Children in Distress: The AIDS Legacy of Orphans and Vulnerable Children

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The Scale of the Orphans Crisis

HIV/AIDS is an epidemic with many faces. There is the silent epidemic of HIV which, for the greater part, is spread by sexual activity. There is the epidemic of the illness of AIDS which has led to more than 20 million deaths over the past two decades. There is the third epidemic of the adverse social reactions, stigma and discrimination that attach to persons infected with or affected by the disease. And there is the fourth epidemic, the one we are concerned with here, of the vast number of children that the disease has plunged and continues to plunge into orphanhood, poverty and untold human misery.

The number of orphans in the world today is almost unbelievably large. All are not as a result of AIDS, but the proportion of children who have been orphaned by AIDS is increasing, while the proportion who have been orphaned by other causes is decreasing. Recent estimates are that there are over 14 million children aged 15 or less in the world who have lost one or both parents to AIDS, and that number is expected to balloon to 25 million by 2010.[1]

Sub-Saharan Africa has the greatest proportion of children who are orphans and the largest concentration in the world of children orphaned by the AIDS pandemic. In 2001, it was estimated that almost one in every eight children across the continent was without one or both parents. Eleven million of these children had been orphaned by AIDS. Traditionally, Ireland Aid has concentrated much of its resources and activity in six countries of Sub-Saharan Africa: Ethiopia, Lesotho, Mozambique, Tanzania, Uganda and Zambia. Current estimates are that in those six countries alone, almost four million children—more or less the same as the population of Ireland—have been orphaned by AIDS, and this figure is expected to rise steeply to more than five million by 2005 and over six million in 2010. The rise would be even greater were it not for three things, the deaths of children born to mothers who are HIV positive, the deaths through AIDS of a large number of women of child-bearing age so that there are fewer women to bear the children, and the reduced fertility of women who are HIV positive.

It is a wonderful thing that the government and people of Ireland have been so generous with their assistance to countries that face so huge a human problem. That assistance has saved the lives of many people. It has given thousands of children a better life. The peoples of Africa, above all the mothers of Africa, and those who work with them will always be grateful for this. But let us understand some of the features of the situation so that we may appreciate that there is need for continued assistance, for assistance on a larger scale, and for assistance over a prolonged period of time.

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[1] Much of the data in these pages comes directly or indirectly from the UNAIDS/UNICEF/USAID report *Children on the Brink 2002. A Joint Report on Orphan Estimates and Program Strategies.*

Features of the Orphans Challenge

First, the orphans crisis and orphans challenge are already with us. These are not something that may occur in the future. They are something that is occurring here and now. Right now in my country, Zambia, every second household, on the average, is home to an orphaned child, the streets are running with orphaned children, there are thousands of homes in which there is no adult. These orphans are not statistics, but flesh and blood human beings, children cheated by life, almost all of them struggling to live without that one commodity which gives meaning to a young life and which no government or aid programme can provide—the love of a connected and concerned adult.

Second, the orphans are young. UNICEF data show that around half the orphans in Sub-Saharan Africa are aged ten or below—30 percent are aged between 6 and 10, 18 percent are under the age of five, while the mean age of orphaning is 6.2 years (Mugabe, Stirling & Whiteside, 2002). This means that in the Ireland Aid priority countries there may well be about 1.6 million children aged six or less who have lost one or both parents to AIDS.

Third, if one parent has died of AIDS, the likelihood is quite high that the other parent will be HIV positive and will die of the disease. This means that children who have lost one parent to the disease are quite likely to experience the loss of the second parent also. Those who have worked in any of the severely affected countries can bear this out from their experiences of the funeral of a young mother followed a year or two later by the funeral of her husband, or of a young father followed probably even more quickly by the funeral of his surviving wife. This is because HIV spreads so readily through sexual activity that if one partner in marriage is infected, then almost certainly the other will also be HIV-infected. When AIDS is the cause of death of one parent, being a single orphan, maternal or paternal, offers almost no protection to the child. The child will almost certainly have to undergo the trauma of being orphaned a second time, and this sooner rather than later.

Here it is relevant to recall some of the features of HIV transmission. One is what we might call the predilection of the disease for the young. Of the estimated 40 million HIV-infected people in the world, 11.8 million are young people between the ages of 15 and 24. More than half of those who become newly infected are in this age range (UNAIDS/UNICEF/WHO, 2002). This points immediately to the critical importance of directing policies, strategies, interventions and budgets specifically towards young people, something that is not yet being done on the scale that is required.

But HIV infection does not affect young people equally. Young women are much more likely than young men to become infected. In every part of the world, apart from Asia and the Pacific, more young women than men are HIV-infected. Globally, there are 7.3 million young women between the ages of 15 and 24 living with HIV and AIDS, compared with 4.5 million young men. In countries such as “Ethiopia, Malawi, Tanzania, Zambia and Zimbabwe, for every 15- to 19-year-old boy who is infected, there are five to six girls infected in the same age group” (ibid., p. 17).

Ten to twelve years later, these HIV infections progress to AIDS and almost inevitable death. This means a very high mortality rate among young adults between the ages of 25 and 40, but with the mortality patterns differing between women and

men. The peak ages for AIDS (and resulting death) are 25 to 35 for women and 30 to 40 for men. Economically and biologically these are the most productive years in a person's lifetime. But the potential to produce and reproduce is wiped out as the disease sweeps away young adults who should be the backbone of household and national economic production. More tragically, it sweeps away young parents during the years when their children stand in greatest need of their nurturance, support and love. And because in most societies the husband tends to be a few years older than his wife, both husband and wife are likely to develop AIDS around the same time, even though she is younger than he, and both are likely to pass on, leaving several young children without parental care and affection.

A further feature of orphanhood is of critical importance. It is that being an orphan is not an event. It is an enduring state or condition that lasts throughout the years of a child's life and accompanies the child into adulthood. A six year-old orphaned child will need support, care and protection for another ten or twelve years. A two year-old orphaned child will need almost a generation of care. In this, the orphans crisis differs from other problems of development. If there is a water shortage in a village, it can usually be set right by the one-off event of sinking a well and thereafter giving periodic attention to its maintenance. One-off interventions and periodic attention are totally inadequate for orphans. Instead, they need sustained regular support and attention over a decade or more. Responding to their needs demands more than the short-term perspective of five-year plans or impending elections. It requires sustained commitment that will remain faithful to individual orphans for as long as is needed, seeing one wave after another of fragile, vulnerable young people through to maturity and adulthood.

One other important aspect of the HIV/AIDS situation is that while we can frequently identify the orphaned child, there are millions of other children affected by the epidemic whom we cannot identify so readily but who suffer from its myriad impacts. Orphans are the tip of the iceberg. Theirs are the pathetic faces that draw our attention to the countless other children in an AIDS affected society, who may differ from orphans only in that their parents have not yet died, but who experience the poverty, stigma, uncertainty, and hopelessness that so frequently accompany AIDS in a household or community.

The Psychological and Emotional Distress of Orphans

The worst thing that the AIDS epidemic can do to a child is to deprive it of its parents. Very correctly, we pay a great deal of attention to meeting the basic needs of children for food, clothing, accommodation, health care, and education. But we pay very much less attention to meeting their needs for love, affection and security. These are not commodities that you can accumulate over time and send out in a container. You cannot place any monetary value on them. A recent book has well asked about the cost of a cuddle forgone (Barnett & Whiteside, 2002, p. 7). HIV/AIDS raises a host of human problems that have no quantifiable or economic dimensions and that we are only beginning to be dimly aware of, and this is one of them. The recent Johannesburg World Summit has alerted us to the issue of sustainable development and made us more deeply aware that development cannot be sustained without care for the environment. But even more fundamentally, the human development of children cannot be sustained with care for the environment of love and security, and it is precisely these that HIV/AIDS places under threat.

The threat begins long before the finality of death eventuates. HIV is a slow-working virus that may spend ten or more years working on the body's immune system before it has weakened it sufficiently for life-threatening opportunistic illnesses to take hold. When they do, they course through the body with an inhuman and devastating savagery. In countries where the medical infrastructure is weak and medical supplies are scarce, the sick person suffers the indignities of AIDS illnesses in his or her own home, very often without as much as a panadol to give even temporary relief. As with others in the household, the children experience the daily trauma of seeing mother or father enduring the devastating effects and remorseless suffering of AIDS and its culmination in what is often a dehumanising death.

> Becoming an orphan of the epidemic is rarely a sudden switch in roles. It is slow and painful, and the slowness and pain have to do not only with loss of a parent but also with the long-term care which that parent's failing health may require. … A young girl of eight or nine may be used to caring for younger siblings: she is unprepared to care for her mother, father, or both of them. … Coping with a parent who is weak and requires food to be cooked or water to be brought is one thing. Coping with a parent's severe diarrhoea, declining mental function and mood changes is quite another (Barnett & Whiteside, 2002, p. 206).

Almost certainly nowadays, the older children will know from what has happened elsewhere that their parent cannot live much longer, while the younger ones will pick up hints and rumours from community talk. They are not capable of putting words on it, but they know that they are orphans in the making, and the only preparation that the majority receive is the experience of trauma and distress.

Faced with this problem, NACWOLA, the National Community of Women Living with AIDS in Uganda, has started the Memory Project which aims to help HIV-positive mothers prepare their children for a time when they will have to cope without parental guidance or support (Kaleeba *et al.*, 2000). The Project helps parents in the difficult task of disclosing their HIV status to their children in ways that are sensitive to the needs of the child. Central to the project is the memory book, prepared jointly by the parent and child, and containing mementoes, short written records about the family and its members, where possible photographs covering various aspects of the family's life, and finally the parent's advice to the children—from the grave, as it were—on how to live, behave and look after one another as brothers and sisters. One of the purposes is to help children, while the parents are still alive, to articulate their fears and concerns about their parents' illness and their own future. A further purpose is to enable parents and children to plan together for the time when the parents will no longer be alive, succession planning as it is called. In the circumstances of so much sickness and the deaths of so many young parents, it is helpful and it is necessary, but doesn't it tear the heart out of us even to think of it?

When death eventually occurs, the trauma and suffering of children continue. Cases have been recorded where bereaved children could not even find sufficient time to grieve or come to terms with their loss, but had to be occupied with funeral arrangements or found themselves bundled off to other families and communities for the entire mourning and funeral period. In some cultures, boys are discouraged from giving adequate expression to their grief. In many cases, the orphaned children may find themselves "allocated" to relatives and other families, without their having had any say in the matter, and almost as if they were property to be disposed of. In these circumstances, many undergo what is almost a second orphaning experience by being

separated from siblings and familiar surroundings and often they find their distress compounded by family dissension over the disposal of the property of their dead parents.

A survey conducted in early 2002 among orphans in Lusaka revealed something of the distress that they suffer (FHI/SCOPE OVC, 2002). Most were still bothered by their parents' deaths, even though, in many cases, these had occurred some years earlier. Very many of the younger children lamented the fact that they had no personal item or memento to remind them of their dead parent. Those with such items would look at the item when they felt especially sad or upset. Almost all said that what they missed most about their mother was the loss of her care and love and being able to be with her, whereas what they missed about the father was the emotional, material and general support he provided. A significant number stated that they experienced bad dreams or nightmares, had trouble with sleeping, felt unhappy and were often worried.

Clearly, things are far from being well with the emotional and psychological status of orphans. The problem is so new and its dimensions so large that we do not know yet whether in time "they will grow out of it". But there are some signs that their psychological development may remain stunted for a long time. In schools, orphaned children can frequently be identified through their apathetic listlessness, excessive reserve, and strained gravity. With the increase in their number, reports are now being received of some tendency to mingle more among themselves than with non-orphaned children, something that could lead to their being inadequately socialised for adult, independent life (Mugabe *et al.*, 2002). One issue that is particularly bothersome is how they will function as parents when their time comes. They have not experienced the joy and happiness of a carefree childhood. Will they be able to ensure that their own children can do so? Will they be so set on ensuring this that they will spoil their children? How will they behave as parents when they themselves have never known what it means to be parented?

These considerations underline the importance of enabling orphaned children to develop in an atmosphere that is normal and emotionally secure. This has two very practical outcomes. One is that orphans should not be singled out as a special category. Above all, those whose parents have died from AIDS should not be categorized as "AIDS orphans". Targeting in this way can increase stigmatization, discrimination and harm for these children. Such targeting is all the more undesirable in situations where, as in all of the Ireland Aid focus countries, there are also large numbers of other vulnerable children whose parents are still living. Within communities, assistance should be directed to the most vulnerable children and households, regardless of orphan status, and one can generally rely on communities to identify those who are in greatest need and most vulnerable.

The second practical outcome is the importance of school education for orphaned children. School attendance is one of the greatest antidotes to an orphan's sense of loss, insecurity and fretfulness. Schooling is strongly characterised by normality and routines, factors that help every one of us make sense out of disturbing and bewildering situations. It provides a social milieu where the orphaned child can relate to peers and adults in a situation of ordinariness, rationality and regularity. In this way it helps the child develop a renewed sense of efficacy in relation to life and its

happenings, restores some of the lost confidence, and offers hope that life can go ahead. “School restores structure to young lives; it provides a measure of stability in the midst of chaos; it trains the mind, rehabilitates the spirit, and offers critical, life-sustaining hope to a child in the face of an otherwise uncertain future” (Donovan, 2000, p. 3).

Other Consequences of HIV/AIDS for Children

On top of their emotional distress, children whose parents have died from HIV/AIDS suffer from numerous adverse social consequences:

- They may arouse sentiments of fear and suspicion in others, are likely to experience stigmatization and discrimination, and are often the subjects of cruel jests, taunts and unreasonable demands.
- They are more likely than non-orphans to be malnourished and under-weight (Foster & Williamson, 2001, p. S281).
- Although the evidence is mixed, in general orphans are more likely than non-orphans to be out of school (Ainsworth & Filmer, 2002).
- The proportion of children aged 5–14 who work more than 40 hours a week is higher among orphans than non-orphans (Mugabe *et al*., 2002, p. 3).
- A large proportion of orphans end up as street children.
- Emotional vulnerability and financial desperation expose orphans to greater risk of sexual abuse and exploitation (UNICEF, 1999)
- Their vulnerability to sexual abuse puts orphans at higher risk than other children of becoming HIV infected.

A related economic issue of concern is how orphans in rural areas can learn to be productive when there is nobody to pass on to them the relevant knowledge and skills. The United Nations Food and Agricultural Organization (FAO) has observed that HIV/AIDS in rural families has disrupted mechanisms for transferring knowledge, values and beliefs from one generation to the next, and that agricultural skills are being lost since children are unable to observe their parents working (FAO, 2001, §14).

In urban areas, where opportunities for formal employment are minimal, orphans may have to live by their wits in their communities, on the streets, or through petty thieving. It is increasingly being recognized that this latter and the increase in the number of poorly socialized young people has implications for security and stability in society. Schönteich (2000) gives details of a number of studies which show that poor parental supervision and low parental involvement with the child (factors which would obviously exist in the case of an orphaned child) are among the strongest predictors of delinquency and violence in later life. Hence there are concerns that the increase in the number of orphaned juveniles as a proportion of the general population could lead to a sustained increase in crime levels in the short to medium term.

How Society Responds to the Needs of Children Orphaned by AIDS

Families and communities are at the heart of the response to the crisis situation of orphans and vulnerable children[2]. Unfortunately, these all-important social entities are being left to deal with the crisis almost on their own, the assistance that comes from outside being quite insignificant in relation to the scale of the problem. Religious

[2] See Appendix I, Strategies to Assist Children, and Principles for the Guidance of Programmes.

associations, local community-based associations (CBOs) and NGOs, international child welfare NGOs (such as Save the Children), UNICEF and some others (such as the European Union) make valiant efforts to scale up the response, but their efforts are to a large extent piecemeal and uncoordinated and are not commensurate with the size of the problem. National commitment to understanding the gravity of the problem and dealing with it appropriately is conspicuously absent. Governments have not taken the orphans situation on board for the crisis it represents. Their responses are too little, too late, too scattered.

International understanding and commitment are also deficient. Several years have passed since it was first noted that orphanhood as a result of AIDS had become the "black hole" of development, the Pandora's box which was kept tightly shut for fear of unleashing ungovernable demand for services and creating expectations that could never be met (Hunter & Williamson, 1997). Notwithstanding the dedication and commitment of UNICEF and other child welfare agencies, the lid was kept on the box until very recently. Thus, only two years ago the World Education Forum, meeting in Dakar, committed itself to meeting the basic educational needs of every child, youth and adult, but though it made mention of vulnerable groups, the Dakar Framework for Action made no mention of orphans.

The situation changed for the better at the United Nations General Assembly Special Sessions held in June 2001 on HIV/AIDS and May 2002 on meeting the needs of children. For the first time, the world has faced up to the challenge of orphans and vulnerable children in its commitments to accountable and measurable progress towards providing for their needs. The declarations of commitment emanating from these high level meetings obligate the world to

- build and strengthen government, family and community capacities to provide a supportive environment for OVCs;
- ensure counselling and psycho-social support for children living in HIV/AIDS-affected families;
- ensure the access of orphans to education, shelter, good nutrition, health and social services on an equal footing with other children;
- protect OVCs from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;
- ensure non-discrimination and full and equal enjoyment of human rights (UNGASS 2001, §§65, 66).

The world has made its promises to orphans and vulnerable children. What remains now is to see those promises fulfilled.

Community Structures for Responding to the Needs of Children Orphaned by HIV/AIDS

The first step that communities take with regard to orphaned children is to ensure their placement in a household. The traditional structure of a nuclear family—father, mother, children—living together but having extensive interaction with an extended family of relatives is being supplemented by various new structures.

Single-parent households

What happens most commonly when the mother dies is that children will be dispersed among relatives or the father will remarry. A household containing children and

headed by a man without a female partner or spouse is not very common. On the other hand, when the father dies, the widow often tries to maintain the household for herself and her children. These female-headed households are very vulnerable.

Because women are so extensively disempowered and do not have equal access with men to land and other resources, these households may be tight-knit socially in the bonds between children and their mother but weak economically. Their livelihood may depend on small-scale horticultural and agricultural ventures, lowly paid domestic employment, petty trading, stone-breaking, street cleaning and similar bottom-of-the range activities. In some cases, women and girls in the household may resort to supplementing their incomes through the sale of sex and petty thieving. In such households, orphan access to basic needs is, to say the least, severely compromised.

Grandparent-headed households

48 percent of those caring for orphans in Tanzania are grandparents, 38 percent in Zambia, and 32 percent in Uganda (Mugabe *et al.*, 2002). Many of these elderly care-givers lack the physical resources and the health, energy and vigour to be able to rear a second, and sometimes even a third, family late in their lives. The age-old question also arises, who will care for the carers? Who will care for these elderly people who had expected that their sons and daughters would look after them in their old age? The orphans for whom they care also face the possibility of being orphaned yet again when the elderly care-giver dies.

Child-headed or sibling households

HIV/AIDS has led to the emergence of a relatively new structure known as the child-headed or sibling household. These are households where all adult members have died and the children must fend for themselves, frequently under the guidance of the oldest among them. This may be a boy or girl aged 14 or less who, by unspoken consent, assumes economic and quasi-parenting responsibility for the others. Generally those in the group will be siblings or at least have close blood ties with one other, though similar households are also formed by street-children whose bond is their common need for survival. Sibling households frequently establish themselves because brothers and sisters who have lived and worked together in caring for their sick and dying parents want to preserve their sense of identity, worth and dignity by remaining together.

In 1998, World Vision estimated that there were 45,000 child-headed households in Rwanda, while in severely affected communities in Swaziland about ten percent of homesteads are headed by children (Subbarao *et al*., 2001; Brody, 2002). Access to basic food, health, education and social needs is on a very precarious footing for children in such households. In many cases, everybody in the household, including even the youngest, must work to generate the resources needed for survival. It can also happen that there might be nobody to ensure that the younger children attend school, though this possibility is counterbalanced by numerous accounts of older children who are sensitive to the importance of education for their younger siblings and who make superb, generous efforts to ensure that at least one of them attends school.

Foster households

In the African context, fostering refers to the placement of the orphan with relatives in the extended family. Initially, this placement may be temporary, with the orphan moving from one set of relatives to another, but eventually the orphan is generally considered as belonging to one family, though there may still be considerable mobility. This pattern leads to some rootlessness that may accentuate the orphan's sense of being without a personal identity. There may also be uncertainty about which school to attend. As noted already, decisions about the placement of orphans with relatives are frequently taken without reference to the wishes and views of the orphan concerned. These decisions may also lead to the dismemberment of sibling groups, and the transfer of the orphan to a new physical location. This is not in accord with the best principles for orphan care. These suggest that ideally orphans should remain with, or be incorporated into, a family with which they have blood ties, stay with their own siblings, and live in the familiar surroundings of a known community (Government of Zambia, 1999, p. 49).

In the majority of cases, orphans who are fostered within the extended family are treated with fairness and dignity. But, as in every human situation, there will always be variations and exceptions. "Ideally, foster families would provide for all of their children, regardless of the child's status, to best of their ability. However, when families feel overburdened or incapable of meeting the needs of the household, foster children may be the first to suffer" (Subbarao et al., 2001, p. 20). Orphan informants sometimes speak of themselves as being the last in line when food is being distributed (or, even worse, being sent on a message around meal time and finding no food left when they return). If family resources are constrained, more may be spent on the household's own children than on orphans as, for example, in meeting school costs.

There is some evidence that the burden of orphan care falls for the greater part on poor families that are least able to assume the additional responsibilities. This means that in many foster households the incorporation of one or more orphans results in the already limited resources being spread more thinly to meet the needs of a larger number. This can reduce the care and nutrition levels all round. It can also lead to some resentment on the part of those who were part of the original household. It was probably because of factors like these that only 56 percent of the 13–18 year-old orphans surveyed in Lusaka said that they were well-treated, and only 71 percent said that they got along well with other children in the household (FHI/SCOPE OVC, 2002). The facts noted already that orphans are more likely than non-orphans to be stunted, to be out of school, or to carry heavier loads of physical work, also point in the direction of orphans being the first to suffer when household resources prove inadequate.

Orphanages

Although they have some place, there are two basic reasons why orphanages are not an appropriate first-line response to the developing orphans crisis. One is that institutional care in an orphanage costs much more than providing a comparable level of care within a family or community. Estimates used for planning purposes in 2001 were that institutional care in Africa might be fifteen times more expensive than community care (World Bank, 2001). At the same time, the absorptive capacity of orphanages is so low that they can cater for only a small fraction of the children who are in need of care and support. The second reason why orphanages are not an

appropriate response is that they do not respond well to the developmental and long-term needs of children, one result being that children find it difficult to adjust to the social and economic situations they encounter when they leave these institutions. There is also the danger that orphanages may be viewed as a way of escape—for the orphan from poverty, for the relatives from responsibility. A further hazard that is almost obscene is 'orphan farming' where developers provide institutional homes for children in the expectation of considerable external support not all of which benefits the orphans (Barnett & Whiteside, 2002).

Orphanages, however, have a place as a temporary arrangement while negotiations are under way for the within-family placement of an orphan. They also have a place as a home for abandoned infants, especially those who are HIV-positive, and for children placed in especially difficult circumstances in post-conflict situations. But given the scale of the problem and the social psychology of community life in Africa, they can only be a partial and emergency response.

Children's Villages

In response to the enormity of the needs and the absence of sufficient care-givers in communities, an alternative quasi-institutional model is developing in many parts of Africa. Essentially this consists in community-based day-care centres where children can receive care (including meals), education and health attention during the day, but continue to live in their own homes (or in simple specially provided structures). Adult visits and supervision may ensure that the living conditions are reasonable and that the children are showing responsibility for their own development. In an analogous development, some communities have appointed designated care-givers to monitor and support on a regular basis children who live on their own.

An example of this approach is the Kenneth Kaunda Children of Africa Foundation which has established day-care centres in five high density locations in Lusaka, Zambia, each catering for twenty or more 3–9 year-old orphans. The orphans continue to live with their grandparents (or other elderly family members), but attend one of the centres during the day. Here they get meals and basic education. They also receive medical treatment at an AIDS clinic run by the Foundation. The clinic has noted that the regular nutritious diet has led to fewer problems needing medical attention, even among children who are HIV-infected. Widows from the community are responsible for the day-to-day running of the centres, the intention being that in time they will assume full responsibility for all operations.

The Bottom Line: Are Families and Communities Coping with the Orphans Crisis?

Families and communities are coping with the orphans crisis to the extent that for the moment the challenge seems to have been contained. Although there has been an increase in the number of street children, so far there has been no manifest breakdown in the functioning of society. The unprecedented crisis is being responded to with unprecedented heroism and generosity, especially on the part of women. Families and communities are being sundered apart as they experience the first and most direct onslaught of HIV/AIDS. But they are bonding together again in the magnificent way they are withstanding the huge pressure that the increase in orphan numbers is placing on them, coping with the challenge almost as if it were normal routine.

But cracks are appearing. The continuing downward spiral into poverty that HIV/AIDS engenders is making it more difficult than ever for families to incorporate orphans. When they do so, they find that they are sucked even more deeply into the poverty vortex. They reduce the number of meals and the quantity of food for each meal. They reduce their spending on health and education items. They sell off household goods and productive assets. They beg from friends, churches and charities. They try heroically, especially if they are women, to provide food, clothing and a home for a larger number, but with no commensurate increase in income. They strive to make less go further. They give the impression that they are managing, but in reality they are coping neither with poverty nor with the orphans challenge.

Re-invigorating the Response to the OVC Challenge

This "myth of coping" (Mugabe *et al.*, 2002) has contributed in no small measure to virtual abdication by governments of their responsibility to provide adequately for orphans. Notwithstanding the severity of the crisis, governments have for the most part failed to recognize and respond to it. They have made only minimal provision for orphans in their plans and budgets, and have been half-hearted in their efforts to coordinate the response. Instead they have left it to families and communities to manage the situation, in the mistaken belief that they are coping.

But governments tend to reflect only two things: their understanding of a situation and its meaning for economic progress, and pressures brought to bear by an enlightened and vote-using public. Therefore, stimulating governments to respond to the OVC crisis requires

- a quantum jump in public awareness of the dimensions of the problem,
- clear recognition by public leaders of the existence of a massive human crisis that has potential to undermine social and economic growth,
- readiness to commit to action and budgetary provision, and
- preparedness to lead in coordinating the response.

There is also need to hold governments accountable for the commitment they made at the United Nations in June 2001, before the international community and their own peoples, to develop by 2003 and to implement by 2005 national policies and strategies to strengthen capacities to manage the OVC crisis (UNGASS, 2001, §65). If they do so, there would be some hope that OVCs might have access to education, shelter, good nutrition, health and social services on an equal footing with other children; that they might be protected from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance; and that they might experience non-discrimination and full and equal enjoyment of human rights.

Very recently, AIDS activists, African health ministers and UN officials have concretised these issues by calling for a dual approach to the orphans crisis. On the one hand, every effort should be made to stem future growth in the number of orphans, on the other tangible steps should be taken at once to turn the tide for those who have already been orphaned or made vulnerable by HIV/AIDS.

The first approach requires determined efforts to keep parents, especially mothers, alive. This would necessitate advice and support that would help HIV infected parents live in a positive and responsible way. The support would involve enhanced health care, participation by agricultural extension services to ensure food security and a

more varied nutritious diet, better access to safe water, sanitation and hygiene, and—when the need arises—access to antiretroviral treatment. Keeping families intact, by helping mothers and fathers to stay alive, would nip the growth of orphan numbers in the bud. The interventions needed for this would be a first step in opening the door for targeted and extensive antiretroviral treatment across Africa.

The second element of the approach focuses on immediate mass sensitisation, action and commitment to responding to the needs of the eleven million children who have already been orphaned by AIDS in Africa:

1. A special parliamentary debate in each country to consider the OVC crisis.
2. A mass mobilization campaign, with education as its centrepiece ("every child in a school") and youth as key participants.
3. Mechanisms that would make countries accountable for achieving progress towards the UNGASS goals, through a reporting mechanism to the African Union or similar body.
4. Fostering of initiatives by faith-based organizations in each African nation to enlist religious leaders in promoting action on the plight of children orphaned by AIDS and the reduction of stigma.
5. The inclusion of the OVC challenge and issues among the required criteria for applications to the Global Fund against HIV/AIDS, Tuberculosis and Malaria.
6. The incorporation of gender perspectives into every response to the OVC crisis since gender impacts so strongly on OVC needs.
7. Mechanisms for ensuring that resources, especially money, get quickly to the grassroots where they are needed and that nothing is diverted along the way, and for identifying where blockages in resource transmission have occurred.

Immediate action along these dimensions will invigorate the OVC response with the energy that it has hitherto lacked. What is needed for this action to take off is leadership at all levels. Paraphrasing the Consensus Statement adopted at the Africa Development Forum in December 2000, it can be said that "this is the decisive moment in Africa's struggle to respond to the continent-wide crisis of children orphaned by HIV/AIDS. Success in responding to this crisis demands an exceptional personal, moral, political and social commitment on the part of every African. Leadership in the family, the community, the workplace, faith-based institutions, schools, civil society, government and at an international level is needed to halt the preventable growth in orphan numbers, and to provide a decent life for every child, orphaned or with living parents, in Africa" (cf. ECA 2001, p. 49).

Given this exceptional personal, moral, political and social commitment on the part of every African, great things could happen. Without it there will be continued failure to address the OVC crisis, children will remain in distress, and the future of individuals and countries will be jeopardized. What needs to be done is clear. But the question remains whether there is a will to do it.

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Appendix I

Strategies to Assist Children

1. Strengthen and support the capacity of families to protect and care for their children.

2. Mobilize and strengthen community-based responses.

3. Strengthen the capacity of children and young people to meet their own needs.

4. Ensure that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children.

5. Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS.

Source: *Children on the Brink 2002*, pages 13–14

Principles for the Guidance of Programmes Aimed at Mitigating the Effects of HIV/AIDS on Children and their Families

1. Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities.

2. Strengthen the economic coping capacities of families and communities.

3. Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers.

4. Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS, and efforts to support orphans and other vulnerable children.

5. Focus on the most vulnerable children and communities, not only those orphaned by AIDS.

6. Give particular attention to the roles of boys and girls, and men and women, and address gender discrimination.

7. Ensure the full involvement of young people as part of the solution.

8. Strengthen schools and ensure access to education.

9. Reduce stigma and discrimination.

10. Accelerate learning and information exchange.

11. Strengthen partners and partnerships at all levels and build coalitions among key stakeholders.

12. Ensure that external support strengthens and does not undermine community initiative and motivation.

Source: *Children on the Brink 2002*, pages 34–35