

**THE CONTRIBUTION OF HIV/AIDS ON FAMILY DISSOLUTION IN MAKETE
DISTRICT, TANZANIA**

BY

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ABSTRACT

The impact of HIV/AIDS on family dissolution is one of the most serious problems facing the world at this era of HIV/AIDS. The traditional African family is collapsing very rapidly due to HIV/AIDS pandemic. Implications of having HIV/AIDS in the family have been documented in many parts of the world. They range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill. Also these problems lead to burdens to the family in terms of human pain, suffering, health care expenditures, school requirements, child-headed households and increased families headed by single parents. Although efforts have been taken by the government and other partners to address these issues, the problems are still rapidly increasing throughout the country and Makete in particular. If challenges that face families are not examined, there is a danger of destroying a large and growing segment of our young population. The overall objective of this study was to determine the impact of HIV/AIDS on family dissolution. The study adopted a cross sectional design by using open and closed ended questionnaires applied to a sample size of 135 respondents. Interviews with key informants, individual in-depth and focus group discussions (FGD) were also used during the study. The analysis of collected data was done using the Statistical Package for Social Sciences (SPSS) and the Statistical Analysis System (SAS). A Logit regression model was used to estimate the influence of socio-cultural, socio-economic and other external factors on respondents' family dissolution. Family dissolution was high (42.6%) among households controlled by widows/widowers. The conclusion is that, family dissolution in Makete is not much affected by migration but is much affected by death of household members and economic hardship of the area. To ease this situation, it is recommended that, among other things, new infections of HIV/AIDS should be

reduced in order to limit the number of widows and orphan headed households and to improve economic well being of the people.

DECLARATION

I, Upendo Attu Sanga, do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my own original work, and has not been submitted for a higher degree in any other University.

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Date

The above declaration is confirmed

Prof. Madundo Mtambo
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Date

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TABLE OF CONTENTS

ABSTRACT.....	ii
DECLARATION.....	iv
COPYRIGHT.....	v
ACKNOWLEDGEMENT.....	vi
DEDICATION.....	viii
TABLE OF CONTENTS.....	ix
LIST OF TABLES.....	xiii
LIST OF FIGURES.....	xiv
LIST OF APPENDICES.....	xv
LIST OF ABBREVIATIONS.....	xvi
CHAPTER ONE.....	1
1.0 INTRODUCTION.....	1
1.1 BACKGROUND INFORMATION.....	1
1.2 PROBLEM STATEMENT.....	3
1.3 JUSTIFICATION.....	4
1.4 OBJECTIVES OF THE STUDY.....	5
<i>1.4.1 General objective.....</i>	<i>5</i>
<i>1.4.2 Specific objectives.....</i>	<i>5</i>
1.5 HYPOTHESIS.....	5
1.6 LIMITATIONS OF THE STUDY.....	5
CHAPTER TWO.....	7
2.0 LITERATURE REVIEW.....	7

2.1 FAMILY TYPES.....	7
2.2 THE IMPACT OF HIV/AIDS ON FAMILY.....	8
2.2.1 <i>The dissolution of the household</i>	8
2.2.2 <i>Reduced labour force</i>	8
2.2.3 <i>Effects of Sex of the head of household to family dissolution</i>	9
2.2.4 <i>Costs for caring HIV/AIDS patient</i>	10
2.2.5 <i>Household poverty and funerals costs</i>	11
2.2.6 <i>Inheritance of widows/ property</i>	11
2.2.7 <i>Impact on children</i>	12
2.2.8 <i>Cut off household basic necessities</i>	13
2.2.9 <i>Children dropout from school</i>	13
2.2.10 <i>Loss of adult members</i>	13
2.2.11 <i>Family size</i>	14
2.2.12 <i>Loss of income</i>	14
CHAPTER THREE	15
3.0 RESEARCH METHODOLOGY	15
3.1 OVERVIEW.....	15
3.2 STUDY LOCATION.....	15
3.2.1 <i>Geographical, administration set up and population characteristics</i>	15
3.3 CONCEPTUAL FRAMEWORK OF THE STUDY.....	18
3.4 MEASURING RESPONDENTS' ATTITUDE ON FAMILY DISSOLUTION.....	20
3.5 RESEARCH DESIGN.....	21
3.6 SAMPLING PROCEDURES.....	22
3.6.1 THE POPULATION.....	22
3.6.2 <i>Sample size</i>	22

3.6.3 Sampling technique.....	22
3.7 DATA COLLECTION METHODS.....	23
3.7.1 Primary data.....	23
3.7.1.1 Structured interview.....	23
3.7.1.2 Focus Group Discussion (FGD).....	24
3.7.1.3 Key informant interviews.....	25
3.7.2 Secondary data.....	26
3.8 Data analysis.....	26
3.8.1 Descriptive statistics.....	26
3.8.2 Regression analysis.....	27
3.8.2.1 Specification of the logistic regression model.....	27
CHAPTER FOUR.....	30
4.0 RESULTS AND DISCUSSION.....	30
4.1 SOCIO-ECONOMIC CHARACTERISTICS AND FAMILY DISSOLUTION.....	30
4.1.1 Sex.....	30
4.1.2 Age of the household head.....	31
4.1.3 Marital status.....	32
4.1.4 Treatment costs.....	35
4.1.5 Working force.....	36
4.1.6 Inheritance.....	37
4.1.7 Family size of the household head.....	38
4.1.8 Education level.....	39
4.1.9 Occupation.....	40
4.2 EXTENT OF FAMILY DISSOLUTION.....	41

4.3 DISTRIBUTION OF LEVEL OF FAMILY DISSOLUTION AMONG HIGHLY AFFECTED AND LESS AFFECTED AREAS.....	43
4.4 SOCIO-ECONOMIC FACTORS RESPONSIBLE FOR FAMILY DISSOLUTION.....	44
4.4.1 <i>Regression model estimation</i>	44
4.4.2 <i>The effect of individual factors on family dissolution Respondents' sex</i>	46
4.4.2.1 Respondents' age.....	47
4.4.2.2 Respondents' education level.....	47
4.4.2.3 Respondents' marital status.....	47
4.4.2.4 Inheritance.....	48
4.4.2.5 Treatment costs.....	49
4.4.2.6 Workforce.....	49
4.4.2.7 Family size.....	50
4.5 THE ROLE OF HIV/AIDS IN FAMILY DISSOLUTION.....	50
CHAPTER FIVE	61
5.0 CONCLUSION AND RECOMMENDATIONS	61
5.1 CONCLUSIONS.....	61
5.2 RECOMMENDATIONS.....	63
REFERENCES	66
APPENDICES	70

LIST OF TABLES

Table 1: A Likert scale for family dissolution.....	21
Table 2: Sex of the household head.....	31
Table 3: Age of the household head.....	32
Table 4: Marital status of the household head.....	34
Table 5: Actual costs incurred due to treatment per month.....	36
Table 6: Working force.....	37
Table 7: Family size of the household head.....	39
Table 8: Education level of the household head.....	40
Table 9: Occupation of the household head.....	41
Table 10: Level of family dissolution in the family.....	42
Table 11: Distribution of level of family dissolution among wards.....	44
Table 12: Analysis of Maximum Likelihood Estimates for family dissolution.....	45
Table 13: Odds Ratio Estimates for family dissolution.....	46
Table 14: Problems experienced by household head and family.....	52
Table 15: Reason for school aged children not attending school.....	54
Table 16: Reason for not living with other family members.....	55
Table 17: The time family member suffered before death.....	57
Table 18: Actual costs incurred due to treatment per month.....	58
Table 19: Contribution of treatment costs to family dissolution.....	59
Table 20: Reasons for family dissolution.....	60

LIST OF FIGURES

Figure 1: Map of Tanzania showing the study area (Makete District).....17

Figure 2: Research framework.....19

LIST OF APPENDICES

Appendix 1: Sample size calculation.....70
Appendix 2: Questionnaire.....71

LIST OF ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ARV	Anti Retrovirus
DSI	Development Studies Institute
FGD	Focus Group Discussion
HIV	Human Immune-deficiency Virus
SPSS	Statistical Package for Social Science
UNAIDS	United Nation Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
NACP	National AIDS Control Programme
NSGRP	National Strategy for Growth and Reduction of Poverty
SNAL	Sokoine National Agricultural Library
SAS	Statistical Analysis System
SUA	Sokoine University of Agriculture
FD	Family dissolution

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background information

The family is the basic unity of a society (Mturi *et al.*, 2005). Family is the central human social unit and has continuously maintained this role for centuries. Family unity means maintaining family identity and togetherness and balancing family priorities with support for individual needs (Mturi *et al.*, 2005). In the African context, the traditional rural societies contains the extended family system which includes several generations plus cousins, uncles and aunts living in a compound or close to one another form the family (Degbey, 2007). This system, with the dominance of the elders aged as the safe of society, has a relatively high degree of social control on the individual especially the youth (Degbey, 2007). The family is responsible for the care and up-bringing of all children. It is a cohesive unity which ideally provides economic (land for farming, etc) social and psychological security to all its members. It defines social and moral norms and safeguards material and spiritual customs and traditions as well as providing a variety of role models preparing the way for adulthood (Degbey, 2007). However, the basic roles played by families have been changing due to change in family structure and composition. For example, nowadays it is common to find families headed by children, and there is increased number of households headed by elderly and widows/widowers (CHG, 2006).

Among many other causes of disruption of the family unity and stability, Human Immunodeficiency Virus (HIV/AIDS) plays a big role. Several studies conducted in various countries like South Africa, Zimbabwe and Zambia found that HIV/AIDS significantly contributed to the disruption of traditional/indigenous families. This is

because HIV/AIDS mostly claims the lives of people who are in their reproductive and productive ages and in most cases are parents (UNAIDS/UNICEF, 1999). Parents who are usually the breadwinners lose their regular income as they fall ill for a long period and eventually die. Many people have perished, and as a result, the traditional family structure is now in a serious jeopardy (Lugalla, 2004). Business and agriculture are suffering a lot from the effect of the HIV/ADS pandemic. This is especially true in Sub Saharan Africa where as much as one-third of the working population is infected with HIV/AIDS (Lamprey *et al.*, 2002). In Tanzania, the most affected groups by the HIV/AIDS pandemic are the youth, women, the poor and the mobile populations (NACP, 1998) which results into changes in family structure and composition.

Historically, during the colonial era the colonial government identified some parts of Tanzania like, Kigoma, Chunya, Sumbawanga, Makete and some parts of Southwest Njombe as labour reserves in order to provide cheap migrant labour to the cash growing areas (Lugalla., 2004). These labourers were paid bachelor wages, slept in dormitory like housing, a situation that forced them to migrate alone without being accompanied by their families (lovers or wives). Unfortunately, a similar situation was adopted by the Tanzania government post independence. Migrant labours have continued to take place, separating married men from their wives, and boyfriends from their girlfriends. In the era of HIV/AIDS pandemic, it has become easier for the disease to spread to partners especially when migrant workers return home for holidays (Lugalla., 2004).

With the intention to maintain family unity, by the late 1990s, many governments, Non Governmental Organizations and major international donors reacted to the growing evidence that one of the impacts of HIV/AIDS is the breaking family integrity and wide

spread of family dissolution. The breaking family unity was due to the adopted coping mechanisms after being affected by HIV/AIDS. The mechanism intends to minimize the impacts and allow households and communities to absorb the loss of members, their incomes, assets and their social responsibilities (CHGA, 2006).

Based on the above changes in family structure and composition as a result of HIV/AIDS pandemic, much attention should be directed in solving the problem. Therefore the aim of this study was to determine/assess the contribution of HIV/AIDS in family dissolution in Makete District.

1.2 Problem statement

As stated in the background information (section 1.1) there is an increasing family dissolution in the recent years (since 1990s) that have led to changes in the family structure or threaten the family system. Nevertheless, there is less information on the contributions of HIV/AIDS on family dissolution in Makete District. Assumptions can be made on what could lead to such dissolutions, one of which being the changing social economic factors like migration to different areas in search for employment away from Makete (Barnett and Blaikie, 1992). However, family conflicts are also reported as a cause of family dissolution.

Many of these structural changes of the family have not been studied in Makete to establish the nature, possible causes and direction of the changes. This study therefore was conducted to establish the contribution of HIV/AIDS towards the ongoing family dissolution in Makete District.

1.3 Justification

The problem of family dissolution in Makete District is immense. If it is not properly contained, a number of families with single parents and those headed by children are likely to increase. Such families are economically and socially disadvantaged. For example, female-headed households normally have poorer access to productive resources (UNAIDS, 2006) and child headed households are faced with problems like dropping out from schools, lack of food, shelter and clothes. Therefore, this research was important to find empirically the ways by which HIV/AIDS causes family dissolution so that interventions might be formulated to reduce the extent of HIV/AIDS causing family dissolution.

The National Policy on HIV/AIDS, among other things, stipulates a target that, during the last two decades the HIV/AIDS pandemic has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population particularly women and men between the ages of 20 and 49 years (URT, 2001). The children under the age of ten years bear the brunt of the impact of HIV/ AIDS and for them the impact is much longer lasting than for adults.

Likewise, the National Strategy for Growth and Reduction of Poverty (NSGRP) which gives special attention to the increased in HIV/AIDS prevalence over the last decade further aggravate the health status and future prospects of Tanzanians. It undermines the foundations of development and attainment of the Millennium Development Goals and National Targets (URT, 2005).

In some countries, HIV/AIDS is undermining progress towards the Millennium Development Goals, particularly those related to poverty reduction, achieving universal primary education, promoting gender equality, reducing child mortality and improving the health of mothers (UNFPA, 2003 cited by CHG, 2006).

1.4 Objectives of the study

1.4.1 General objective

The main objective of this study was to investigate the contribution of HIV/AIDS to family dissolution in Makete District.

1.4.2 Specific objectives

- i. Extent of family dissolution in Makete District.
- ii. Compare levels of family dissolution between highly affected and less affected areas.
- iii. Socio economic factors responsible for family dissolution in Makete.
- iv. The role of HIV/AIDS on family dissolution in the study area.

1.5 Hypothesis

Based on the specific objectives listed above, the hypothesis was tested as follows:

H_A: HIV/AIDS has no significant contribution to family dissolution.

1.6 Limitations of the study

- (i) Lack of data on family dissolution was experienced in this study.

- (ii) Some respondents were reluctant to cooperate during data collection. Some respondents were not willing to give answers to some questions particularly on income. The alternative used to get information of income for that respondent were to ask how much did he/she get from yields, and once he/she decide to sale at what price the sell would be.

- (iii) The research period collided with other research activities in the same area. It was sometimes difficult to get the respondents, also it was difficult to get the pupils head of households till they were back from school. Therefore, the research project spent more time and money than anticipated before.

CHAPTER TWO

2.0 LITERATURE REVIEW

In chapter one, background information on consequences that family face before and after death of one member of the family probably due to HIV/AIDS is discussed. This chapter reviews literature of what is known about family and challenges that they face in light of the HIV/AIDS pandemic and the changes that have occurred overtime is made. Various changes that are happening in societies have brought about drastic effects in family structure and composition. In more recent years, the world has been witnessing remarkable transformation in family structure and composition especially in the developing countries. This has been mostly influenced by the effects of HIV/AIDS in the developing countries, Tanzania inclusive.

2.1 Family types

The definition of family used in this work is adopted from Cherlin's (2004) which identifies two types of families as private and public family. A public family consists of one adult or two adults who are related by marriage, partnership, or shared parenthood, which is /are taking care of dependants. The key part of this family is the existence of dependants, which are children, disabled persons and / or elderly. A private family consists of two individuals (male and female) who maintain an intimate relationship.

As mentioned before; there are many problems which are potential causes of family dissolutions. In the system of life, a family may sometimes face an HIV/AIDS problem which always leads to dissolution of that family.

2.2 The impact of HIV/AIDS on family

2.2.1 The dissolution of the household

Under the impact of HIV/AIDS it appears that a significant number of households cease to exist, especially if the deceased is a man. Basing on the report, a widowed woman may return to her home community and children are taken by the relative of the deceased man. If both parents die, the children are likely to live with other relatives or care for themselves (CHGA, 2006).

Family dissolution seems to follow the death of an HIV/AIDS-infected responsible adult in a family. According to a study in Kwa Zulu-Natal province in South Africa, households where an adult member had died of HIV/AIDS or related causes were nearly three times more likely to have dissolved by the end of the year than other households (CHGA, 2006).

On the other hand, the impacts of HIV/AIDS on households are always very severe. Oftenly the poor individuals are most vulnerable to infection and the consequences are mostly severe including mortalities and family disintegration. A study conducted in Zambia revealed that 65% of households in which the mother had died had dissolved (Hosegood and McGrath, 2004). Following HIV/AIDS affection to the income earners, the family income drops drastically. This accelerates further poverty, difficult life and consequently dissolution of that family.

2.2.2 Reduced labour force

Baier (1997) outlines that household labour quality and quantities are reduced in terms of productivity when the HIV/AIDS-infected person is ill and later the supply of household

labour falls following death of that person. The author further noted that, other household members will devote productive time in caring for the sick persons and traditional mourning customs which can adversely affect labour availability.

The response to labour shortages may be to reduce the area under cultivation for crops. There is also a shift from high labour-intensive to low labour –intensive crops which result into decline in crop yields, reduced ability to control crop pests, loss of soil fertility, shift from cash-oriented to subsistence production and loss of agricultural knowledge and management (Barnett and Whiteside, 2002).

HIV/AIDS pandemic adds to food insecurity in many areas, as agricultural work is neglected or abandoned due to household illness. In Malawi, where food shortages have had a devastating effect, it has been recognised that HIV/AIDS increases the country's poor agricultural performance. It is thought that by year 2020, Malawi's agricultural workforce will be 14% smaller than it would have been without HIV/AIDS (Pembrey, 2006).

2.2.3 Effects of Sex of the head of household to family dissolution

A recent study in Kenya demonstrated that crop production in households where the head of the family died of HIV/AIDS were affected in different ways depending on the sex of the deceased (UNAIDS, 2006). As in other Sub-Saharan African countries, it was generally found that the death of a male reduced the production of cash crops such as coffee, tea and sugar, while the death of a female reduced the production of grain and other food crops necessary for household survival (UNAIDS, 2006). Therefore, the death of household head regardless of sex leads to a family dissolution.

2.2.4 Costs for caring HIV/AIDS patient

The economic and social consequences of the HIV/AIDS disease directly affect the family. In the absence of well functioning medical care systems in African countries, medical costs and caring for sick family members must be borne entirely by the nuclear family or by the extended network. In addition to the medical costs, which include the cost of drugs and traditional medical treatment, funeral expenses of family members are a heavy burden on the family budget (Baier, 1997).

However, taking care of a person suffering from HIV/AIDS is not only an emotional strain for household members, but also a major strain on household resources. Loss of income, additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees push affected households deeper into poverty. It is estimated that, on average, HIV-related care can absorb one-third of a household monthly income (Kaiser, 2002).

Furthermore, research in New Delhi, India, found that average monthly expenditures exceeded income among families living with a member who is affected by HIV/AIDS, partly because of a doubling in purchase of medicines. Families spent fewer resources on children education and entertainment but rather spent more income on care, support and treatment of HIV/AIDS patients. This forced families to sell assets and borrow money from friends and relatives for caring sick persons (UNAIDS, 2006).

Moreover as observed by Msambichaka *et al.* (1997) cited by Mbonile (2004), HIV/AIDS pandemic disrupts the cash flow of households in several ways that include household engagement to traditional healers, households employ hospital personnel or social workers who normally charge by using the number of contact hours or frequency of visits either to the hospital or at home.

2.2.5 Household poverty and funerals costs

Studies in three countries, Burkina Faso, Rwanda and Uganda, have shown that HIV/AIDS will not only retard efforts to reduce poverty, but also will increase the percentage of people living in extreme poverty from 45% in 2000 to 51% in 2015 (UNDP, 2003). In Botswana, for example, household income for the poorest quarter of households is expected to fall by 13% by 2015. Income earners in these households are also expected to take on an average of four more dependants because of HIV/AIDS (UNDP, 2003).

In traditional societies it is common for the deceased to be buried at the place of origin or birth. This has compelled households to incur expenses of hiring vehicles to send the sick or deceased to their home areas. Depending on the distance of the place of birth the expenses range from Tshs150 000 to 500 000 (Msambichaka *et al.*, (1997) cited by Mbonile (2004).

2.2.6 Inheritance of widows/ property

A further impact of HIV/AIDS pandemic in family dissolution is very much related with the problem of widowhood. In the past widowhood in most African societies was solved by the inheritance of widows. The widow inheritance was being practiced in order to ensure the care of widows and children, however, since the inheritance of a woman whose husband has died of HIV/AIDS is very risky, as a result deceased relatives in some societies nowadays are left with one outlet of impoverishing the widow by plundering or confiscating the properties like land, house and other property of the deceased. Sometimes widows have been forced to migrate to other places in order to avoid the plundering or they become so defensive leading to a total separation from relatives of the deceased

husband/wife that further endangers the security of orphans when she/he also passes away (Barnett and Whiteside, (2002).

2.2.7 Impact on children

The impact of HIV/AIDS on children continues to mount in various parts of the world. After illness and death, the impact on children is the loss of their parents' affection, support and protection. The HIV/AIDS pandemic not only causes children to lose their parents or guardians, but sometimes their childhood as well. The emotional shock of losing one parent may be inexorably followed by the death of the other. Separation from siblings is frequent as orphans from large families are often sent to live in different households. Children normally suffer from the psychological trauma, poverty, social dislocation, stigma and discrimination (UNAIDS 2006).

As parents and family members become ill, children take on more responsibility to earn income, produce food and care for family members. It is harder for these children to access adequate nutrition, basic health care, housing and clothing. Fewer families have the money to send their children to school (Pembrey, 2006).

Change in family structure and composition affects family relationships and interaction. The elderly, adults and children are all affected in various ways by the prevailing changes in family structure and composition. In cases where children either live alone or with the elderly, their physical growth and social development is impacted upon. This is due to the fact that the necessary requirements for normal growth which include adequate nutrition, shelter, health, clothing and clean environment are met differently by different families

(URT, 1996). Basing on that fact, children who are in such families are highly affected as a result of the low economic status of their families.

2.2.8 Cut off household basic necessities

A survey conducted in South Africa found that poor households with members sick from HIV/AIDS had reduced expenditure on basic necessities like clothing (21%) and electricity (16%) (Kaiser, 2002). Moreover, because of fall of income, 6% of households were forced to reduce the amount of money spent on food and this predisposed the family members to malnutrition and other deleterious health effects due to insufficient food. (Kaiser, 2002).

2.2.9 Children dropout from school

There are numerous barriers to school attendance in Africa. Children may be removed from school to care for parents or family members, or they may be living with HIV/AIDS themselves. Many are unable to afford school fees and other expenses like school uniforms, books, etc (GCE, 2004). For example, the field survey in Rakai District in Uganda where the husband fell sick from HIV/AIDS, the youngest girl was taken out of school to reduce pressure on the household budget, to help on the farm activities and care for her father (Barnett and Blaikie, 1992).

2.2.10 Loss of adult members

Households and communities already suffering conditions of poverty are usually most harmed by the loss of adult members to illness, including HIV/AIDS. Female and elderly-headed households are likewise least able to cope with the economic, labour and social

and social losses arising from HIV/AIDS. Thus, if we want to know whether households are coping with the impact of HIV/AIDS, we need to include the wider socioeconomic context in the analysis and identify who is affected, and within that group, who is most affected (CHG, 2006).

2.2.11 Family size

In addition to the daily care of people ill with HIV/AIDS or related illness, the care of children while a parent is dying and after the death is a major burden for immediate and extended families. Increasingly, one hears that the extended family system is overwhelmed by the magnitude of the burden of caring for so many orphaned children. The changes in living arrangements, well-being and opportunities for a secure future for children is one of the most significant long-term outcomes of the HIV/AIDS pandemic (CHG, 2006).

2.2.12 Loss of income

The economic impact of HIV/AIDS is significant and often dramatic in terms of changes in income, asset wealth and longer term prospects for economic security. A study in the Free State Province found that HIV/AIDS affected households tended to have monthly incomes one-third less than non-affected households. In Cote d'Ivoire, the income of affected families was half that of total average household income (CHG, 2006).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Overview

This chapter presents the methods used to collect, organise and analyse data in order to investigate the extent of contribution of HIV/AIDS to family dissolution. The chapter is divided into six sections. Section one presents the study location and justification of its selection. Section two discusses the research design which includes the type of respondents involved in the study and section three presents the sampling procedures employed. Section four describes the methods for data collection. Section five presents procedures for data processing and analysis.

3.2 Study location

3.2.1 Geographical, administration set up and population characteristics

The research was conducted in Makete District in Iringa region. Makete is among the seven Districts of Iringa Region. It lies adjacent to the northern shores of Lake Nyasa separated by a steep escarpment. On the northern and eastern sides, it shares borders with Mbeya and Njombe Districts while on the eastern and southern sides, it shares borders with Ludewa District. On the western side it borders with Kyela District. Administratively, Makete District is divided into six divisions namely Bulongwa, Magoma, Matamba, Ikuwo, Lupalilo and Lupila. There are 17 wards, 98 villages and 467 hamlets (Figure 1) (Makete District, 2006).

The district covers an area of 5 800 square kilometres, most of which are steep hills, ridges, valleys and escarpment. The area available for human settlement and agricultural production is 4 194 sq. km. which is equal to 72 % of the total land. The district has two climatic zones, namely highland and lowland zones. The high altitude lies between 1,500 to 3,000 m above sea level, and has a temperate type of climate with temperatures ranging between 2^oC to 20^oC. The lowland of Usangu plains lies on the North East whose altitude ranges from 900 to 1,500 m above sea level; the zone has a hot climate with unreliable rainfall. The District receives heavy rainfall ranging from 1,300 to 1,800 mm per annum. The long wet season starts from November to March and the short rains from April to May. The dry spell is from June to October.

The estimated population of Makete District, according to the Population and Housing Census General Report (2002), was 106 061 with annual growth rate of 0.2 percent (URT, 2004) which is below the average growth rate of Tanzania (2.9%). In 1988 the population was 115 480 people with an annual growth rate of 1.2 percent (Makete District Socio-economic Profile, 2006). The population comprises two ethnic groups namely Kinga and Wanji. The household size for people in Makete according to research findings is 5.2 compared to 3.8 of 2002 Population and Housing Census.



Figure 1: Map of Tanzania showing the study area (Makete District)

3.3 Conceptual framework of the study

HIV/AIDS causes pain and suffering to patients and their families, it imposes a heavy financial and social burden of caring for the sick, and it leaves misery and poverty in its wake. HIV/AIDS, therefore, has serious implications for households, and for national social and economic development (URT, 2001).

The impacts of HIV/AIDS to family dissolution are in turn influenced by a number of factors, which include demographic characteristics (age, sex, marital status, occupation and education), socio-cultural and socio-economic factors.

Figure 1 shows the conceptual framework of the study which is divided into two stages. Stage 1 of the model shows that various demographic factors contribute to family dissolution. In this stage, demographic characteristics are independent variables while family dissolutions are dependent variables. Stage 2 supports that, social cultural impacts and socio-economic impacts as independent variable contribute to family dissolution, the dependent variable. Other factors being equal, HIV/AIDS impacts have a negative impact on family dissolution. It was expected that if a household was affected by HIV/AIDS automatically the family would ultimately experience high costs of caring for the patient and burials leaving heavy burden on the already overburdened households, orphaned and dependants.

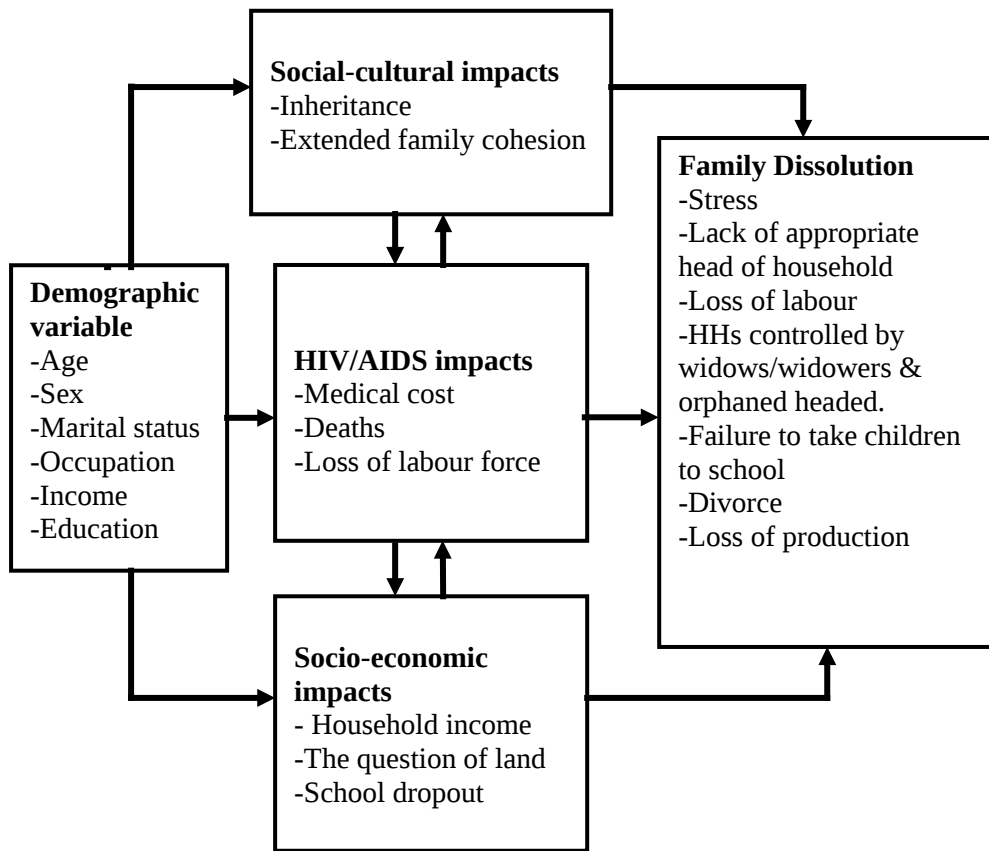


Figure 2: Research framework

Basing on the above conceptual framework, the influence of a number of variables can be explained. For example, it was expected that household heads with primary school education and above have less family dissolution than those below primary school education. These households' heads are more likely to do away with unnecessary social cultural factors like inheritance of widows/widowers, and can at least afford medical costs because of self-employment using life skills obtained during their studies (CHG, 2006). Also these are the people who know the importance of education. Therefore, dropout from school may be reduced from these households.

3.4 Measuring respondents' attitude on family dissolution

As stated earlier, respondents' levels of dissolution in the family were used in various stages to determine how they were influenced by demographic variables, social cultural impacts, HIV/AIDS impacts and socio-economic impacts, and how they were in turn affecting the dissolution in the family. Since dissolution is an abstract variable, a Likert scale was used to collect data on those variables (Mogey, 1999).

According to Bernard (1994) and Mogey (1999), the Likert scale was used to measure attitude of respondents toward family dissolution. For each statement respondents were asked to express one of the following five responses: strongly agree, agree undecided, disagree or strongly disagree on a five point scale. Each degree of agreement was given a numerical value from one to five as shown in Table 1. Thus a total numerical value was calculated from all the responses. Statements indicating contributions of HIV/AIDS to family dissolution were assigned values 1, 2, 3, 4 and 5 for strongly disagree, disagree, uncertain, agree and strongly agree, respectively.

Table 1: A Likert scale for family dissolution

Variable	Mean					
		1	2	3	4	5
1. Family dissolution causes stress						
2. The death of father/mother cause family to lack proper head of household						
3. Loss of labour influence the split of family						
4. Split of family is high among households controlled by widows, widowers and orphaned headed house hold						
5. Failure to take children to school is the outcome of split of family						
6. Divorces cause split of family						
7. Loss of production for several years cause split of family						
8. Split of family is the outcome of change of area						

Note: Data set were based on strongly disagree (1), disagree (2), undecided (3), agree (4) strongly agree (5)

For analytical convenience, the scale in Table 1 was collapsed into three levels (disagree, uncertain and agree). For each statement respondents were asked to state whether they disagree, uncertain or agree as shown in Table 6 in chapter four.

3.5 Research design

The cross-sectional research design was used in this study. This method allowed data to be collected at one point in time. It also helped to establish relationships between variables for the purpose of testing the hypothesis (Bailey, 1998). The method was useful because of time limitation and resource constraints.

3.6 Sampling procedures

3.6.1 The population

The population from which the sample for this study was drawn involved heads of households including ordinary heads of households, widows, widowers and orphaned head of households from the three wards of Iwawa, Lupalilo and Ikuwo.

3.6.2 Sample size

The sample size was 135 households (Appendix 1), 45 households were sampled from each ward and 15 households from each of the three villages of the ward. The sampling frame was obtained from ward and village offices.

3.6.3 Sampling technique

Purposive and simple random sampling techniques were employed for selection of the widows, widowers, orphans and non affected households. This selection was done at different levels such as division, ward and village level. Purposive sampling was used to get wards/villages based on Makete District reports that are the mostly affected areas by HIV/AIDS and the least affected ones. The most affected wards were Iwawa (45 respondents) and Lupalilo (45 respondents) and the least affected ward was Ikuwo (45 respondents) (Gowele, M. personal communication, 2006). Simple random sampling technique was used to select three villages from each ward.

In selecting each village, the researcher listed the names of villages in each ward, and then recorded them on small pieces of papers, folded, shuffled and picked the folded papers at random. The names of the villages that were picked through this method were written in a sheet of paper for each ward. These were Ndulamo, Ivalalila and Isapulano (Iwawa),

Lupalilo, Tandala and Usagatikwa (Lupalilo) and Ikuwo, Matenga and Mlengu (Ikuwo). In each ward an equal number of respondents were selected for the study, the selection was done randomly. The village leaders took the researcher and research assistants to the respondents' households for interview. During the interviews with the respondents; village leaders accompanied the researchers. Participants in the area participated willingly on provision of information needed by the researcher. The permission to carry out this study was granted by District Commissioner before the study started. In addition, village leaders issued the permission.

3.7 Data collection methods

3.7.1 Primary data

3.7.1.1 Structured interview

Both quantitative and qualitative data collection methods were used to obtain primary data. The main instrument for quantitative data was a structured questionnaire containing both closed and open-ended questions (Appendix II). Data collection began on the first week of October 2006 and was completed after six weeks. Both qualitative and quantitative data were collected subsequent to a pilot study conducted in Iwawa ward one week before the main study. The preliminary study survey was used to test the clarity, sequence of the questions and the discussion guides proposed as well as estimated time for each questionnaire.

The revised version of the questionnaire that was used in the study was translated into 'Kiswahili', the national language understood by majority of Tanzanians. The researcher and four trained research assistants administered the questionnaires. Where there were focus group discussion (FGD), the researcher and one research assistant were used to

moderate. During data collection, principal researcher and research assistants worked as a team and each interviewed an average of seven respondents per day. During the field work, the principal researcher supervised the interviews periodically with the aim of making sure that, there were proper data collection procedures and to solve any administrative problems. In addition to that, every day the principal researcher went through the completed questionnaires to check clarity and accuracy of responses.

3.7.1.2 Focus Group Discussion (FGD)

A total of three FGD were conducted in the study villages (of Iwawa, Lupalilo and Ikuwo wards) involving 34 participants targeting influential people, extension staffs, other professionals, village leaders, and ordinary people in order to solicit causes and consequences of the study. The selections were based on their knowledge on family issues. FGDs were made in the village office premises but privacy was maintained. The principal researcher was the discussion facilitator assisted by one research assistant. Gender balance and age distribution was considered during the selection of members; each FGD comprised of 8-10 participants.

All the discussions were conducted in Swahili except in rare cases where Kinga (a vernacular language of Makete people) was used in case a respondent did not understand Swahili. The facilitator introduced the topic and allowed the group members to discuss, all the discussions were recorded (both tape and video) and the discussions were held for about two hours for each session. The FGD were guided by focused topics including causes of family dissolution, consequences of family dissolution, ownership of assets like land and contribution of HIV/AIDS to family dissolution.

3.7.1.3 Key informant interviews

Some of information was collected from key informants such as District Magistrate, Ward Tribunals and all sections which deal with family affairs. Informants were requested to give their views on contribution of HIV/AIDS to family dissolution.

Key informants formulated eight factors hypothesised to influence dissolution to the family. The factors hypothesised to influence dissolution were stress, lack of appropriate head of household, loss of labour, split of the family was high among households controlled by widows, widowers and orphaned children, failure to take children to school, divorces, loss of production for several years and change of area. The respondents were then asked to rank the above factors based on their perceptions on the extent to which they can influence dissolution of the household. This was accomplished by the respondents being required to respond to the statements in terms of whether they strongly agree (SA), agree (A), undecided (UD), disagree (DA) or strongly disagree (SD) with the fact that they influence dissolution to the family. Responses were classified and given weights as follows:

Strongly agree	= 5
Agree	= 4
Undecided	= 3
Disagree	= 2
Strongly disagree	= 1

To develop the dissolution attitude index, the weights of all the selected factors were added up for each of them. The dissolution index shows the level of attitude toward dissolution if a household is affected by those factors.

In the data description; the cut off point between families with dissolution and those with no dissolution was 29. All those which had index less than 29 were given the value 0 others with more than 29 ie from 30 and above were given value 1. Hence our Y was (0, 1) that is:

Y= 0 when a family had scores less than 29 (i.e. family has not dissolved)

Y= 1 when a family had scores more than 29 (i.e. family has dissolved)

The distribution of level of family dissolution among wards were determined, all those which had value 1 were termed as semi-urban (Iwawa and Lupalilo) and the one with value 2 was termed as remote (Ikuwo).

3.7.2 Secondary data

Secondary data has been used to enrich the primary data source. These were obtained from sources such as District Planning Office where data on District profile were obtained; District Magistrate provided information on cases related with deceased properties and the same for Ward tribunal, reports from various institutions and international organizations dealing with HIV/AIDS issues. Additional secondary information was collected from Sokoine National Agricultural Library (SNAL).

3.8 Data analysis

3.8.1 Descriptive statistics

Data from field survey were coded and analysed using the Statistical Package for Social Sciences (SPSS 11.5) and the Statistical Analysis System (SAS). The Statistical Analysis System (SAS) software which is more robust than SPSS was used to run logit regression model. SPSS was used for descriptive statistics such as mean, frequencies proportion and standard deviations to find extent of HIV/AIDS on family dissolution with different

variables. Results from descriptive statistics were used to construct frequency distribution tables.

3.8.2 Regression analysis

The index on variables that influence family dissolution was developed. The index was made using sets of statements which were included in the questionnaire administered to the sample households. Setting of such statements was necessary because it was not easy to solicit information for such variables by asking one question to a respondent. Answers from those statements were entered into factor analysis to determine the most important among the sets of statements determining each index variable.

3.8.2.1 Specification of the logistic regression model

The logit regression model was run to establish the relationship between the dependent (family dissolution) and independent variables.

$$FDL_i = \beta_0 + \beta_1(AGE) + \beta_2(SEX) + \beta_3(OCC) + \beta_4(LEV) + \beta_5(MART) + \beta_6(LWF) + \beta_7(INH) + \beta_8(FMS) + \beta_9(TRC) + \beta_{10}(INC) + e_i.$$

Where:

- AGE = Age of head of household
- SEX = Sex of the respondent (Dummy: 1 if female, 0 if otherwise)
- OCC = Occupation (Dummy: 1 if agriculture, 0 if otherwise)
- LEV = Education level (Years in school)
- MART = Marital status (Dummy: 1 if widow/widow, 0 if otherwise)
- INH = Inheritance (Dummy: 1 if inherited wife/husband, 0 if otherwise)
- FMS = Family size (No. of people in the household)
- TRC = Treatment costs (Tsh)
- LWF = Lost productive working force (Dummy: 1 if lost, 0 otherwise)
- INC = Household income per month (Tsh)
- β_i = Parameters to be estimated
- β_0 = Intercept of the computed regression line
- e_i = Random error term.

The impact of HIV/AIDS on family dissolution was hypothesized as function of workforce, treatment costs, inheritance and family size. Workforce have been more affected by HIV/AIDS since most of those who are infected are between the ages of 20-49 years and this is the potential working labour force (Baier, 1997: Pembrey, 2006 and URT, 2001). Therefore, positive relationship was hypothesized between workforce and contribution of HIV/AIDS on family dissolution.

Treatment cost was hypothesized to have positive influence on family dissolution because treatment cost is associated with major strain on household resources. Taking care of a person sick with HIV/AIDS puts a family into loss of income, additional care-related expenses and mounting medical fees push affected households deeper into poverty (Steinberg, 2002).

Family size was hypothesized to have positive influence on family dissolution, because the care of children while a parent is dying and after the death is a major burden for immediate and extended families. The extended family system is overwhelmed by the magnitude of the burden of caring for so many orphaned children (CHG, 2006).

Inheritance was hypothesized to have positive contribution on family dissolution, deceased wives are more likely to be replaced, the widowed man remarries. However, the children from the previous marriage may still be sent away (CHG, 2006).

Regarding other variables, sex of the household head was hypothesized that being female head of household is more likely to have dissolution than being male. The loss of a male

adult can leave the remaining women and children with fewer economic opportunities and less control over productive assets, including equipment and land (CHG, 2006).

Work force was hypothesized to have positive influence on family dissolution, reduced work force cause family to dissolve. It is estimated that, rural families have reduced their agricultural work or even abandoned their farms because of HIV/AIDS. In Ethiopia, HIV/AIDS affected households were found to spend 11-16 hours per week performing agricultural work compared with an average of 33 hours for non HIV/AIDS affected households (Bojang, 2006).

Meanwhile, sex of respondents, age, marital status, education, occupation, income, and school dropout were not significant predictors ($P>0.05$) of respondents' family dissolution.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

In this chapter, the results of the study are presented and discussed in line with the study objectives and hypotheses. The main purpose of this chapter is to provide detailed information on the contribution of HIV/AIDS to family dissolution. The chapter includes sub-sections on respondents' socio-economic characteristics and contribution of HIV/AIDS to family dissolution.

4.1 Socio-economic characteristics and family dissolution

4.1.1 Sex

Results in Table 2 indicate that most of the dissolved families especially in Iwawa and Lupalilo were female headed compared to non-dissolved families in which most of them were males. Result for Chi-square test revealed these differences to be significant ($P < 0.05$). In contrast, most of the households in Ikuwo in both dissolved and non-dissolved families were male headed. However, there was a noticeable proportion of the households in dissolved families which were female headed compared to non-dissolved families (i.e. 47% vs 22%). These observations could be due to the fact that once men and women have been infected by HIV/AIDS, men are dying more quickly than women (Baier, 1997).

Table 2: Sex of the household head

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 - value	
		Freq.	%age	Freq.	%age	Freq.	%age		
Iwawa	Sex	Male	10	66.7	10	34.5	20	45.5	4.13*
		Female	5	33.3	19	65.5	24	54.5	
	Total	15	100	29	100	44	100		
Lupalilo	Sex	Male	12	60.0	8	32.0	20	44.4	3.53*
		Female	8	40.0	17	68.0	25	55.6	
	Total	20	100	25	100	45	100		
Ikuwo	Sex	Male	21	77.8	10	52.6	31	67.4	3.21NS
		Female	6	22.2	9	47.4	15	32.6	
	Total	27	100	19	100	46	100		

NS= Non- significant ($P > 0.05$), * = Significant at ($P < 0.05$)

4.1.2 Age of the household head

In the current study respondents i.e. head of the households were also asked to state their age. Results from Table 3 reveal that although most of the respondents in nearly all wards had ages between 30 to 44 years, however, there was substantial proportion of respondents in dissolved families (32 to 48%) which had ages below 30 years (i.e. very young), and in non- dissolved families (33 to 35%) which had age above 44 years (i.e. old). These differences in age distribution between dissolved and non dissolved families were statistically significant ($P < 0.05$) in Iwawa and Lupalilo wards. In most African tribes, females tends to get married at younger age compared with their male counterparts, and as the outcome of HIV/AIDS pandemic, males are dying quickly than females. Since most of the dissolved families were headed by females, and furthermore, since some of these families were headed by orphaned children. Therefore, existence of significant proportion

of respondents in dissolved families having younger age compared to non dissolved families is not a surprise

Table 3: Age of the household head

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 - value
		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Age <30	3	20	13	44.8	16	36.4	6.02*
	30 - 44	7	46.7	14	48.3	21	47.7	
	>44	5	33.3	2	6.9	7	15.9	
	Total	15	100	29	100	44	100	
Lupalilo	Age <30	5	25.0	12	48.0	17	37.8	5.65*
	30 - 44	8	40.0	11	44.0	19	42.2	
	>44	7	35.0	11	44.0	9	20.0	
	Total	20	100	25	100	45	100	
Ikuwo	Age <30	4	14.8	6	31.6	10	21.7	2.00NS
	30 - 44	14	51.9	7	36.8	21	45.7	
	>44	9	33.3	6	31.6	15	32.6	
	Total	27	100	19	100	46	100	

NS= Non- significant ($P > 0.05$), * = Significant at ($P < 0.05$)

4.1.3 Marital status

Results from Table 4 indicate that while most of the respondents (42%) in dissolved families in highly affected areas (i.e. Iwawa and Lupalilo) were widows/widowers, a different picture was observed for non dissolved families in which most of them (51%) were married. Results from Chi-square test show the difference between dissolved and non dissolved families in distribution of marital status to be significant ($P < 0.05$). On the other hand, most of the respondents in less affected areas in dissolved and non- dissolved families were married. However, a proportion of widows/ widowers in less affected area of 31% cannot be ignored as this accounts for nearly one third of total respondents in

dissolved families compared to only 10% in non dissolved families. The above observations suggest that family dissolution was common among widows/widowers. This could probably be due to the fact that, female-headed households tend to be among the poorest in the communities because in most African societies women do not own properties like land and major means of production like tractors. These results are in line with the findings by Baier (1997) that widows with dependent children became entrenched in poverty as a result of the socio-economic pressures related to HIV/AIDS.

Table 4: Marital status of the household head

Ward	Parameter		Not dissolved		Dissolved		Total		χ^2 - value
			Freq.	%age	Freq.	%age	Freq.	%age	
Sub-urban	Marital status	Married	18	51.4	18	33.3	36	40.4	14.51**
		Single	8	22.9	7	13.0	15	16.9	
		Divorced/separated	4	11.4	1	1.9	5	5.6	
		Widow/ widower	4	11.4	23	42.6	27	30.3	
		Orphaned	1	2.9	5	9.3	6	6.7	
		Total		35	100	54	100	89	
Remote	Marital status	Married	18	66.7	9	47.4	27	58.7	5.46NS
		Single	5	18.5	2	10.5	7	15.2	
		Divorced/separated	0	.0	0	.0	0	.0	
		Widow/ widower	4	14.8	6	31.6	10	21.7	
		Orphaned	0	.0	2	10.5	2	4.3	
		Total		27	100	19	100	46	

NS = Non-significant ($P > 0.05$), ** = Significant at ($P < 0.01$)

4.1.4 Treatment costs

Results in Table 5 show that, most of the dissolved families in Iwawa and Lupalilo spend more money on treatment costs compared to non dissolved. Result for chi-square test revealed these differences to be statistically significant ($P < 0.01$). The case is not like that for Ikuwo where there were no statistical significant association ($P > 0.05$) between treatment costs and family dissolution. However, 48.0% spent by dissolved families in Ikuwo cannot be ignored compared to 35% of not dissolved. This suggests that family dissolution is common among households spent between 10 000-50 000 Tshs. These results support findings by Bojang (2006) and CHG (2006) that households dissolved probably due to HIV/AIDS spent nearly twice the proportion of their budgets on medical care compared to households not dissolved.

Table 5: Actual costs incurred due to treatment per month

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 - value
		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Cost<10 000	9	60.0	3	10.3	12	27.3	13.00**
	10 000- 50 000	5	33.3	16	55.2	21	47.7	
	>50 000	1	6.7	10	34.5	11	25.0	
	Total	15	100	29	100	44	100	
Lupalilo	Cost<10 000	11	55.0	3	12.0	14	31.1	10.80**
	10 000- 50 000	7	35.0	12	48.0	19	42.2	
	>50 000	2	10.0	10	40.0	12	26.7	
	Total	20	100	25	100	45	100	
Ikuwo	Cost<10 000	16	59.3	7	36.8	23	50.0	2.40NS
	10 000- 50 000	9	33.3	9	47.4	18	39.1	
	>50 000	2	7.4	3	15.8	5	10.9	
	Total	27	100	19	100	46	100	

NS= Non- significant ($P > 0.05$), ** = Significant at ($P < 0.01$)

4.1.5 Working force

It is documented that household's labour quality and quantity are reduced, initially in terms of productivity when the HIV/AIDS infected person is ill, and later the supply of household labour falls with the death of that person. In Table 6 results indicate that households with less working force had highest percent of families' dissolved. The chi-square test statistic showed significant association ($P < 0.01$) for Iwawa and Lupalilo and ($P < 0.05$) for Ikuwo. These findings suggest that families dissolved had less working force than those not dissolved and this is inline with the findings by Baier (1997) that there is a positive relationship between working force and family dissolution due to HIV/AIDS. This is probably because the disease affects the farming population, especially people at their most productive years.

Table 6: Working force

Ward	Parameter	Not dissolved	Dissolved	Total	χ^2 - value
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		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Working force	1	6.7	9	31.0	10	22.7	12.85**
	1-3	6	40.0	18	62.1	24	54.5	
	>3	8	53.3	2	6.9	10	22.7	
	Total	15	100	29	100	44	100	
Lupalilo	Working force	0	0.0	7	28.0	7	15.6	10.75**
	1-3	12	60.0	16	64.0	28	62.2	
	>3	8	40.0	2	8.0	10	22.2	
	Total	20	100	25	100	45	100	
Ikuwo	Working force	1	3.7	6	31.6	7	15.2	8.17NS
	1-3	17	63.0	11	57.9	28	60.9	
	>3	9	33.3	2	10.5	11	23.9	
	Total	27	100	19	100	46	100	

* = Non- significant ($P < 0.05$), ** = Significant at ($P < 0.01$)

4.1.6 Inheritance

The difference between families dissolved and not dissolved in respect to inheritance was explored. Lupalilo ward showed high percentage (57.1) of families dissolved because of inheritance problems compared to those not dissolved. The difference between families dissolved and not dissolved were statistically significant ($P < 0.05$) with respect to inheritance. This implies that family dissolution was associated with inheritance. The findings of this study was in agreement with other studies found in the report by CHG (2006) that deceased wives are more likely to be replaced, this does not necessarily mean that the members of the original household stay together.

4.1.7 Family size of the household head

The household heads were asked to indicate the number of household members in their families. Results in Table 7 indicate that, most of the dissolved families have large family size compared to non dissolved. The chi-square test denoted statistical significant relationship ($P < 0.05$) for Iwawa and Lupalilo. On the other hand, most of the respondents in less affected area in dissolved and non dissolved showed no difference ($P > 0.05$).

However a proportion of family size comprised 9-29 members was 21.1%, this cannot be ignored as it accounts for nearly one third of total respondents in dissolved families compared to only 7.4% in non dissolved families. The above observation suggests that family dissolution was associated with large household sizes probably due to increased number of orphaned children which is a major factor in pushing many extended families beyond their ability to cope. These results are in agreement with other studies by CHG (2006) that the care of children while a parent is dying and after the death is a major burden for immediate and extended families. The extended family system is overwhelmed by the magnitude of the burden of caring so many orphaned children. The change in living arrangements, well-being and opportunities for secure future for children is one of the most significant long term outcomes of the HIV/AIDS pandemic.

Table 7: Family size of the household head

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 - value
		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Family size							6.88**
	1-3	6	40.0	3	10.3	9	20.5	
	4-8	8	53.3	17	58.6	25	56.8	
	9-29	1	6.7	9	31.0	10	22.7	
	Total	15	100	29	100	44	100	
Lupalilo	1-3	8	40.0	3	12.0	11	24.4	4.90*
	4-8	10	50.0	18	72.0	28	62.2	
	9-29	2	10.0	4	16.0	6	13.3	
	Total	20	100	25	100	45	100	
Ikuwo	1-3	16	33.3	3	15.8	12	26.1	2.94NS
	4-8	2	59.3	12	63.2	28	60.9	
	9-29	27	7.4	4	21.1	6	13.0	
	Total	27	100	19	100	46	100	

NS= Non- significant ($P > 0.05$), * = Significant at ($P < 0.05$)

4.1.8 Education level

In Table 8 results indicates that majority of the respondents had primary education. Further, results reveal that 79.3% of household in Iwawa were dissolved. However, the chi-square test indicated no statistical significant association ($P > 0.05$) between education level of household head and family dissolution. This implies that being a non formal education or otherwise has no effect on family dissolution.

Table 8: Education level of the household head

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 -value
		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Education							3.34NS
	Non formal	2	13.3	4	13.8	6	13.6	
	Primary	9	60.0	23	79.3	32	72.7	
	Secondary	4	26.7	2	6.9	6	13.6	
	Overall	15	100	29	100	44	100	
Lupalilo	Non formal	4	20.0	7	28.0	11	24.4	4.12NS
	Primary	13	65.0	18	72.0	31	68.9	
	Secondary	3	15.0	0	.0	3	6.7	
	Overall	20	100	25	100	45	100	
Ikuwo	Non formal	3	11.1	3	15.8	6	13.0	0.63NS
	Primary	21	77.8	15	78.9	36	78.3	
	Secondary	3	11.1	1	5.3	4	8.7	
	Overall	27	100	19	100	46	100	

NS= Non- significant ($P > 0.05$)

4.1.9 Occupation

Table 9 shows the distribution of respondents with respect to their major occupation in relation to family dissolution. Agriculture was the major occupation for both dissolved and not dissolved. The chi-square test indicated non significant association ($P > 0.05$) between occupation of the household head and family dissolution. This implies that dissolution of the family was not necessarily associated with the occupation of the household head.

Table 9: Occupation of the household head

Ward	Parameter	Not dissolved		Dissolved		Total		χ^2 - value
		Freq.	%age	Freq.	%age	Freq.	%age	
Iwawa	Occupation							0.59NS
	Others	4	26.7	5	17.2	9	20.5	
	Agriculture	11	73.3	24	82.8	35	79.5	
	Total	15	100	29	100	44	100	
Lupalilo	Others	3	15.0	3	12.0	6	13.3	0.08NS
	Agriculture	17	85.0	22	88.0	39	86.7	
	Total	20	100	25	100	45	100	
Ikuwo	Others	3	11.1	3	15.8	6	13.0	0.22NS
	Agriculture	24	88.9	16	84.2	40	87.0	
	Total	27	100	19	100	46	100	

NS= Non- significant ($P > 0.05$)

4.2 Extent of family dissolution

The main objective of this section was to identify and estimate the extent of family dissolution among respondents in the study area. Since the extent of the problem cannot be directly observed, a Likert scale (Mogey, 1999) which comprised of 8 statements as described in the methodology section indicating respondents' extent of family dissolution was used. Results in Table 10 indicate that, majority of respondents (80.6%) strongly agreed that family dissolution (FD) was high among household controlled by widows, widowers and orphaned headed household, while 76.1% of respondents strongly agreed that FD is high among families which lack appropriate head of household after the death of either father or mother. About 70.1% of respondents agreed that FD was contributed by loss of labour in the family and divorces. About 59.0% of respondents agreed that FD was caused by loss of production for several years, while 53.0% of respondents agreed that FD was the outcome of failure to take children to school and 44.8% of respondents agreed that FD was the outcome of change of the area. Therefore, basing on the above explanations FD was high among household controlled by widows/widowers and orphaned headed

households. This may be due to the fact that, these are the households which experience shortage of food, lack of school materials, unaffordable treatment costs and lack of proper guidance.

Table 10: Level of family dissolution in the family

Variable	Mean	Percent (n = 135)				
		1	2	3	4	5
Family dissolution causes stress	4.46	0.7	2.2	7.5	29.9	59.7
The death of father/mother cause family to lack proper head of household	4.58	0.7	6.0	4.5	12.7	76.1
Loss of labour influence the split of family	4.63	0.7	2.2	0.7	26.1	70.1
Split of family is high among households controlled by widows, widowers and orphaned headed household	4.71	0.0	3.0	3.7	12.7	80.6
Failure to take children to school is the outcome of split of family	4.28	1.5	4.5	11.9	29.1	53.0
Divorces cause split of family	4.58	0.0	1.5	9.0	19.4	70.1
Loss of production for several years cause split of family	4.51	0.0	1.5	5.2	34.3	59.0
Split of the family is the outcome of change of area	4.04	0.0	11.2	18.7	44.8	25.4

Note: Data set were based on strongly disagree (1), disagree (2), undecided (3), agree (4) strongly agree (5)

However, families mostly affected by deaths probably due to HIV/AIDS have higher extent of FD than families not affected. This means that the extent to such dissolutions in the families was contributed by other factors. The difference in the frequency of extent of FD could be due to the fact that, families affected by deaths due to HIV/AIDS lack proper guidance, basic requirements like food, shelter, clothes, school materials, love and care than those families affected less.

In addition to the above results, a null hypothesis which stated that “HIV/AIDS has contribution to family dissolution” was tested using *T-test*. Results showed that there was a significant difference ($P < 0.05$) between highly affected wards and those less affected. The highly affected wards, each household had an average of 5 deaths, while less affected ward; each household had an average of 4 deaths. Therefore, highly affected wards had high level of family dissolution compared to less affected ones.

4.3 Distribution of level of family dissolution among highly affected and less affected areas

Basing on the results obtained during the study, it was observed that the control ward which was termed as ‘remote ward’ was less affected while the treatment wards which was termed as ‘sub-urban wards’ were highly affected (Table 11). According to Levene’s Test for equality of variance; there was no significant difference in levels of dissolution between highly affected and less affected wards ($P > 0.05$). Meanwhile, *T-test* for equality of means showed a significant difference in level of dissolution between highly and less affected wards ($P < 0.05$).

Table 11: Distribution of level of family dissolution among wards

Ward	Parameter	Not dissolved		Dissolved		Overall	
		Freq.	%age	Freq.	%age	Freq.	%age
Male	Sub-urban (Iwawa and Lupalilo)	12	46.2	23	63.9	27	56.5
	Remote (Ikuwo)	14	53.8	13	36.1	6	43.5
	Overall	26	100	36	100	62	100
Female	Sub-urban (Iwawa and Lupalilo)	23	63.9	5	86.5	55	75.3
	Remote (Ikuwo)	13	36.1	37	13.5	18	24.7
	Overall	36	100	37	100	73	100

4.4 Socio-economic factors responsible for family dissolution

4.4.1 Regression model estimation

In order to test how demographic and other factors responsible for family dissolution (when considered simultaneously), a logit regression model was used. Results for logit regression analysis are presented in Table 11 and 12 as presented below:

Table 12: Analysis of Maximum Likelihood Estimates for family dissolution

Parameter	df	Estimate	Standard Error	Chi-square	P value
Intercept	1	-2.7916	1.3729	4.1343	0.0420
Inheritance	1	1.5392	0.7579	4.1242	0.0423*
Treatment costs	1	1.1653	0.4789	5.9223	0.0150*
Workforce	1	-0.8191	0.2627	9.7261	0.0018**
Family size	1	+0.3311	0.1049	9.9679	0.0016**
School dropout	1	1.8511	1.0465	3.1289	0.0769
Income	1	-0.2137	0.5788	0.1363	0.7120
Occupation	1	-0.1697	0.5645	0.0904	0.7636
Sex	1	0.3322	0.4509	0.5427	0.4613
Age	1	0.0281	0.0201	1.9529	0.1623
Marital status	1	0.3801	0.6564	0.3354	0.5625
Education	1	0.1544	0.5271	0.0858	0.7696
Statistical test of the model					
Test	df	Chi-square		P value	
Likelihood Ratio	14	30.1		0.0072**	
Score	14	26.8		0.0201*	
Wald	14	21.6		0.0861	

* P<0.05, ** P<0.01 Pseudo R² = 0.297

The logit model convergence criterion was satisfied, the model Chi-square (Likelihood ratio test) fitted well being significant at P<0.01. The score statistic, which is similar in function to model chi-square and the Wald statistic test were both statistically significant at P<0.01.

Results in Table 12 show that respondent' inheritance, and treatment costs, were significant predictors (P<0.05) of respondents' family dissolution. Similarly for, working force, family size (P<0.01), and treatment cost (P<0.05). The effect of other variables included in the model were not significant (P>0.05). In this study coefficients were exponentiated to compute odds ratio as shown in the Table 13.

Table 13: Odds Ratio Estimates for family dissolution

Effect	Point Estimate	95% Confidence Limits	Wald
Inheritance	4.661	1.055	20.587
Treatment costs	3.207	1.255	8.198
Workforce	2.269	1.356	3.796
Family size	0.718	0.585	0.882
School dropout	6.367	0.819	49.515
Income	0.808	0.260	2.511
Occupation	0.844	0.279	2.551
Sex	1.394	0.576	3.374
Age	1.028	0.989	1.070
Marital status	1.462	0.404	5.294
Education	1.167	0.415	3.279

4.4.2 The effect of individual factors on family dissolution Respondents' sex

Results in Table 12 indicates that sex was not a significant predictor ($P>0.05$) of family dissolution. However, the coefficient of sex was positive implying that being a female had high influence on family dissolution. In Table 13, these results imply that the likelihood of family dissolution increased by a factor of 1.394 if that respondent was a female. In other words, female respondents had higher chances of being affected by the impacts of HIV/AIDS on family dissolution than male respondents. This could be due to the fact that, widows lost access to land, labour, inputs, credit, and support. Similar findings have been reported by UNAIDS (2006) that food production in households where the head of the family died of HIV/ AIDS were affected in different ways depending on the sex of the deceased.

4.4.2.1 Respondents' age

The findings in Table 12 have shown that, the coefficient for age was positive. However, respondents' age was not a significant predictor ($P>0.05$) of respondents' family

dissolution. For every one year increase in age, the odds of respondents being affected by the impact of HIV/AIDS on family dissolution increased by a factor of 1.028. In other words, although respondents' age was not significant, each addition year of age increased the odds of respondents' family dissolution.

4.4.2.2 Respondents' education level

Results in Table 12 show that, respondents' level of education had no significant influence ($P > 0.05$) on the respondents' family dissolution. However, the coefficient of education was positive implying that high level of education had a favourable influence on family dissolution. Using the odds ratio in Table 13, the results show that, for every year increase in education, the odds of respondent's being dissolved decreased by a factor of 1.167 with 95% confidence interval

These results have a relationship with the results obtained from cross tabulation between the respondents' level of education and family dissolution, where there was no significant association ($P > 0.05$) between respondents' level of education and family dissolution.

4.4.2.3 Respondents' marital status

Marital status was not significant predictor ($P > 0.05$) of family dissolution. However, since the coefficient estimate for marital status was positive, it indicates that the probability of being dissolved increases with head of household being widow or widower. Using odds ratio estimates in Table 13, as family being controlled by widow/widower, the probability that family being dissolved increased by a factor of 1.462. In other words, as marital status of an individual head of household change by being widow or widower the probability of that household to dissolve increases.

Similar findings have been reported by CHG (2006) that female headed households are likewise least able to cope with the economic, labour and social losses arising from HIV/AIDS. This was positive indicator though it was a poor performance variable in the model ($P>0.05$) while it was significant during descriptive statistics. The reason for poor performance was probably due to summations and effects of one variable against another in the model example, multicollinearity and autocorrelations.

This was vividly explained by female and male from Iwawa FGD who said “Female headed households are likewise least able to cope with the economic, labour and social losses arising from HIV/AIDS”.

4.4.2.4 Inheritance

Results in Table 12 show that, inheritance had a significant influence ($P<0.05$) on respondents family dissolution. Using the odds ratio on Table 13, the probability of respondents being dissolved rose with inheritance. The odds of respondents being dissolved increased by a factor of 4.661.

Family dissolution was more common in the inherited respondents compared to their counterparts who have not been inherited. These results are similar to findings observed by Mbonile (2004) and Barnett and Whiteside (2002) who found that widowhood in most of African societies was solved by the inheritance, since the inheritance of a woman whose husband died due to HIV/AIDS is risky, the relatives are left with one outlet of impoverishing the widow by plundering or confiscating the property of the deceased.

4.4.2.5 Treatment costs

Results in Table 12, shows that treatment costs had significant influence ($P < 0.05$) on the respondents' level of family dissolution. Using the odds ratio in Table 13, the results show that an increase in treatment costs by one unit increases the odds for family dissolution by a factor of 3.207. This implying that, taking care of a person sick with HIV/AIDS is not only an emotional strain for household members, but rather a major strain on household resources. Loss of income, additional care- related expenses, and mounting medical fees push affected house holds deeper into poverty. As it was observed by Baier (1997), Kaiser (2002) and UNAIDS (2006) that the disease directly affect the rural family as it has higher medical costs people which are a heavy burden on the family budget.

4.4.2.6 Workforce

Workforce had significant influence ($P < 0.05$) on the respondents family dissolution (Table 12) Using the odds ratio in Table 12, the probability of respondents being dissolved is high; the odds of respondents being dissolved increased by a factor of 2.269.

These results imply that, HIV/AIDS has been a disaster since most of those who are infected are between the age of 20-49 years and this is a potential working labour force and breadwinners for their families. Studies by Baier (1997), Pembrey (2006) and URT (2001) suggested that, HIV/AIDS reduced household participation in daily production, this is a fact that those who are affected most of them are at the age of production.

4.4.2.7 Family size

Family size was a highly significant predictor ($P < 0.01$) of respondents family dissolution (Table 12). Since the coefficient estimate for family size was positive, it indicates that the probability of the family to dissolve increases with family size increased. Using odds ratio

estimates in Table 13 as family increases the probability of that family to dissolve increased by a factor of 0.718. This implying that, in many cases the presence of HIV/AIDS have higher possibilities of household dissolution as parents die since children normally are sent to relatives for care and upbringing. As a result, the families where the orphaned children are sent will have large family size which also may be difficult to manage. Basing on 2002 Population and Housing Census, average size of household in Makete District was 3.8 (Census Report, 2002), according to this study, average size of household was 5.2. The increment was probably due to the increased number of orphans who are been taken by the deceased relatives.

4.5 The role of HIV/AIDS in family dissolution

As it was stated earlier in the back ground information, since colonial era Makete was among those Districts which were identified as labour reserves in order to provide cheap migrant labour. Unfortunately the migrant labour has continued to take place. Basing on Makete's difficult socio-economic environment, many people especially men migrate to other places of the country like Mufindi (tea production), Mbeya and Makambako (business centres) to provide cheap labour, others for business purpose (Makete District, 2005). During the absence of a partner it has become easier for the other partner to be involved in romantic relationships with other partners which put them at high risk of HIV/AIDS infections (Lugalla, 2004).

The impact of HIV/AIDS is significant and often dramatic in terms of changes in income, asset wealth and longer term prospects for economic security (CHG, 2006). HIV/AIDS strips families of their assets and income-earners. Taking care of a person sick with HIV/AIDS is not only an emotional strain for household members, but also a major strain on household resources, loss of income, additional care-related expenses and reduced

ability of care givers to work and higher medical fees (Steinberg *et al.*, 2002). A study conducted in South Africa suggested that, households with one member died with HIV/AIDS were four times more likely to dissolve than those where no death had occurred (Hosegood *et al.*, 2004).

Such a situation is likely to have repercussions for every member of the family. Children may be forced to abandon their education, child-headed households, and child labour like those of domestic work. In some cases women and girls may be forced to turn to sex work, which predisposes them to a higher risk of HIV/AIDS transmission which further exacerbates the situation (Pembrey, 2006).

The role of HIV/AIDS in family dissolution is significantly higher ($p < 0.05$) (Table 12). For example, 34.8 % of respondents from Lupalilo show that, poor economic status in the area causes people especially men to migrate to other places of the country in order to search for better economic opportunities. However, these end up practising prostitution with other women in order to satisfy their sexual desire. About 15.0% of Iwawa respondents agreed that migration could contribute to HIV/AIDS infection, and Ikuwo respondents disagreed with the fact. This probably could be because of the fact that, Ikuwo is strong economically compared to Iwawa. Therefore migration of people out side the area to search for employment is not like of Iwawa.

Table 14: Problems experienced by household head and family

Parameter	Percent (n = 135)		
	Iwawa (n = 45)	Lupalilo (n = 45)	Ikuwo (n = 45)
Harassed by sister in-law	0.0	0.0	2.9
Failure to pay house renting charges	5.0	0.0	2.9
Shortage of food and clothes	25	0.0	20.6
Harassed by died husband's relatives	0.0	4.3	2.9
Harassed by land lord	0.0	0.0	2.9

Poor housing condition	10.0	0.0	8.8
Poor economic status	15.0	34.8	0.0
Heavy burden of caring orphaned children	25	43.5	38.2
No funds for buying far inputs	0.0	4.3	8.8
Chronic illness	5.0	13.0	8.8
Shortage of funds for school requirements and medical care	20.0	0.0	17.6
Old age illness	0.0	0.0	2.9
Shortage of land	5.0	0.0	0.0

Note: Data set were based on multiple responses

Furthermore, about 43.5% of respondents in Lupalilo indicated that, heavy burden of caring orphaned children most probably are the outcome of HIV/AIDS contributes to family dissolution. The impact of HIV/AIDS on households can be very severe, although no part of the population is unaffected by HIV/AIDS. It is often the poorest society that is the most vulnerable to the HIV/AIDS pandemic. In many cases, the presence of HIV/AIDS means that the household is likely to dissolve, as parents die children are sent to relatives for care. About 38.2% and 25% of Ikuwo and Iwawa respondents respectively agreed on that statement. Meanwhile, 25% of respondent from Iwawa agreed that, shortage of food and clothes cause family dissolution. This is because Iwawa is the leading ward for high infection rate in Makete. Some villages of this ward are along to the main road of Makete-Njombe where various business activities like lumbering and road construction take place. Also almost all villages of this ward are nearby district headquarters where by members of the family interact and socialise with different people of various status hence infection rate for HIV/AIDS likely to be high.

Basing on the above factors, Iwawa is the leading ward by having a greater number of orphaned headed households and families headed by single parent who are sometimes sick and fail to manage to take care of the family through provision of basic necessities.

Automatically these families lack food, clothes, school requirements and others lack shelters.

Results obtained from Focus Group Discussion (FGD) also revealed the same trend. Majority of FGDs members supported that, once one member of the family die most probably due to HIV/AIDS, chances for that family to dissolve is high because; firstly the remaining single parent will not be able to manage to take care of the family because he/she will also be suffering. As a result children drop out from school to take care of sick parent. Table 14 indicates that, about 33.3% of respondents' from Lupalilo reported children dropout from school because of taking care of parents who are suffering from chronic illness. Other children dropout from school because of lacking school requirements like school uniforms and exercise books as shown in Table 14. About 66.7% and 33.3% of respondents' in Iwawa and Lupalilo respectively showed that their children dropped out from school because of lack of funds to buy school materials and other expenses associated with the school. Also it was revealed that, some children after the death of one or both parents are taken by other people, some are relatives while others are not. As a result where they go they don't proceed with school. Some of them are turned to be house girls/boys. In the long run such families are most likely to remain in the cascade of poverty and poor life.

Furthermore, it was observed in FGDs that most of families dissolve after the death of either one or both parents because of shortage of food. As it was observed in Table 14, about 33.3% of respondents' in Iwawa and Lupalilo agreed that dropout from school is also a result of shortage of food. The main reason for food shortage is probably due to the reduced working force which is wiped by HIV/AIDS in which most of them are breadwinners for their families.

Table 15: Reason for school aged children not attending school

Parameter	Per cent (n = 135)		
	Iwawa (n= 45)	Ikuwo (n = 45)	Lupalilo (n = 45)
Shortage of food	33.3	0.0	33.3
Lack of school requirements	66.7	0.0	33.3
Chronic illness	0.0	0.0	33.3
Lack of funds	33.3	0.0	33.3
Disabled child	33.3	0.0	33.3

Note: Data set were based on multiple responses

Moreover, results in Table 15 show that, 66.7%, 37.9% and 37.0% respondents of Lupalilo, Iwawa and Ikuwo respectively were widows in which their husbands had died probably of HIV/AIDS. The percent for Lupalilo was high (66.7%) compared to other places, then followed by Iwawa. The main reason for these two areas to have high percent of widows than Ikuwo can be due to the fact that; Lupalilo and Iwawa wards are found along the main road from Njombe to Makete, where by there are various development activities like lumbering and road construction. Therefore, interaction and socialisation with different people of different characteristics and behaviours is high. The case is not like for Ikuwo where by the area is very isolated and not easily accessible, as a result interaction with other people is not high compared to Lupalilo and Iwawa. Experience obtained from FGD show that, most families dissolved were those families headed by female head of households. This is because most of the widows after the death of their husbands they undergo stress and feel as helpless. They fail even to cope with the situation, as a result they don't get the basic needs to their children of which the outcome is always family dissolution.

Table 16: Reason for not living with other family members

Parameter	Per cent (n = 135)		
	Iwawa (n = 45)	Ikuwo (n = 45)	Lupalilo (n = 45)
Wife died	17.2	10.3	22.2
Gone to look for employment	13.8	7.7	11.2
Children died	3.4	7.4	12.8
Both parents died	13.8	5.1	18.5
Husband died	37.9	37.0	66.7
They are schooling	3.4	5.1	7.4
Divorced	0.0	0.0	2.6
Father died	0.0	0.0	2.6
Mother died	10.3	0.0	3.7

Note: Data set were based on multiple responses

Results in Table 16 shows further that, 18.5% of Lupalilo, 13.8% of Iwawa and 5.1% of Ikuwo respondents had lost both parents. About 4.8% and 1.4% of households are headed by male and female orphaned head of households as it was shown in Table 3. The families headed by children experienced a lot of problems, leading to children's poor attendance in schools and others dropping out of school completely.

However, 17.2% of respondents from Iwawa, 22.2% of respondents from Lupalilo and 10.3 of respondents from Ikuwo lost their partners, most probably due to HIV/AIDS. Those who had lost their partners were probably the one who had been inherited (Table 16). Inheritance had a significant influence ($P < 0.05$) on family dissolution. During the study it was also observed that, 13.8 % of Iwawa, 11.2% of Lupalilo and 7.7% of Ikuwo respondents left in search of employment. The main reason for them to go out of the district to look for employment was because of economic hardship of the district which made them fail to sustain their relatives who are suffering especially from chronic illness and others because of sustaining their families. As a result they came back while were already infected with HIV/ AIDS.

Regarding the time family member suffered before death, results in Table 17 shows that, 49.4% of respondents indicated that their family members suffered for one year or more before dying. This was probably due to HIV/AIDS. As it was observed during the study, taking care of patients especially those who were suffering from HIV/AIDS was very expensive (Table 5), taking into consideration those patients who are suffering for more than a year. Poor households coping with members who are sick from HIV/AIDS were cutting down spending on other basic necessities, the most likely expenses to be cut were food, clothing and other services. Such situation was likely to have repercussions for every member of the family. Children may be forced to abandon their education (Table 15) and in some cases women may be forced to turn to sex work. This can lead to a higher risk of HIV/AIDS transmission which further accelerates the situation.

Table 17: The time family member suffered before death

Parameter	Per cent (n = 135)			Total
	Iwawa (n = 45)	Ikuwo (n = 45)	Lupalilo (n = 45)	
Died				
< 3 Months	19.0	18.2	5.9	13.0
4-6 Months	19.0	13.2	20.6	18.2
7-11 Months	4.8	0.0	5.9	3.9
1 Year	23.8	27.3	2.9	15.6
> 1 Year	33.3	40.9	64.7	49.4
Total	100	100	100	100

Furthermore, it was observed that about 78.3% of respondents from Ikuwo spent between Tshs 1000- 50 000 for treatment during their suffering, 48.9% of respondents from Lupalilo spent 1000- 50 000 Tshs, (Table 18). About 38.6% of respondents from Iwawa spent between 1000 and 50 000Tshs per month for treatment. The main reason for Ikuwo and Lupalilo to have the highest treatment costs was due to the fact that, these two areas have no government hospital around. This necessitated them to travel long distance to private hospitals of Bulongwa, Ikonda and Chimala. For Lupalilo, they used private hospital (Ikonda) which its treatment costs are higher compared to those costs available in the government hospitals. Likewise, most of traditional African societies, the caring of a patient relies on relatives and other clan members who are the main producers of food and other services to the household and the community.

Since HIV/AIDS is a new complex disease associated with many opportunistic infections, its treatment is undertaken in health centres and hospitals which are located in urban areas. Therefore some members of the household are forced to travel long distances to these centres and it disrupts the whole income of the family and labour force management of the

household or community. However, high medical fees push affected households deeper into poverty; the situation which accelerates into family dissolution.

Table 18: Actual costs incurred due to treatment per month

Parameter	Per cent (n = 135)		
	Iwawa (n = 45)	Ikuwo (n = 45)	Lupalilo (n = 45)
0 – 999Tshs	25.0	10.9	0.0
1 000 – 50 000 Tshs	38.6	48.9	78.3
51 000 – 100 000 Tshs	31.8	26.7	8.7
> 100,000 Tshs	4.5	24.4	2.2

High treatment costs to contribute to family dissolution were evidently observed in all the three wards. About 66.7% of respondents from Lupalilo, 37.9% of respondents from Iwawa and 37.0% of respondents from Ikuwo argued that, high costs for food and treatment contributes to family dissolution.

Nevertheless, results in Table 18 show that, 22.2% of the respondents from Ikuwo, 17.2% from Iwawa and 10.3% from Lupalilo argued that, lack of funds to take care of patients contributed to family dissolution. As it was mentioned earlier that most of families affected in the district have some of their members opt to go out to look for employment opportunities or business.

Table 19: Contribution of treatment costs to family dissolution

Parameter	Per cent (n = 135)		
	Iwawa (n = 45)	Ikuwo (n = 45)	Lupalilo (n = 45)
Family splits due to high costs for food and treatment	37.9	37.0	66.7
Re-allocation of funds for treatment	13.8	11.2	7.7
Relatives may abandon the patient because of lack funds	3.4	12.8	7.4
Other members of the family goes out to seek job in order to get money	13.8	18.5	5.1
Patients of long time, poverty the family	0.0	2.6	0.0
Poor financial position	3.4	7.4	5.1
Lack of funds to take care the patient	17.2	22.2	10.3
Loss of production and funds	0.0	2.6	0.0
The patient becomes burden	0.0	2.1	0.0
Segregation between members of the family	2.6	0.0	0.0
Sales of properties and debts to others	10.3	3.7	0.0

Note: *Data set were based on multiple responses*

Furthermore, it was observed in Table 19 that lack of assistance from dependants and family conflicts contribute to family dissolution. The proportion of respondents giving this reason was consistently high in all three wards being 44.4% in Lupalilo, 31.0% in Iwawa and 26.7%. In Ikuwo also it was observed that, about 19.4% of respondents from Lupalilo, 10.3% from Iwawa and 6.7% from Ikuwo argued that mistreatment of widows and orphaned children contributed to family dissolution. In addition to that, 13.8% and 16.7% of respondents from Iwawa and Ikuwo respectively discussed that, death of one or both parents encourage children to run away to big cities in order to sustain their livelihood. However, it was observed that 13.8% of respondents from Iwawa, 8.9% from Lupalilo and 26.7% from Ikuwo that lack of proper household head contribute to family dissolution.

Table 20: Reasons for family dissolution

Parameter	Percent (n = 135)		
	Iwawa (n = 45)	Lupalilo (n = 45)	Ikuwo (n = 45)
Lack of assistance to dependants and family conflicts	31.0	44.4	26.7
Loss of productive labour force	20.7	5.6	6.7
People are tired because of frequent deaths, no time for other activities	3.4	2.8	3.3
Presence of witchcraft believes	3.4	2.8	13.3
Mistreatment of widow and orphaned	10.3	19.4	6.7
Encourage child labour, running away to big cities	13.8	0.0	16.7
Burden to the family	3.4	13.9	0.0
Lack of proper household head	13.8	8.9	26.7
Distribution of deceased's children's property	0.0	2.8	0.0
Total	100	100	100

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions

This study investigated the contribution of HIV/AIDS to family dissolution in Makete District. From the findings; it is therefore concluded that:

- (i) The extent of family dissolution in Makete District is very high being accelerated by factors like too big family size, reduced working force, high HIV/AIDS treatment costs and inheritance. Other factors were age, sex, marital status, occupation and income.
- (ii) Families with either or both husband and wife died of HIV/AIDSs were dissolved or likely to dissolve compared with families with father and mother.
- (iii) Families headed by females (widows) whose husbands had died of HIV/AIDS were more likely to dissolve compared to families headed by men (widowers). This probably was due to poverty because of denied rights for women to inherit property like land.
- (iv) Families headed by orphaned children whose their parents had died of HIV/AIDS also were at dangers of dissolution because of lack of income earners for the family, shortage of food, lack of school materials, unaffordable treatment costs and lack of proper guidance.

- (v) HIV/AIDS treatment costs were significantly higher such that the affected families can not afford. Consequent to this the poor family became poorer leading to their dissolution.
- (vi) Lack of working force due to HIV/AIDS in the families contributed significantly to dissolution of families as the productive age (15 to 45 years) are the most vulnerable groups to HIV/AIDS pandemic.
- (vii) Inheritance of widows and property of the deceased father of household also had impacts on family dissolution because of inheritance problems compared to those not dissolved. Family dissolution was more common in the inherited respondents compared to their counterparts who had not been inherited. The relatives are left with one outlet of impoverishing the widow by plundering or confiscating the property of the deceased.
- (viii) Large household family sizes were more dissolved probably because of increased number of orphaned children beyond their ability to cope.
- (ix) Families affected by deaths caused by HIV/AIDS had higher extent of dissolution than families not affected. Several factors were put forward including lack proper guidance and deficient of basic requirements like food, shelter, clothes, school materials, love and care than those families affected less.
- (x) Wards which had higher income were found to have low rate of HIV/AIDS mortalities than the low income wards. This further showed that poverty has

significant contributions to HIV/AIDS infections and as parents die children are sent to relatives for care.

- (xi) Higher costs for care, treatment and funerals of HIV/AIDS affected family members had a significant influence on family dissolution. HIV/AIDS was found not only to affect emotional strain for household members, but ruining much family resources.
- (xii) Migrations in search for employment, staying in camps during activities like lumbering and road construction especially for men; and living in urban areas are among the HIV/AIDS predisposing factors. These factors had significantly contributed to HIV/AIDS infections in the district, which consequently caused increased family's dissolutions.

5.2 Recommendations

Basing on the findings from this study, the following are recommendations on what can be done to improve the welfare of the impact of family as well as economic well being of Makete people in order to reduce family dissolution.

- (i) In this study, it has been found that widows and orphaned children do not know their rights; they don't know that is their right to inherit properties left by their husbands or parents. Even for those who are aware they seem to be reluctant once it happens that, one of the deceased's relative is claiming on those properties. That is why even at the district magistrate level there were only reconciliation cases. Therefore, sensitization campaigns are needed to raise awareness on the rights to inherit.

- (ii) Increased treatment costs was a result of requirements of Ministry of Health and Social Welfare that, in order for the area to have hospital it should have a population of not less than 100 000 people regardless of its geographical location and communication problems. Basing on that requirement, it is advisable that the government should strengthen service provision at health center and dispensary level so as to bring closer to the people all the necessary services like provision of Anti retrovirus (ARVs) drugs which are currently provided at hospital level.

- (iii) The study found that, even though there is no family which in one way or another is not affected by HIV/AIDS, still it shows that taking care of HIV/AIDS patient is not that much a big task. The main problem is poor economic status of the people. For this reason, the central and local government need to provide assistance on formulation of either SACCOS or small groups of farmers or businessman and provide to them adequate knowledge and financial assistance so as to make them sale their products like timbers, irish potatoes, tropical fruits and wheat at a reasonable price which will improve their income, instead of insisting on finding a solution for pyrethrum market.
- (iv) Strong strategies should be put in place in order to reduce new infections of HIV/AIDS so as to limit the number of widows and orphaned headed households.

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APPENDICES

Appendix 1: Sample size Calculation

The simple formula used:

$$n = \frac{Z^2 pq}{d^2}$$

Where n = sample size

Z = Standard normal deviate, set at 1.96 (\approx 2.0) corresponding to 95% confidence level,

p = proportion in the target population estimate; if not known use 50%.

$$q = 1.0 - P$$

d = degree of accuracy desired, set at 0 .05 or 0 .02.

Therefore sample size will be

$$n = \frac{Z^2 pq}{d^2} = \frac{(2)^2 (0.50 \times 0.50)}{(0.05)^2} = \frac{4 \times 0.25}{0.0025} = \frac{1}{0.0025}$$

$$= 400 \text{ respondents.}$$

34 percent of the sample size which is equivalent with 135 respondents was used in this study due to cost implications

Appendix 2: Questionnaire

GENERAL IDENTIFICATION

1. Date of interview-----
2. Name of the interviewer-----
3. Name of the household head-----
4. Village-----
5. Ward-----

GENERAL HOUSEHOLD AND HEAD OF HOUSEHOLD INFORMATION

6. Sex of the head of house hold 1=Male 2 = Female----- []
7. Age of the head of household-----
8. Marital status of the head of household ----- []
 1. Married 2. Single 3. Divorced 4. Widow 5. Widower 6. Separated 7. Orphan 8. Others (specify)
9. If married, how many wives do you have-----
10. Are you married to a man/woman who was married before----- []
 1. Yes 2. No
11. Was the diseased husband/wife your relative----- []
 1. Yes 2. No
12. Ethnic group of the head of house hold----- []
 1. Kinga 2. Bena 3. Hehe 4. Nyakyusa 5. Others (specify)
13. Religion of the head of household 1. Christian 2. Muslim 3. Traditional 4. Others (specify) ----- []
14. What is your education level----- []
 1. No formal education 2. Primary education 3. O-level secondary education 4. A-level secondary education 5. College 6. University
15. What is your occupation----- []
 1. Agriculture 2. Business 3. Employment 4. Others (specify)
16. What is your monthly income-----
17. What is your family size-----

18. How many are at the age of

<18 years	18-64 years	>64 years

19. Referring to question 16 above, how many are actively working-----

20. School dropout rate

How many are pupils	How many are going to school	How many are not going to school	Reasons for not going to school

21. Were you born in this village 1. Yes 2. No----- []

22. If no, where were you before -----

23. What is the major reason for migrating to this village/ place-----

24. Whose house are you living now-----

25. If not the parents/husband/wife/other(specify) house where is the mentioned house-----

26. Is there any thing which you experience through living with them-----

27. Are all members of the family living with you----- []

1. Yes 2. No

28.If Yes where are they-----

1. Husband/wife/children died

2. Looking for job 3. Diseases 4. Shortage of land

29. If is death/ diseases, then how long the husband/wife/children suffered----- []

1.Long time 2. Short time

HEALTH

30. Do you have health facilities around----- []

1. Yes 2. No

31. What is the quality of health services-----[]

32. Are there any costs related to caring of sick persons-----[]

1. Yes 2. No

33. If yes, what are those costs-----

34. Do you go for institutional health services when you or your family member is sick
----- []

1. Yes . No

35. If 'No' why ----- []

1. Too high costs 2. Bureaucracy 3. Poor medical services

36. Do you think high costs of medical care contributes to split of the family----- []

1. Yes 2. No

37. If Yes, how-----

SOCIAL WELFARE

38. Have you ever experienced death in your family----- []

1. Yes 2. No

39. If yes, how many have died-----

40. What kind of assistance did you receive from the kinship members-----

41. Is there any traditional system for burial ceremonies which is still existing--- []

1. Yes 2. No

42. If Yes/ No explain how/why-----

43. How was the system before, compared to now days-----

44. Due to the increasing number of deaths nowadays in most of the families, do you think this accelerates family split----- []

45. If Yes, how-----

SOCIO-ECONOMIC FACTORS

46. Do you think deaths which occurs in the family causes shortage of income in the family-----[]

1. Yes 2. No

47. If Yes, how-----

48. Who owns land in this village-----[]

1. Men 2. Women 3. Both men and women

49. Do the traditions and norms allow widows/widowers/children to inherit properties like land, properties left by husband/wife/father/mother ----- []

1. Yes 2. No

LEVEL OF DISSOLUTION IN THE FAMILY

50. Circle one number based on whether you strongly agree (SA), agree (A), undecided (UD), disagree (DA) or strongly disagree (SD) with the statement

Statements	SA	A	UD	DA	SD
1. Split of the family causes stress	5	4	3	2	1
2. If father/mother die, the family lack appropriate head of household	5	4	3	2	1
3. Loss of labour can influence the split of the family	5	4	3	2	1
4. Split of the family is high among house holds controlled by widows, widowers and orphaned headed of house hold	5	4	3	2	1
5. Failure to take children to school is the outcome of split of the family	5	4	3	2	1
6. Divorses cause split of the family	5	4	3	2	1
7. Loss of production for several years cause split of the family	5	4	3	2	1
8. Split of the family is the outcome of out migration	5	4	3	2	1
9. Family split is associated with low production of food and cash crops	5	4	3	2	1

CHECKLIST GUIDE FOR FOCUS GROUP DISCUSSIONS

1. Have you ever heard about family dissolution in this village?
2. If yes, what are the causes of family dissolution?
3. What are the consequences of family dissolution?

4. Do you think that HIV/AIDS contributes to family dissolution in this village? If yes, how?
5. Do you know any family that has disintegrated after the death of one member of the family due to HIV/AIDS?
6. If yes, please can you explain how it happened?
7. Are there differences in terms of family dissolution between families affected by HIV/AIDS and how affected family?
8. If yes, what are differences?
9. What is the opinion on orphaned children being taken by relatives
-Do you think is Ok or it is a burden to the family (relative)
10. Who owns land in this village?
11. Do the traditions and norms allow widow/widower/children to inherit land in this village? If yes, explain; if no why?