



# Policy brief

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## HIV/AIDS and its impact on orphans

Some two decades after the first cases were reported, AIDS has become a worldwide devastating disease. In 2005, an estimated 38.6 million people worldwide were living with HIV, 4.1 million became newly infected and an estimated 2.8 million lost their lives to AIDS (UNAIDS, 2006). The epidemic also has long-term impacts on economic development by affecting the human capital accumulation in the next generations. In this context, the Millennium Declaration articulated the global commitment to halt and begin to reverse the spread of HIV/AIDS by 2015. Despite significant national and international commitments and initiatives, the impacts of HIV/AIDS on children and adolescents are devastating and tragically liable to get worse. In 2004, 2.2 million of 40 million people living with HIV and AIDS were children under the age of 15. The number of children orphaned by AIDS in 2003 was estimated at 15 millions (UNICEF, 2005). In sub-Saharan Africa, more than one out of nine children lost a parent predominantly due to the HIV/AIDS pandemic (UNAIDS/UNICEF/USAIDS, 2004)<sup>1</sup>.

There is a common understanding that parental death has an adverse effect on surviving children but a more complete comprehension of these effects (psycho-social, educational, survival) is essential for the design and implementation of programmes to successfully assist orphans. This policy brief provides an overview of the research undertaken in the field of HIV/AIDS orphanhood, its impacts on children and accordingly draws the policy implications.



### Scale of the AIDS orphans crisis and important trends

Over the last two decades, much has been learned about HIV/AIDS and orphan hood. From the most important trends worldwide, we know that:



#### Sub-Saharan Africa is the worst hit by HIV/AIDS

Although HIV/AIDS has reached almost every part of the world, no region has been hit harder than sub-Saharan Africa. In fact, sub-Saharan Africa is home to 24 of the 25 countries with the world's highest levels of HIV prevalence, which is also reflected in the rapid increase in the number of orphans. Between 1990 and 2001, the proportions of orphans whose parents died from HIV/AIDS rose from 3,5 percent to 32 percent. Today, there are more than 12 million children orphaned by HIV/AIDS in Africa. While sub-Saharan Africa is proportionally the region hardest hit by HIV/AIDS, the absolute number of orphans -due to all causes- is much twice as high in Asia<sup>2</sup> (UNAIDS/UNICEF/USAIDS, 2004).





### There is increasing pressure on the extended family as traditional support system

In nearly all of sub-Saharan Africa, extended families have assumed the responsibility of orphaned children. A recent analysis by UNICEF in 40 countries in sub-Saharan Africa shows that extended families have assumed responsibility for more than 90 percent of orphaned children (UNICEF, 2003a). This traditional support system is however under severe pressure and largely overwhelmed in some countries, as HIV/AIDS is generating orphans ever more quickly. Most worryingly is the fact that those countries which will see the largest increase in orphans over the coming years are the ones where the extended family is already under severe pressure because of the care for orphans. Moreover, households with orphans are more likely to become poor, primarily because of the increased 'dependency ratio' (income of fewer earning adults sustains more dependents).

<sup>1</sup> There has been considerable debate among organisations and scholars about how to refer to children affected by HIV/AIDS. Orphans and Vulnerable Children (OVC) is commonly used by international development agencies to replace the arguably stigmatising or discriminatory term of 'AIDS orphans'. The term 'Orphan' refers to a child under the age of 18 (or in some instances 15) whose mother (maternal orphan) or father (paternal orphan) or both (double orphan) are dead.

<sup>2</sup> In Asia, 87.6 million were orphaned due to all causes in 2003, twice the 43.4 million orphans from all causes in sub-Saharan Africa. This is due to much larger populations in Asia, which has almost four times more children (1,2 billion) than sub-Saharan Africa (350 million). (UNAIDS/UNICEF/USAIDS, 2004)

*"Almost throughout sub-Saharan Africa, there have been traditional systems in place to take care of children who lose their parents for various reasons, but the onslaught of HIV slowly but surely erodes this good traditional practise by simply overloading its caring capacity. HIV also undermines the caring capacity of families and communities by deepening poverty due to a loss of labour and the high cost of medical treatment and funerals".*

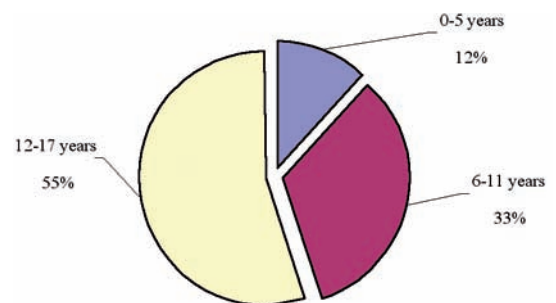
Statement by UNICEF representative Bjorn Ljungquist, HIV/AIDS orphans survey finding conference, April 8<sup>th</sup> 2003.

Despite these intensive pressures, the extended family system will continue to be the central social welfare mechanism in most parts of sub-Saharan Africa (UNICEF, 2003a). Clearly and as a result of several factors including modernization, migration and AIDS, the very nature of the extended family is rapidly evolving and relationships within families are changing (Barnett and Whiteside, 2002).



### The children above 12 years are the worst affected

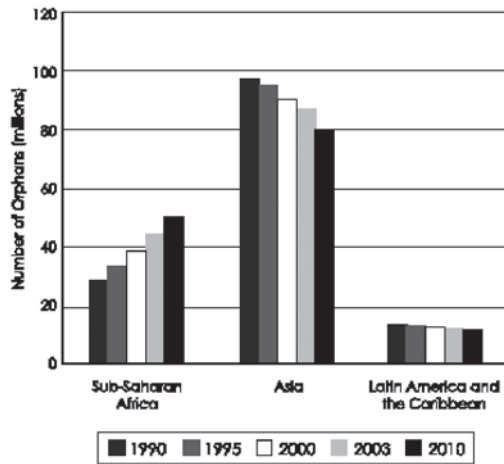
The age of orphans is fairly consistent across countries. Surveys suggest that overall about 12% are orphans 0-5 years old, 33% are 6-11 years old and 55% are 12-17 years old (UNAIDS/UNICEF/USAIDS, 2004). That is more than half of all orphans are age 12 or older. As discussed further in the paper, this age pattern has important implications for the allocation of resources for programmes.



Source: UNICEF, 2004 (Children on the brick)

### The orphans' number is decreasing but the worst is yet to come in Sub-Saharan Africa

Generally, the trend in Asia and Latin America shows a decreasing number of orphans. It should however be noted that the HIV/AIDS epidemic has only recently begun in some countries like China and Pakistan, where the number of children orphaned by HIV/AIDS could potentially grow dramatically (UNAIDS/UNICEF/USAIDS, 2004). As shocking as the numbers already are, the orphan crisis in sub-Saharan Africa is just starting to unfold.



Source: UNICEF, USAID, UNAIDS 2004

(Children on the brick)

As today's young adults die in growing numbers, they will leave growing number of orphaned children. By 2010, HIV/AIDS will have robbed an estimated 20 million children one or both parents, which is nearly twice the number or orphaned in 2001 (UNICEF, 2003a).

### Children orphaned by AIDS, their survival and their school enrolment

In this section, the impact of AIDS orphan hood on children is investigated by looking at the vulnerability, the health and survival implications for children including labour and exploitation as well as the consequences for school enrolment and education in general.

#### The vulnerability of children starts before they are orphans

Parental AIDS mortality is thought to have different effects on the well-being of children than other terminal illnesses, mostly due to the fact that the vulnerability of AIDS orphans starts well before the death of a parent (Stein, 2003). The concept of vulnerability is, however, difficult to define. Indeed, while some children may be vulnerable on several measures and through different mechanisms, others will be made vulnerable in just one dimension through a particular adverse effect of HIV/AIDS. Mechanisms of vulnerability include for instance taking adult responsibilities, stigmatization and premature withdrawal from school.

When a parent develops HIV-related symptoms, children often shoulder new responsibilities including domestic chores, care giving activities (feeding, bathing, giving medication for treatment), agricultural or income generating activities and child care duties (Foster & Williamson, 2000). Arguably, it is the stigma attached to HIV/AIDS, which makes AIDS orphans experience a different set of traumas and long-term effects from those who lose parents from other illnesses (Bray, 2003). Children grieving for dying or dead parents are often stigmatised and discriminated by society through association with HIV/AIDS and the assumption that children who have lost parents through AIDS are infected themselves. The distress and social isolation experienced by these children, both before and after the death of their parent(s), is strongly exacerbated by the shame, fear and rejection that often surround people affected by HIV/AIDS.



*"Please can I have a doll and a dummy for my doll, because then I can play with my doll in my mother's room and near her grave. The doll will be my friend because I don't have friends because they say I am dirty" (Busine, 7 years old, National Children's Forum on HIV/AIDS, cited in Stein, 2003)*

In addition, the heavy burden of nursing for ill parents, often forces children to miss or drop out of school, increasing their vulnerability. A survey done in Uganda show that 26 percent of children living with parents infected by HIV/AIDS said that their attendance at school declined, citing the need to stay home to care for sick parents, increased household responsibilities and falling incomes (Gilborn et al, 2001)



### **Orphanhood has important health and survival implications for the children**

Several recent studies suggest that children orphaned by HIV/AIDS suffer significantly more hunger and are less healthy than non-orphans. For instance, by using panel data sets from Indonesia and Mexico, a recent study indicates that children with a deceased parent are generally less healthy than non-bereaved children (Gertler et al., 2004). Research from Tanzania shows that in non-poor families, the loss of a parent raises stunting (low height for age and a basic indicator of malnutrition) to levels found among children in poor families with living parents while in poor families, orphaning raises stunting levels even higher (Ainsworth et al., 2000). Similarly, research in the Northwestern region of Tanzania suggests that the loss of either parent will worsen a child's height for age, while maternal death causes a permanent height deficit of about 2 cm (Beegle et al., 2005). In addition, the loss of a parent can be associated with an increase in child mortality during the first year after his death (including HIV-negative orphans), as is indicated by a cohort study undertaken in south-west Uganda (Nakiyingi et al, 2003). Although not conclusive, evidence therefore suggests that orphan hood has negative health implications for the children.

### **HIV/AIDS orphan hood increases likelihood of child labour and exploitation**

A recent analysis undertaken in Thailand of the intersecting risks between HIV/AIDS and labour market concludes that children orphaned by HIV/AIDS are more likely to enter the workforce and to be exploited than other children (Rau 2002, cited in Bray 2003). Some of the reasons for this greater risk include for instance the impoverishment of natal and fostering household as well as AIDS-related discrimination, which prevents access to lower risks employment (ibid). In addition, rapid assessments carried out by the International Labour Organisation in several countries (including Zambia, Tanzania and Ethiopia) indicate strong links between HIV/AIDS, orphanhood and the worst forms of child labour (Semkiwa et al, 2003; Mushingeh et al, 2002; Kifle, 2002)

### **Orphans are less likely to be in school and more likely to fall behind or drop out**

The HIV/AIDS pandemic makes scarce resources even scarcer for families trying to cope with an adult death. One common strategy in HIV/AIDS affected households is taking children out of school because either help is needed at home or because the family can no longer afford school fees (Ainsworth et al., 2000). A substantive amount of qualitative and quantitative studies from several countries show lower school enrolment rates in orphans than non-orphans. For instance, a study from Mexico and Indonesia found that children with a deceased parent are more likely to drop out of school and are less likely to start school (Gertler et al, 2004). Similarly a long-term impact study undertaken in a Northern region of Tanzania, shows that maternal death causes persistent impact on years of education of almost one year (Beegle et al., 2005). Evidence shows that effects are largest for children whose mothers died, for young girls (under age 12) and for children with low basic academic performance (Evans et al., 2005). On the other hand, some researchers argue that orphans are not at any particular disadvantage over equally poor non-orphans (Foster et al., 1995) and that female orphans are not systematically disadvantaged (Case et al., 2003). The findings on the impact of orphanage and schooling are therefore mixed, as is pointed out by a World Bank report that notes that in low enrolment countries, both orphans and non-orphans face significant school constraints (World Bank, 2002).



However, it is recognised that while poverty is identified as an essential factor, it is not the sole determinant of an orphan's school attendance. An alternative view is that children,



who are cared for by adults other than their parents, are disadvantaged even holding resource fixed. In other words, even if the financial situation of household is not affected by the inclusion of an orphan, he might not be given the opportunity to attend school if the caregivers are only privileging their own children. The different enrolment rates of orphans and non-orphans could then be explained by the greater likelihood that orphans will live with more distant relatives or unrelated caregivers (Case et al., 2003 and 2004).

Undoubtedly, HIV/AIDS has devastating effects on the entire education system. In Zambia for instance, 40 percent of all teachers are HIV-positive and are dying at a faster rate than they can be replaced by new graduates (Daly et al., 2000). Depriving children of the essential survival kit of education is not only a threat to their individual future welfare but it also influences the development of the community at large and has therefore large policy implications, which is considered in the following section.

### Policy implications

There is ongoing policy debate about the best means to maintain orphans' living standards. An effective policy response to the orphan crisis requires timely information about the characteristics of the orphans as well as the overall risks they face. This section outlines some of the policy implications deriving from the research evidence elaborated above and provides examples of policy options.

#### Who should be targeted? Who is most at risk and how to best reach them?

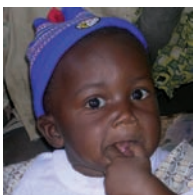
**Age pattern.** The age pattern of the orphan children has important implications for the allocation of resources for programmes. The substantial differences in the needs of children of different ages determine relevant child protection measures for each group (infancy and early childhood, middle childhood and adolescence) and how programmes should address each group. While programmes for very young orphans are important, new needs and different elements of the protective environment must be addressed to protect and provide for the nearly 90 percent of orphans above the age of 6.

**Household's (caregiver) members.** In the case extended family (or other caregivers) do provide adequate insurance, then governments need not target orphans specifically, but instead, assistance could be channelled through households. On the other hand, evidence showing that orphans are less likely to be in school than non-orphans with whom they live, suggest that policies should be targeted at the orphans specifically. In addition, if resource allocation within households is biased against orphans, unconditional cash transfers to their household may not reach the intended orphans.

**Orphans and poor non-orphans.** Several studies showed that orphans do not have any particular disadvantage over equally poor non-orphans. This information suggests that programmes linked to the impact of adult mortality should target children in the poorest families more generally. Finally, if households (or caregivers) are aware of the benefits of education but do not regard this as profitable, another strategy could be to improve the quality of learning instead.

#### Eligibility and stigmatization

According to a recent UNAIDS report, the term 'AIDS orphans' contributes substantially to the labelling and stigmatisation of children whose parents have died of AIDS, as opposed to other causes. It might, therefore, be essential to define eligibility criteria taking the stigmatization problem into consideration.





### Which type of aid?

Most organisations, governments and donors have felt that the material, economic, and physical needs are the most critical, therefore, requiring immediate response. As a result, psychosocial needs of orphans are most often neglected in programme design, despite being essential. Recently, several studies have shown that even if caregivers may be able to deal with the purely economic impact of parental loss, they may lack the tools to deal with the emotional distress faced by the orphans. This suggests that emotional based support for orphans should not be neglected but rather provided hand in hand with monetary aid.

### What is the objective of the policy?

While designing a policy aiming at HIV/AIDS orphans, it is critical to clearly define its objectives. Examples could be one or a combination of the following:

- Strengthening the capacity of families to protect and care for orphans
- Mobilizing and supporting community-based responses
- Ensuring access for orphans to essential services (education, health care, etc)
- Meeting emotional needs
- Raising awareness through advocacy and social mobilization
- Protecting the legal and human rights of orphans

Clearly, there is no one size fits all. Different communities depending on their specific needs and prevailing national and local contexts require specific responses. On the other hand, principles of responses and 'best practices' are being agreed upon. Policy making should, therefore, draw from these experiences as well as from ongoing research and debates.

## Policy implementation and examples on the field

Many efforts have been put in place in HIV/AIDS prevalent countries in order to provide care and support for the orphans. Some examples are shortly described here below.

### Supporting Alternatives to Institutional Care

Orphanages, children's villages or other group residential facilities may seem a logical response to growing orphan populations. But in fact, this approach can impede national solutions for orphans and vulnerable children. Although institutions can provide clothes, food and shelter, they often fail to meet emotional and psychological needs of orphans. Moreover, they tend to segregate children and adolescents by age and sex and from other young people and adults in their communities. Institutional life tends to promote dependency rather than autonomy. In addition, institutional care is a rather expensive way of coping with poverty and a growing orphan population. In fact, the ongoing costs of supporting one child in institutional care could support many times that number of children in family-based care.

The alternatives to institutional care should therefore be seriously considered. These include foster placements, local adoption, surrogate family groups integrated into communities and smaller scale group residential care in homelike setting. Placement in residential institutions is best reserved as a last resort where better care options have not yet been developed or as a temporary measure pending placement in a family. (UNAIDS/UNICEF/USAID, 2004)

### Multi-sectoral and community responses: The COPE programme in Malawi

The Community-based Options for Protection and Empowerment (COPE) of Save the





Children in Malawi has developed an example of 'multi-pronged strategies' of assisting communities to respond to the needs of children, families and communities affected by HIV/AIDS. The programme works through existing structures and organisations including community based religious organisations or local Community-Based Organisations (CBOs). As part of the general structure, there are four technical sub-committees, which are tasked with the different areas of response: orphans, youth, home based care and prevention. The committees are trained to raise resourced internally and externally. All communities then decide on what activities they will implement (for ex. Community gardens, stimulation and psychosocial activities for children, peer education activities, etc) but they all include identification, monitoring, assistance and protection of orphans.

Under increasing demand from neighbouring communities, COPE has entered in partnership with the government and seriously considers scaling up the programme to cover the whole country. *For more information:*

<http://synkronweb.aidsalliance.org/graphics/OVC/documents/0000086e03.pdf>

### **Country response to the AIDS orphan crisis**

Botswana, which is one of the countries most hit by HIV/AIDS in sub-Saharan Africa, has established a National Orphans Programme in 1999 to respond to the immediate needs of orphaned children. The programme is run by various government departments, NGOs, CBOs and the private sector. The government strongly encourages communities to provide care for orphans within the community and to only rely on institutional care as a last resort. As an example of the programme in action, the rural district of Bobirwa is implementing the project by contracting the Bobriwa Orphan Trust the delivery of essential government services to orphans in the village. First, the members of the trust identify and register orphans in the districts and they screen orphans using established criteria to identify the type of assistance they need. After that, they initiate community-based foster placements and identify local groups who purchase food and clothing to distribute to the orphans. Needy orphans are directly assisted with food, clothing, counselling, toys, bus fares to and from school, school uniforms and other educational needs. This is to avoid cases which have been experienced in the past, where families taking care of orphans use government orphans packages for their own benefit (not reaching the intended beneficiaries, i.e. the orphans).

**Source:** UNICEF/UNAIDS (1999), *Children Orphaned by AIDS, front lines responses from Eastern and Southern Africa*



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## Colophon

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