The Impact of HIV/AIDS on the Rights of the Child to Education

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on
The Rights of the Child in a World with HIV and AIDS

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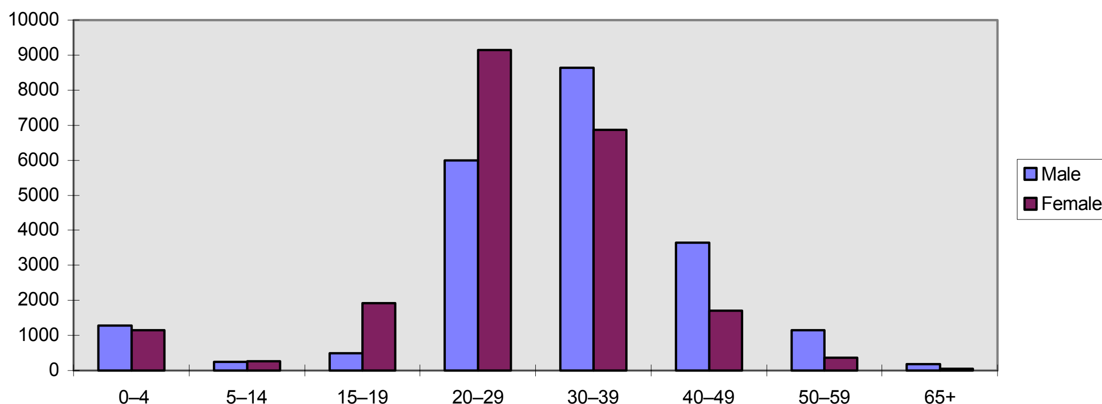
HIV/AIDS and the Rights of the Child

Strengthening the rights of the child is a priority area for SADC-EU cooperation. The HIV/AIDS epidemic in the SADC countries places many of these rights in jeopardy, among them the right to education. But to see this in context, it will be helpful first of all to run through the Convention on the Rights of the Child so that we might appreciate the extent of the risk the epidemic poses to children:

Article 3 The child has the right to protection against all forms of discrimination on the basis of the status of the child's parents or family members. This right is infringed when children from AIDS-affected families experience discrimination, stigma or taunting in school or elsewhere.

Article 6: Every child has the inherent right to life. HIV/AIDS attacks this right, with infant and child mortality rates being so very much higher than they would be in a no-AIDS scenario (Annex Table 1), and with a significant occurrence of HIV infection in the ages 5 to 14 and subsequent death in the ages 15 to 19, when technically the individual is still a child (Figure 1).

Figure 1: Reported AIDS and AIDS-Related Cases in Zambia through July 1997



Source: Zambia, Ministry of Health, September 1999, p. 17

Article 8 The child retains the right to preserve his or her identity, including nationality, name and family relations, something that may be denied to those orphaned by AIDS who are in danger of losing all human identity in the way they are treated as anonymous statistics.

Article 9 Every child retains the right not to be separated from his or her parents against their will, a right that is scorned by HIV/AIDS as it leaves millions of children orphaned in our countries. Perhaps this right needs to be amplified by a further right, not to be separated from one's siblings, something which orphaned children often experience against their will.

Article 12 In all matters affecting the child, the views of the child shall be given due weight in accordance with the age and maturity of the child, a right that is flagrantly

violated when orphans are transferred—one might almost say “disposed of”—from one family to another, from one location to another, without the views of the orphans themselves being taken into account.

Article 13 The child shall have the right to freedom of expression, including the right to seek, receive and impart information and ideas of all kinds. But for the greater part, children orphaned by AIDS are denied correct information on the cause of the death of their parents, and they are not provided in the home or in school with the information they need to protect themselves against HIV infection.

Article 16 No child shall be subjected to arbitrary interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation. Surely this is also a right to be free from discrimination and stigma because of HIV/AIDS in the family, a right that many affected children do not enjoy.

Article 18 The best interests of the child shall be the basic concern, and where necessary governments shall render appropriate assistance to parents and guardians in the performance of their child-rearing responsibilities. It is recognised that families and communities are the first line of response to the needs of orphans, but to what extent are these receiving the appropriate assistance that this right enshrines?

Article 19 All necessary measures shall be adopted to protect the child from any form of physical or mental violence or abuse. But we all know that the myth is widespread that AIDS can be cured by having sex with a virgin or with a very young child, and so cases of child abuse are mushrooming in badly affected countries.

Article 20 A child temporarily or permanently deprived of his or her family environment shall be entitled to special state protection and assistance. What budget lines do we have for ensuring this right? How does this special protection and assistance extend to street children?

Article 24 The child has the right to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. This includes the combating of disease and malnutrition within the framework of primary health care. The data on infant and child mortality rates speak volumes to the neglect of this right.

Article 28 The child has an inalienable right to education, and with a view to achieving this right states shall make primary education compulsory and available free to all. In the majority of our countries, primary education is not universally available; it is neither compulsory nor free; the ones most likely to be excluded from its benefits are the marginalised children in society—the poor, girls, orphans; and the AIDS epidemic poses the real risk that ministries of education will not be able to continue to offer educational services as in the past (see Figure 2 below for the way orphans are disadvantaged in their access to schooling, and Table 3 for the number of children whom HIV/AIDS has left without a teacher).

Article 31 The child has a right to rest, leisure, play and recreation. One of the most tragic features of the impact of HIV/AIDS on children is that so many must forego this right. Because of AIDS, they must bypass this whole stage of childhood and shoulder adult responsibilities at a very young age, as carers for the sick, as generators of income for their own families, as heads of households with responsibilities to younger siblings.

Article 32 The child has a right to be protected from economic exploitation and from work that is likely to interfere with the child's education or to be harmful to the child's moral or social development. How does this right accord with the obligations that young children must assume as heads of households? with the need to undertake social and economic activities support activities for themselves and their families?

Article 34 The child has the right to be protected from all forms of sexual exploitation and sexual abuse. This right is patently violated by the need so many young girls experience to turn to prostitution in order to find school fees for themselves or for their younger siblings. It is patently violated by the sexual violence experienced by girls and young children, only too often within their own families. It is patently violated by the sexual hazards children experience in boarding schools, or when travelling considerable distances to school always by the same route, or when thrown together without adequate information or protection in large classes with other children of very mixed ages and very mixed sexual experiences.

HIV/AIDS and Children's Right to Education

Let us now move to considering more specifically the plight and the educational prospects of children affected by the HIV/AIDS epidemic. Orphans constitute one of the most tragic and visible outcomes of the disease, but adverse effects are also experienced by other children. Throughout this whole discussion we should bear in mind that the peak ages for AIDS cases are 20–29 for females and 30–39 for males (see Figure 1 above). The majority of women who contract HIV die before their 35th birthday, when their children are still young. The majority of HIV men die before their 40th birthday, when they should be the principal bread-winners for their families.

Box 1: Conceptual Framework for the Educational Impacts of HIV/AIDS on Children

HIV/AIDS

- leads to a rapid increase in the number of orphans and disadvantaged children
- makes it likely that a substantial number of children will not be able to enrol in school in the normal way
- has negative impacts on the school attendance of affected children
- affects the quality of education for all children
- causes anxiety to children through trauma, discrimination and stigma
- leads to a growing problem of street children
- makes it necessary for many children to provide social and economic support for themselves and/or their families/siblings
- deprives children of the formation, experience and role models they need for their subsequent adult life
- places a massive strain, through the orphanhood problem to which it gives rise, on the extended families and communities, and thereby further jeopardises a child's right to education.

Box 1 presents a simple framework for the subsequent analysis.

HIV/AIDS Leads to a Rapid Increase in the Number of Orphans and Disadvantaged Children

The most visible demographic impact of the HIV/AIDS epidemic is the growth in the number of orphans. Estimates are that in the SADC countries (not including Angola) there are currently 5.096 million children below the age of 15 who have lost their mother or both parents, plus a further 6.228 million who have lost their father (Table 2; see also Annex Table 2). Apart from cases in Mozambique and the Democratic Republic of Congo, countries with a heavy war legacy, the great majority of the maternal (mother dead) and double orphans are believed to have lost their parents as a result of AIDS. But many of the paternal orphans (father dead) are likely to lose their mother also within a few years, since if the father, especially the father of a young child, dies as a result of AIDS, the mother too will almost certainly be infected and will not have long to live. In almost all of the eleven countries the number of orphans will rise during the coming decade, increasing from 11.324 million in 2000 to 15.671 million in 2010 (Table 2).

Table 2: Orphan Estimates for SADC Countries

	Total Number of Orphans from All Causes		
	Estimates for 2000	Estimates for 2005	Estimates for 2010
Botswana	102,000	170,000	206,000
Dem. Rep. Congo	3,357,000	3,422,000	3,476,000
Lesotho	76,000	126,000	174,000
Malawi	947,000	1,000,000	1,005,000
Mozambique	1,511,000	1,966,000	2,216,000
Namibia	124,000	204,000	253,000
South Africa	1,283,000	2,504,000	3,581,000
Swaziland	75,000	127,000	174,000
Tanzania	1,533,000	1,851,000	2,149,000
Zambia	1,249,000	1,229,000	1,173,000
Zimbabwe	1,067,000	1,244,000	1,264,000
Total	11,324,000	13,843,000	15,671,000

Source: Hunter & Williamson, July 2000

The current estimates are at their worst for Zambia, where it is believed that 27.4 percent of children below age 15 have lost their mother or father or both, the greater part of the loss being due to AIDS. The picture changes somewhat during the coming decade, the projection being that by 2010 the worst hit countries will be Botswana and Zimbabwe, in each of which more than one third of the children aged below fifteen will have lost one or both parents, mostly due to AIDS, followed by Mozambique, Namibia and South Africa, in each of which more than one quarter of all children will be orphans.

The orphans problem is of such magnitude that it is quantitatively and qualitatively different from anything hitherto experienced by humanity. The figures quoted can be compared with the 13 million children orphaned in Europe during the 1939–1945 war, or the 440,000 children separated from their families in the 1994 Rwanda genocide. The orphans crisis in the SADC countries is on a par with these massive dislocations. It surpasses in extent the refugee problem that has plagued the world for almost a century and that is consuming national and international resources in many of our countries. It is in danger of surpassing in extent the ability of society to deal with it.

The Educational Participation of Orphans and Children Affected by HIV/AIDS

HIV/AIDS makes it likely that a substantial number of children will not be able to enrol in school in the normal way. Orphans run greater risks of being denied education than children who have parents to look after them. This effect is seen steadily across countries. (Figure 2). In some countries the enrolment gap between orphaned and unorphaned children is very wide—in Mozambique, for instance, only 24 percent of children whose parents are dead attend school, compared with 68 percent of those with both parents still living. In other countries, such as Uganda, it is narrower. But the gap exists in all countries, and in every case the enrolment ratio of orphaned children is lower than that of those who are living with at least one parent. These differences are coming about for two reasons: lower proportions of orphaned children commence school, and higher proportions of children who were orphaned while attending school drop out of the system, without completing the relevant school cycle.

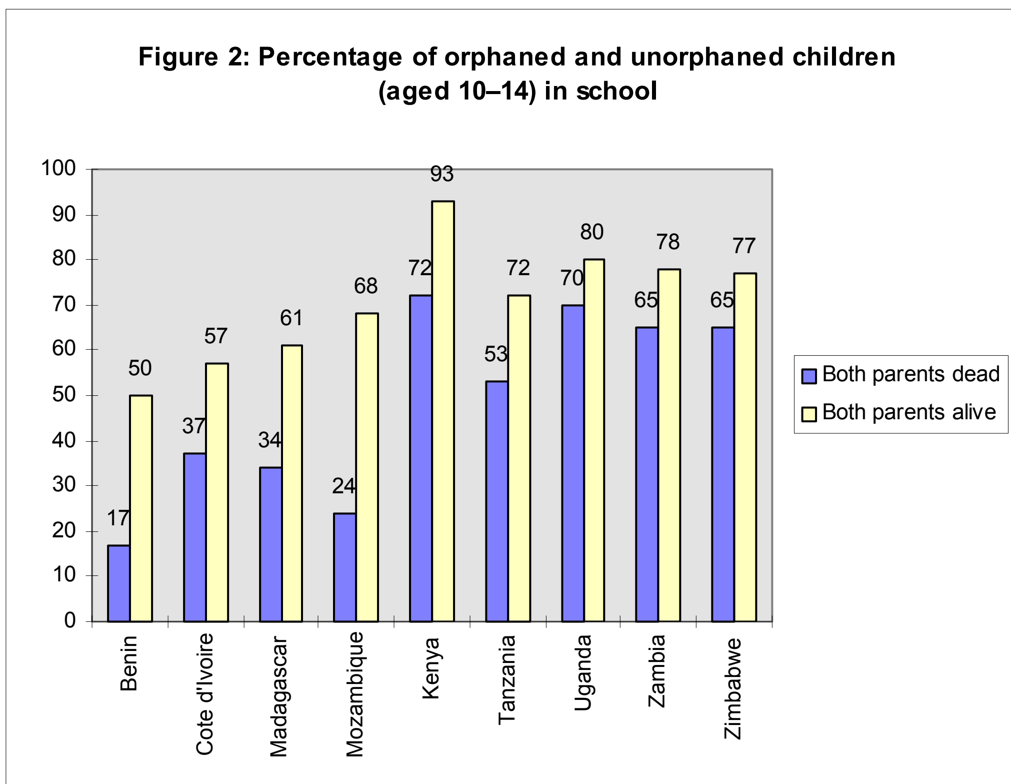


Figure 2: Percentage of orphaned and unorphaned children (aged 10–14) in school

Source: UNICEF, *The Progress of Nations 2000*, p.30

While the diagram refers to the situation of orphaned children, there is good reason to believe that something similar is occurring for children from families affected by AIDS, who have not yet been orphaned, but who will become orphans in the very near future. Some of the reasons for this will be explored below.

Impacts on the School Attendance and Performance of Affected Children

School enrolments in badly affected countries fall into three categories: orphans, children from AIDS-affected families, and children from families which have not been touched directly by the epidemic. The high proportion of children who are orphaned means that in addition to those who never enter school, or drop out early, many of those attending school are orphans. Ongoing studies in Malawi report that in one urban school orphans comprised 30 percent of the total enrolment, while in other schools at least 15 percent of the enrolment were orphans (Kadzamira & Swainson, 2000). Anecdotal evidence from teachers indicates that these orphaned children who remain in school may be at a disadvantage—they can be identified because they look thin, do not have pencils or exercise books, do not wear the full school uniform. There are reports of higher rates of

absenteeism among orphans, partly because they are more susceptible to illness, partly because they cannot attend school every day (or cannot be punctual) due to home demands for their labour or for the care of the sick or younger children, partly because they fear to attend school lest they be sent away because their clothes are torn or have not been washed recently. Similar circumstances and problems are encountered by non-orphan children from families where a parent, sibling or relative has an AIDS-related sickness, but because such children are less identifiable, there is an absence of concrete evidence.

The Impact of HIV/AIDS on the Quality of Education

Additionally, there is need to take account of the fact that HIV/AIDS may be impairing the right of every child to education of good quality, regardless of the HIV/AIDS status of the family or child. This is because of the epidemic's devastating effect on teachers and all types of educators and educational administrators. In almost all countries, these are experiencing mortality and morbidity rates that are higher than those in the general population.[1] Because AIDS-related information systems have not been developed in most education ministries and institutions of higher learning, good information on the infection and mortality of educators is not available. But the little information that is to hand shows the kind of losses that education systems face:

- in Kenya, the Teaching Service Commission has reported that teacher deaths rose from 450 in 1995 to about 1,500 in 1999;
- between January and the end of April 2000, 21 teachers in one of Zambia's urban education districts died; this was the equivalent of an annualised loss of about 9 percent (the loss may have been exceptionally high because of the deployment of sick teachers into the urban centre so that they might be near to medical services);
- in Cote d'Ivoire teachers are reported to be dying at the rate of five per teaching day (900–1,000 a year);
- an estimated 860,000 children in Sub-Saharan Africa, many of them in SADC countries, lost their teachers to AIDS in 1999 (see Table 3, below);
- schools have closed in the Congo because AIDS has left them without teachers;
- severe losses through death are occurring among teacher trainees—teacher training colleges and the university School of Education in Zambia report that student deaths are now the equivalent of 1.5–3.0 percent of enrolments (up from 0.15 percent ten years ago);
- in many countries teachers are said to abuse alcohol, a factor that conduces not only to their own HIV/AIDS vulnerability but also to that of their students.

In addition to these mortality losses, education systems are experiencing increased rates of attrition as they lose teachers and other educators to areas of employment which offer better remuneration. The attrition which has been a long-standing running sore for education has been aggravated by the search for educated personnel to replace those lost to AIDS in other sectors of government, business and industry.

Table 3: Teacherless Children because of AIDS, 1999

[1] The exception is Botswana where mortality rates for teachers are lower than those in the general population and mortality trends appear to be falling (Bennell, 2000). The reason may lie in Botswana's ability to provide its teachers with access to life-preserving anti-retroviral therapies.

	Number of Primary School Children Who Lost a Teacher to AIDS in 1999
Democratic Republic of Congo	27,000
Ethiopia	51,000
Kenya	95,000
Malawi	52,000
Nigeria	85,000
South Africa	100,000
Tanzania	49,000
Uganda	81,000
Zambia	56,000
Zimbabwe	86,000
Total for ten countries	682,000

Source: UNICEF, *The Progress of the Nations*, 2000, p. 8

Losses are also occurring due to AIDS-related sicknesses:

> Though mortality represents the final outcome, it may be that morbidity resulting from AIDS takes the higher toll. .... It is improbable, ... once a teacher develops full-blown AIDS, that he or she could contribute much professionally. Since, on average, it is about a year from the development of AIDS to death, a fair assumption is that each new AIDS case results in the loss of one year of professional time. But the immune system can be breaking down for a long period of time, and the infected person can be beset by a series of illnesses long before diagnosis of full-blown AIDS. A conservative assumption might be that, on average, each infected teacher loses six months of professional time before developing full-blown AIDS and then, 12 months thereafter (dies). (World Bank, 2000, p.21).

Two other aspects of the loss of educators are important for their impact on the education system. One is that the capacity of teacher education programmes to keep pace with teacher attrition will be undermined by their own staff losses. The second is the problem of finding replacements for specialist teaching and other staff. When the loss is that of a general educator, there is some possibility of others moving over to cover the needs. This is not possible when the loss is that of a highly specialised educator, such as an A-level teacher of mathematics or science, or a college lecturer in infant teaching methods.

Teachers are also suffering from overwhelming stress and psycho-social trauma. They are deeply affected personally by the incidence of HIV/AIDS among their relatives and colleagues, and by fear and uncertainty about their personal infection status. Though these are major causes of concern for them, they are areas in which they may receive little support. Thus, it has been found that less than one-third of a sample of teachers who had experienced AIDS sickness or death among their relatives had talked about the problem with friends or relatives. The remainder felt either unable or unwilling to do so.

. Unhappily, the HIV-related stress which many teachers experience is aggravated by the expectation that they will incorporate HIV/AIDS education (possibly in the form of reproductive and sexual health education) into their teaching. Many feel poorly equipped to do so, saying they have not received the necessary training or support materials to enable them to teach in this area. Several show by their teaching and responses to questionnaires that their knowledge and understanding are very deficient. Others are afraid to raise issues of sexuality with their students lest they tread on taboo areas, give offence to parents, or be accused of teaching immoral practices to children. Many are personally very sensitive on the whole subject of HIV/AIDS, knowing or suspecting that they themselves or one of their family may be infected.

This teacher loss, and other AIDS-related factors, will almost certainly have very negative effects on the quality of education. It seems very unlikely that learning achievement will remain unaffected by such factors as:

- frequent teacher absenteeism;
- repeated bouts of teacher sickness;
- shortages of qualified teachers;
- increased reliance on less qualified teachers;
- sporadic student attendance;
- intermittent student participation, following an irregular "drop-out/drop-in" pattern
- low teacher morale;
- considerable student and teacher trauma;
- inability on the part of both teacher and student to concentrate on school work because of concern for those who are sick at home;
- repeated occasions for grief and mourning in the school, in families and in the community;
- a widespread sense of insecurity and anxiety among young learners, especially orphans;
- fear by girls and young boys that they may be sexually abused or maltreated;
- uncertainty and distrust in the relations between learners and teachers (who may be caricatured by the community as those responsible for the introduction of HIV);
- unhappiness and fear of stigmatisation and ostracisation on the part of both teachers and students who have been affected by HIV/AIDS;
- teacher uneasiness and uncertainty about personal HIV status.

Trauma, Discrimination and Stigma

HIV/AIDS induces anxiety in children through the trauma, discrimination and stigma to which it leads. Each of these may be experienced more severely by orphans, but they may also be experienced by children from AIDS-affected families and communities.

There are many dimensions to the AIDS-related trauma from which children suffer:

- grief at witnessing the wasting, dehumanising sickness of a parent or other loved person;
- being left in the dark about their parents' sickness, but picking up hints from rumours and community talk;
- inability to give adequate expression to grief at the loss of a parent, and sometimes even the absence of sufficient time to grieve and come to terms with the loss;
- anxiety lest others in the family, or even oneself, should also be infected with HIV/AIDS;
- distress at family dissension over and disposal of the property of dead parents[2];
- separation from siblings and familiar surroundings;
- anxiety at starting life in a new location, with new surrogate parents, and possibly in a new school—with the obverse, separation from friends and age-mates;
- concern that HIV/AIDS may strike again, taking away the aunt/uncle or grandparent with whom one now lives;
- sense of insecurity and instability;
- depression and moodiness;

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[2] The Convention on the Rights of the Child seems to be silent on the property rights of children. If the best interests of the child are the basic concern, then there is need to enshrine in the CRC an explicit statement about a child's right to inherit the property of deceased parents. Making such a statement justiciable, against marauding property grabbers, is another question.

- sense that life is empty and is not to be trusted (cf. also Carr-Hill, Katabaro & Katahoire, 2000).

Children from AIDS-affected families may also experience stigma and discrimination. This can take the form of petty hole-in-the-wall teasing and taunting by peers—"your mother died of *that* disease". It can take the form of ostracisation when the child finds other children less willing to share than in the past. It can take the form of silent condemnation of a child's dead parents or AIDS-infected relatives as being promiscuous and immoral. Teachers can aggravate the situation by insensitive remarks or by unwillingness to make allowances for the late-coming, absenteeism or shabby clothing to which AIDS in the family may lead.

The personal dislocation that experiences such as these may occasion can take away much of the joy that other children associate with school life. It can also lead to a greater disposition to truancy and to poorer performance in school work.

Street Children and their Needs

Street children offer a further manifestation of the impact of HIV/AIDS on children. The number of street children in SADC countries is believed to be increasing rapidly, as is the number of children who are at high risk of being drawn into this way of life. Street-children include children of the street (those who live, work, eat and sleep on the street) and children on the street (those who work on the street but go home to their families at the end of the day). The majority of street-children are boys, these being quite visible on the streets; but possibly up to about one-third of the total number may be girls, most of whom are found around markets or selling points. Most have never been to school or have dropped out before completing primary education. Many engage in substance abuse (tobacco, alcohol, drugs). A high proportion are sexually active and, among these, sexually transmitted diseases are common. Although well informed on what HIV/AIDS is, many know little about its prevention.

Poverty and family disintegration due to death and divorce are the major factors leading to children being on the street. The family structures that should have supported them have collapsed, frequently because of HIV/AIDS, leaving them with no choice but to have recourse to the streets to support themselves. The rural counterparts of urban street-children are children from HIV/AIDS affected families, who do not attend school because AIDS care has absorbed the meagre family resources, leaving nothing for school fees.

The increase in the number of street children is one outcome of the complex interaction between economic hardship, the disintegration of social structures, and the increase in sickness, especially HIV/AIDS. This escalating problem of street children is inextricably linked with that of orphans. Street children are two to three times more likely to be orphans than children with a living parent. For most of these young people the situation is grim. They cannot access a decent life today and feel themselves excluded from the prospects of a better life tomorrow. Tragically, HIV/AIDS has contributed to their being on the street, while the fact of being on the street significantly increases their risk of contracting HIV/AIDS, through income-generating prostitution on the part of both boys and girls and through their undisciplined life-style (cf. Box 2). For street children, especially those of the street, the high-sounding commitments of the Convention on the Rights of the Child must sound particularly hollow.

Box 2: The Vulnerability of Young Street Children to Sexual Exploitation

Mpulungu, on the shores of Lake Tanganyika, is Zambia's principal inland port. As an important trading and border post, it also has a high HIV prevalence rate (13.2 percent for the district in 1999). Poverty rates are very high and school enrolments low. Living on the street, because of economic necessity or because orphaned by AIDS, is an unquestioned fact of life that begins at an early age for a large number of children. Though all children are affected, boys who live on the street—*mishanga* boys—are more obvious than girls.

When they are very hungry or cold, young *mishanga* boys, aged 8–10, go to their "sugar mummies", giving sex in return for some material assistance and shelter. In the process, many contract HIV.

Local mores show little concern about sexual play among children of this age. One strongly held misconception is that a boy who is too young to impregnate a girl cannot transmit the AIDS virus since this is believed to be passed to another through the sperm but not through sexual fluids.

In these uninhibited but lethally misinformed circumstances, the infected *mishanga* boy spreads the infection received from his "sugar mummy", infecting girls who are his own age or slightly younger.

How relevant is it to talk about safe sex for such children? Where will they get condoms? How can they use them? Will they fit?

How can an educational programme protect such children? How can the erroneous views on HIV transmission be corrected when taboos prohibit factual discussion?

Source: Personal Communication, anonymous Mpulungu NGO

The Need Experienced by Many Children to Provide Social and Economic Support for Themselves and/or their Families/Siblings

The AIDS epidemic has created an almost completely new category of disadvantaged children, those who must head households. In some cases it happens that the extended family no longer has the capacity to absorb more orphans. In others it can be that the orphaned children resist efforts to separate them from one another: when their parents were alive, but ill, they learned to live together, tend to their parents, and carry on with the semblance of a normal life, mostly under the authority of the eldest child; when the parents die, they want to stay together, maintain this way of life, and make-do as best they can. Some countries with a mature and extensive AIDS epidemic report that between five and ten percent of households are of this type, headed by a boy or girl below the age of fifteen.

Meeting the basic learning needs of children from such child-headed households poses grave problems. Household responsibilities and income-generating needs make it virtually impossible for the eldest child, the one heading the household, to attend school. It may be just as difficult for the others to do so. Many of these child-adults make heroic efforts to raise the cash needed to pay for the educational costs of their younger brothers and sisters, but meeting the basic needs for food, clothing, accommodation and necessary medicines receives first priority. Regardless of international conventions and national laws on child labour, children in charge of such households and many of the younger siblings must work to sustain themselves. What they earn from their work is often pitifully small, because as children they cannot demand or negotiate for more. It may not be sufficient to meet their basic needs. It will seldom be enough to pay their educational expenses.

While child-headed households on the scale now being experienced are something new in social history, this is not so with child labour. The world has made significant progress towards the elimination of exploitative forms of child labour. But HIV/AIDS is working against this. It is not so much that HIV/AIDS has ushered in an increase in factory or plantation/farm type exploitative labour (though there may be some of the latter), but it is reinforcing the dependence of families on the labour of their children. This is especially so in two areas, caring for the sick and helping the family to generate income. When AIDS goes hand in hand with poverty, as it so often does, the dependence on child labour increases.

Caring for the sick can be the direct care that a child may give in tending to the needs of a sick person, shopping for medicines and palliatives, taking the sick person to a clinic, remaining physically with the sick person.. It can also be indirect, taking over certain adult responsibilities and tasks so as to enable the adult care directly for the sick person. This kind of indirect care includes looking after children, cooking, washing the sick person's soiled coverings, drawing water, collecting firewood. It also includes tending a garden, weeding, caring for animals, petty trading, running messages. All of this means less time available for school or school-work, and while all children can be affected, the likelihood is greater that girls rather than boys will be kept away from school for these purposes or have their time for school work reduced.

The negative impacts which HIV/AIDS are known to have on household incomes also heighten the pressure for poor families to depend more extensively on child labour to supplement their incomes. Adult morbidity and mortality reduce the crop production potential of agricultural families—they plough less, they weed less, they have less money for spending on good varieties of seeds or fertilisers. To survive at all they must get more work from their children, even if this means withdrawing them from school, or making their attendance so erratic that they learn very little.

In this bleak scenario, which is being faced by hundreds of thousands of families throughout the SADC countries, two special risks face young girls and their educational prospects. One is that they will be forced into early marriage, partly in order to relieve the family of the burden of their upkeep, partly in order to bring in the bride-price which can help to regenerate the family's HIV/AIDS depleted stock of capital assets. The second risk is that of commercial sex activities, instigated either by the girl herself or by her family. This seldom occurs because of promiscuity on the part of the girl, but arises mostly from sheer economic necessity.

Today's Orphans as Tomorrow's Parents

HIV/AIDS deprives children, especially orphans, of the formation, experience and role models they need for their subsequent adult life. In recent years, much attention has rightly been given to the impact of HIV/AIDS on economic systems and household economies. We are also considering in greater depth its impact on education and other sectors. But perhaps we have not yet begun even to contemplate what it may mean for the fundamental unit of society, the family—not so much the family of today, but that of tomorrow, tomorrow's parents and young adults.

The basic problem with regard to orphans is not that of getting them into schools or educational programmes. The basic problem is not even ensuring their survival within extended families and communities. The really basic issue is the kind of adult they will grow up to be. An enormous number will have been cheated of their childhood. From a

very early age they will have been ‘juvenile adults’. They will have been catapulted from infancy or very early childhood into adult status and responsibilities without passing through the formative years of a normal childhood, being parented in a normal family with father, mother, brothers and sisters. They will not have known the love, security and stability within which the human personality normally develops. Some will have known little more than the company of a very much older generation—their grandparents; some only the company of those who are inexperienced children like themselves. Some will have moved from one surrogate parent to another. Some will have been almost forcibly separated from the only stable focus they have known in their lives, their own siblings and the familiar surroundings of the place where they were reared.

What kind of adults will these children grow up to be? What can society do to try to compensate the millions of orphans in our countries for this absence of normal human upbringing? What must the education system do to ensure the orphaned child's right to the full, human development of his or her personality, so that when they pass to full adult status these ‘juvenile adults’ will do so as mature individuals, capable of founding and sustaining a family?

HIV/AIDS and the resultant orphans crisis are too recent an experience for us to be able to answer these questions with any certainty. But perhaps the questions point to the need to ensure that all educational programmes compensate orphans for what they have lost in life, that they provide them with security, stability, affection, human warmth, an opportunity for joy, gaiety and laughter, and above all, deep, trustworthy human love.

The Strain that Orphanhood is Placing on Families and Society

The growth in the number of orphans is taxing the coping strategies of families and society at large. In many cases, the extended family is finding it extremely difficult to cope economically and psychologically with the numbers it is required to absorb. Reports speak of the extended family ‘unravelling’ or ‘collapsing under the strain’ of the orphans' problem.

Moreover, the burden of orphan care is falling more and more on the elderly, many of whom 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. They may be too old to give young children the care they need, to provide for their material needs, to meet the costs of schooling, and to exercise the control needed to ensure school attendance and attention to school-work. Furthermore, the age-old question—who will care for the carers?—is fast becoming a major question in regard to these elderly care-givers. The traditional form of insurance for care and support in old age is to invest in one's children. But many elderly people have lost all of these to AIDS, and instead find themselves caring for very young children who will not be capable of supporting them in their advancing years.

Notwithstanding these problems and strains, it is encouraging to note that so far, with few exceptions, the extended family structure has responded magnificently to the orphans crisis, holding up in face of the huge pressures being placed on it, coping with the problem almost as part of its normal routine. A proverb from West Africa is applicable: “the tortoise knows how to make love with its mate”. What seems virtually impossible to outside agencies is being dealt with almost as a matter of course by families and communities. It is at this level that the problems arising from HIV/AIDS and orphanhood are first encountered, the first tentative solutions are tried out, and more permanent solutions are institutionalised. It is through these structures above all that the rights of children, including their educational rights, can be safeguarded. The corollary to this is

that first priority must be given to strengthening this almost innate coping response, to expending resources that will enable families and communities deal in even more sustained ways with the problems and issues of orphans and vulnerable children.

A further guiding principle for the care of orphans is that, following the death of one or both parents, they remain within their communities in a family-like setting with an adult guardian or care-giver. Ideally, they should also stay with their own sibling group and live in the familiar surroundings of a known community. In other words, every effort should be made to avoid the dismemberment of families, the separation of siblings from each other, and the 'repatriation' of urban children to unfamiliar rural areas of family origin.

A final principle is to ensure that orphans themselves are given a real say in moves towards a solution of their education and other problems. Orphans are not statistics or objects to be moved about at the will of adults. Decision-making like this in their regard may be synonymous with trampling on their rights. Orphans are bereaved children who are likely to have experienced great trauma in ministering to their parents during a lengthy period of harrowing sufferings. But they remain aware of their own needs, especially the need to be inserted into a known and welcoming family, without separation from their siblings. It is essential that everybody who deals with their problems ensures that orphans themselves can express their views on how their needs should be met.

Conclusion

It is said that history will judge cultures by the care they give to their most needy members. Likewise, it will judge all of us educated people in the SADC countries, and the people we represent, by the way we put aside individual and organisational differences and marshal our collective resources—financial, technical and human—to make a lasting and beneficial difference to the orphans question. The challenge is to respond in an effective and humane way to the plea of orphans and all AIDS-affected children to belong as full and equal members of the human family, with their needs being attended to and their rights protected.

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Annex Tables

Annex Table 1: Infant and Child Mortality, SADC Countries, 2000

	Infant Mortality		Child Mortality	
	With AIDS	Without AIDS	With AIDS	Without AIDS

Botswana	61.7	27.6	136.0	38.9
Dem. Rep. Congo	101.7	96.7	153.9	139.2
Lesotho	83.0	62.5	132.6	85.9
Malawi	122.3	105.2	219.6	175.4
Mozambique	139.9	123.1	225.5	174.9
Namibia	70.9	44.6	139.0	63.4
South Africa	58.9	41.1	119.6	65.6
Swaziland	109.0	86.1	183.2	118.4
Tanzania	81.0	71.6	127.5	101.2
Zambia	92.4	69.6	168.8	106.5
Zimbabwe	37.9	69.9	132.8	41.3

Source: Stanecki, 2000, Tables 1 & 2

Annex Table 2: Orphan Estimates, SADC Countries, 2000

	Maternal & double orphans from all causes (thousands)	Percentage of maternal & double orphans from AIDS	Paternal orphans from all causes (thousands)	Total orphans from all causes (thousands)	Total orphans as percent children below age 15
Botswana	46	84.0	56	102	16.0
Dem. Rep. Congo	1,511	29.6	1,846	3,357	13.4
Lesotho	34	42.1	42	76	8.9
Malawi	426	64.1	521	947	20.3
Mozambique	680	42.1	831	1,511	18.4
Namibia	56	68.2	68	124	16.3
South Africa	577	62.1	706	1,283	16.9
Swaziland	34	56.1	41	75	15.2
Tanzania	690	70.0	843	1,533	9.7
Zambia	562	76.3	687	1,249	27.4
Zimbabwe	480	87.0	587	1,067	23.7
Total: 11 countries	5,096	46.9	6,228	11,324	15.5

Maternal orphans have lost their mothers, paternal orphans their fathers, double orphans both parents.
Source: Hunter & Williamson, July 2000