers or adults.

"My first coital experience was not negotiated; I was persuaded to do so. It takes the grace of God for me to engage in any prospective relationship in life" – said an 18 years old orphan.

Orphaned children are highly traumatized by loss of parents. The death leads to a disastrous lack of adult attention, guidance and social examples:

"I have no parents, my mother was suspected to have died of AIDS. My relations rejected me, so I resorted to a beggar to be able to feed" – a 12 year old boy.

DISCUSSION AND CONCLUSION

In this study, we investigated on orphans and children vulnerable to HIV/AIDS as well as sexual violence. There was generally a sizeable prevalence of HIV amongst the respondents, though it was lower in orphaned and vulnerable children (OVC) (9.2%) than their parents or primary caregivers (67.2%).

The extent of paternal orphan-hood was higher in Nnewi North LGA (315) than in Ekwusigo LGA (159), though the relative frequency of Ekwusigo supersedes that of Nnewi – 48.0% and 36.6% respectively. The study furthermore identified that the leading cause of paternal death are other health related problems other than HIV/AIDS, such as occupational hazards. The death toll of both father and mother was considerably lower than that of paternal death alone. Children whose parents were living with HIV often experienced many negative changes

Table 1: Sex distribution of characters associated with orphans and vulnerable children to HIV/AIDS in Ekwusigo LGA, Anambra State, Southeastern Nigeria (August 2007-July 2008)

Characteristics	Female	Male	Number	Mean	Std. Deviation
Paternal Orphan					
No	80	92	172	8.5615	4.74103
Yes	86	73	159	9.8786	9.68366
Double Orphan					
No	150	143	293	8.9855	7.86210
Yes	16	22	38	10.8026	4.16799
Maternal Orphan					
No	157	150	307	9.1523	7.73208
Yes	9	15	24	9.7292	4.66946
Parents Chronically Ill					
No	159	158	317	9.2974	7.63851
Yes	7	7	14	6.8571	4.68807
At least One Adult Died in Past 12 Months or Sick At least 3 Months					
No	78	79	157	7.6655	4.50938
Yes	87	86	173	10.5883	9.31566
*Unspecific	1	0	1	8.0000	0
At least One Adult Seriously Ill 3 Months in the Past 12 Months					
No	91	97	188	9.3570	9.05587
Yes	64	59	123	9.1544	4.89353
*Unspecific	11	9	20	7.9080	5.16944
Live Outside of Family Care e.g. institution, street, etc					
No	163	162	325	9.2675	7.57338
Yes	2	3	5	4.0660	4.56281
*Unspecific	1	0	1	11.0000	0
HIV Status of Child					
Negative	124	120	244	9.8119	8.25788
Positive	5	10	15	5.4553	4.41814
HIV Status of Parent or Primary Caregivers					
Negative	93	87	180	10.4750	9.01315
Positive	42	47	89	7.4149	5.13016
Basic Care Package					
No	38	33	71	9.1514	4.70969
Yes	112	123	235	9.2192	8.48528
*Unspecific	16	9	25	9.0800	4.09186
∑	166	165	331	9.1941	7.54846

in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. In one study carried in rural Uganda, high levels of psychological distress were found in children who had been orphaned by AIDS. 12% of AIDS orphans affirmed that they were dead, compared to 3% of other children interviewed [12, 13].

We identified a higher number of parents or primary caregivers positive to HIV (67.1%) which was considerably higher than that of the orphans and vulnerable children (9.2%). The level of vulnerability to orphan-hood was found to be significant since 25.3% of parents are chronically ill. This could eventually lead to the children being orphans. Loss of a parent to AIDS can have serious consequences for a child's access to basic necessities such as shelter, food, clothing, health and education.

Considering the social well-being of the child, sexual violence can have profound consequences for the victims. We identified 475 (39.9%) children who were direct and or indirect victims of sexual violence. Indirect victims were those whose birth were not planned, perhaps their conception was as a result of a persuaded sexual act. At birth most of them were abandoned and rejected. However, available data indicate that as many as one in five women report sexual violence by an intimate partner

Table 2: Sex distribution of characters associated with orphans and vulnerable children to HIV/AIDS in Nnewi North LGA, Anambra State, Southeastern Nigeria (August 2007-July 2008)

Characteristics	Female	Male	Number	Mean	Std. Deviation
Paternal Orphan					
No	241	303	545	6.6067	5.00926
Yes	154	160	315	9.6112	4.79714
Double Orphan					
No	383	447	832	7.6312	5.15628
Yes	13	16	29	9.7931	4.05656
Maternal Orphan					
No	378	442	822	7.7375	5.15644
Yes	18	21	39	7.0000	4.69042
Parents Chronically Ill					
No	253	320	574	6.6734	4.88843
Yes	143	143	287	9.7653	5.00479
At least One Adult Died in Past 12 Months or Sick At least 3 Months					
No	241	304	546	6.6034	4.89931
Yes	154	158	313	9.5838	4.98561
*Unspecific	1	1	2	14.0000	1.41421
At least One Adult Seriously Ill 3 Months in the Past 12 Months					
No	249	307	557	6.6021	4.91347
Yes	145	155	301	9.7104	4.92817
*Unspecific	2	1	3	11.0000	5.29150
Live Outside of Family Care e.g. institution, street, etc					
No	394	459	855	7.7008	5.14219
Yes	2	3	5	7.4000	4.61519
*Unspecific	0	1	1	12.0000	0
HIV Status of Child					
Negative	348	414	764	7.8407	5.17409
Positive	47	48	95	6.6938	4.73575
HIV Status of Parent or Primary Caregivers					
Negative	73	75	148	7.0068	4.63722
Positive	322	387	711	7.8610	5.22660
Basic Care Package					
No	13	10	23	8.6448	4.54196
Yes	10	15	25	6.8968	4.03645
*Unspecific	373	438	813	7.7023	5.18193
∑	396	463	861	7.7041	5.13602

and up to one third of girls report forced sexual initiation [14]. Sexual violence as affirmed in this study goes unreported for the following reasons: shame, fear of retribution, powerlessness, lack of support, high cost of litigation, poor access to justice, inefficiency of police authorities. This complies with the work of Gbadamosi [2].

The results of the study revealed that some cultural practices of the people contribute to the risk factors associated with sexual violence and risk of being infected with the HIV virus. The HIV status of Orphans and vulnerable children and Parents or primary caregivers was higher in Nnewi North LGA than Ekwusigo LGA (Table 1 and Table 2). This results from the fact that Afia-olu festival in Nnewi, which draws national attention, predisposes the inhabitants and participants to a varying level of sexual misconducts.

To respond effectively to the problem of sexual violence, there is a need for reliable data from all regions of the country. Data are needed on the magnitude and nature of problem, its health impact and risk factors.

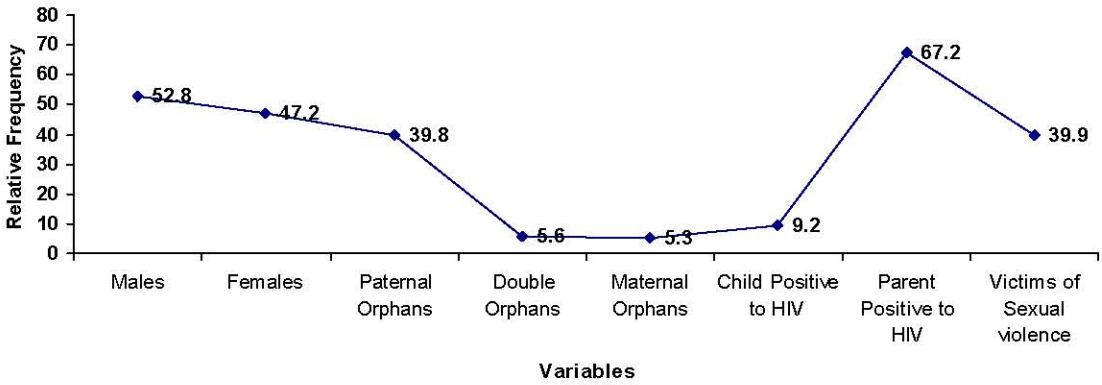

Fig. 1: Percentage prevalence of Important variables in the two studied LGAs in Anambra State, Southeastern Nigeria (August 2007 - July 2008

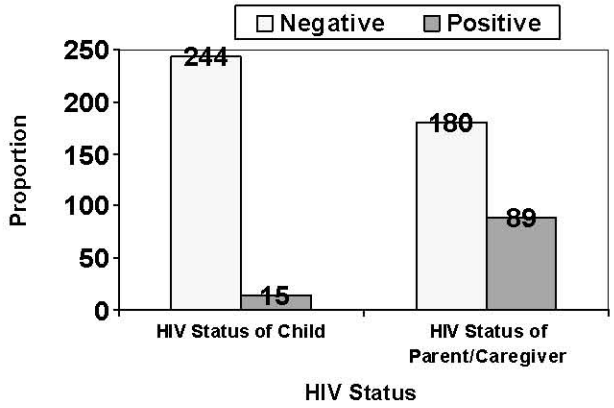

Fig. 2: HIV Status of OVC and Parents/Primary caregivers

Table 3: Age distribution of characters associated with orphans and vulnerable children to HIV/AIDS in Nnewi North LGA, Anambra State, Southeastern Nigeria (August 2007-July 2008)

	Age groups			
Characteristics	0 – 6 / (%)	7 – 12 / (%)	13 -18 / (%)	Total (%)
Paternal orphan				
No	215 (18.0)	264 (22.1)	238 (20.0)	717 (60.2)
Yes	152 (12.8)	157 (13.2)	165 (13.8)	474 (33.8)
Double Orphan				
No	401 (33.6)	385 (32.3)	339 (28.4)	1125 (94.4)
Yes	19 (1.6)	25 (2.1)	23 (1.9)	67 (5.6)
Maternal Orphan				
No	369 (31.0)	312 (28.2)	448 (37.6)	1129 (94.7)
Yes	24 (2.0)	25 (2.1)	14 (1.2)	63 (5.3)
Parents Chronically Ill				
No	307 (25.8)	315 (26.4)	263 (22.1)	891 (74.7)
Yes	150 (12.6)	110 (9.2)	41 (3.4)	301 (25.3)
At least One Adult Died in Past 12 Months or Sick At least 3 Months				
No	291 (24.4)	234 (19.6)	178 (14.9)	703 (53.0)
Yes	153 (12.8)	175 (14.7)	158 (13.3)	486 (40.8)

Table 3: Continued

At least One Adult Seriously Ill 3 Months in the Past 12 Months					
No	249 (20.9)	251 (21.1)	245 (20.6)		745 (62.5)
Yes	140 (11.7)	149 (12.5)	135 (11.3)		424 (35.6)
Live Outside of family care					
No	381 (32.0)	370 (31.0)	423 (35.5)		1180 (93.0)
Yes	1 (0.3)	4 (1.2)	5 (1.5)		10 (0.8)
HIV Status of Child					
Negative	336 (28.2)	342 (28.7)	330 (27.7)		1008 (84.6)
Positive	59 (4.9)	36 (3.0)	15 (1.3)		110 (3.2)
Victims of Sexual Violence					
No	214 (18.0)	262 (22.0)	239 (20.1)		715
Yes	133 (11.2)	141 (11.8)	201 (18.9)		475 (39.9)
				∑	1192 (100.0)

HIV being one of the risk factors for Sexual violence can be arrested in three ways: firstly, new HIV infections must be prevented so that children do not lose their parents; secondly, access to antiretroviral treatment needs to be stepped up; and finally care must be provided for those children who are already orphaned.

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