

AIDS ORPHANHOOD AS A SOCIAL PROBLEM

3.1 INTRODUCTION

The HIV/AIDS epidemic has altered and will progressively alter the demographic structure of many societies. In chapter 2 it was shown how HIV/AIDS is cutting away the middle generation of society. Population pyramids are becoming indented. This chapter focuses on one of the most affected group, the orphans or vulnerable children created by the epidemic. Under normal circumstances the young are cared for by their parents and later provide support for those parents however, this has changed. So far, the AIDS epidemic has left behind an estimated 15 million children under the age of 15 orphaned worldwide and the worst lies ahead (Avert, 2005: 1; UNICEF, 2004: 1). Barnett and Whiteside (2002: 199) note that the bare statistics are troubling. They tell of a generation of children deprived of their childhood.

In times past it was usually war or neglect or famine or poverty that resulted in a child being orphaned. Now many children who are being orphaned are as a result of HIV/AIDS. Every year tens of thousands of children lose their parents to AIDS. The impact of HIV/AIDS on children is seen most dramatically in the wave of AIDS orphans. According to a Children on the Brink Report as mentioned by Tracey (2005: 1) by 2010, at least 44 million children will have lost one or both parents to AIDS. This report reveals the fact that AIDS has become a social nightmare creating international communities of orphans at an alarming rate. With the staggering death toll that HIV/AIDS takes, it is easy to overlook the challenges faced by the people the disease leaves behind. These orphans, the majority of whom are HIV-negative, are at enormous risk of growing up without adequate health care, food, education or emotional support (Avert 2004: 3; Deame, 2001: 2; Robbins, 2004: 1).

Estimates from the UNAIDS/WHO AIDS Epidemic Update (2004: 1) reflect that at the end of 2004, 37.2 million adults and 2.2 million children were living with HIV and deaths among those already infected is expected to increase for some years even if prevention programmes manage to cut the number of new infections to zero. Ruiz-

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Casares (2001: 2) notes that for every adult who die as a result of AIDS, four or five children are left behind. According to UNAIDS, executive director Peter Piot, “more children have been orphaned by AIDS than people who developed AIDS” (Ruiz-Casares 2001: 2). With the HIV – positive population still expanding UNICEF (2003: 2) maintains that HIV/AIDS will cause unprecedented suffering among children for at least the next decade if not longer.

Although the number of AIDS orphans is rising in most parts of the world there is a major crisis brewing in Africa. Africa is the hardest hit by the disease – more than 12 million children under the age of 15 have been orphaned by the disease. Because of the ongoing epidemic, children in Africa are becoming orphans in overwhelming numbers (Africa’s child, 2005: 1; Tracey, 2005: 1; UNAIDS, 2004: 1). This crisis is most acute in sub-Saharan Africa. Around 90% of AIDS orphans live in sub-Saharan Africa and the number is increasing daily. The number of AIDS orphans in the region is projected to double or triple by 2010 (Africa’s child, 2005: 1; Avert, 2004: 1; Robbins, 2004: 1; Ruiz-Casares, 2001: 3; UNAIDS, 2004: 1).

However, the orphan crisis is not restricted to sub-Saharan Africa. This region is hardly alone in facing such wrenching ramifications of the AIDS pandemic. Other regions especially in the Caribbean and Asia are expected to experience large increases in the number of children orphaned by AIDS (Barnett & Whiteside, 2002: 198; UNAIDS 2002: 1;). At the end of 2001 there were an estimated 1.8 million orphans living in South and South-East Asia; 85, 000 in East Asia and the Pacific; 330, 000 in Latin America; 250,000 in the Caribbean and 65,000 in North Africa and Middle East (Avert: 2004, 1). Furthermore, with infection rates in highly populous countries such as China projected to skyrocket, so too are the number of AIDS orphans there (Laino: 2002, 3). India had 1.2 million AIDS orphans in 2001 and predicted to rise to 2 million in five years and 2.7 million in ten years (Boseley, 2002: 1).

But statistics do not capture the misery that HIV/AIDS can bring to children. The death of a parent pervades every aspect of a child's life from emotional well-being to physical security, mental development and overall health. According to Bartholet (2000: 13) it is not only the raw numbers that make this orphan crisis unlike any ever seen. Most of these children do not have AIDS but are in danger of slavery, dying of

childhood diseases or being forced into prostitution to survive. AIDS affects children long before their parents die. The toll taken by the disease begins during the period of illness, continues through death and bereavement and will likely to persist into adulthood if adequate support and protection are lacking. What is more, the stigmatisation and discrimination that people affected with HIV often live with is passed onto their children, making their fight for survival that much more precarious. The strain that these children endure, watching their parents die and then forced to forage for themselves could create a generation of horribly disaffected people (Avert, 2004: 3; Tracey, 2005: 1; UNAIDS, 2000: 2; UNICEF, 2004: 1; UNICEF, 2003: 1).

The onslaught of AIDS on people of reproductive age is increasing the numbers of orphans at such a rate that communities cannot rely on traditional means caring for these children. The children, who have often watched their parent die alone and in pain, are left in a world where AIDS has unravelled such traditional safety nets as the extended family and in household where not a single adult is able to earn a living. This is particularly true in many sub-Saharan African countries lacking adequate basic social services. The inability of communities to respond adequately and appropriately to the situation has resulted in social, psychological and economic deprivation for the children. The absence of parental protection and care, combined with many other factors, has contributed significantly to the increase in deaths of children. This is likely to continue for the long term if nothing is done (Avert, 2005: 1; Avert, 2004: 3; UNAIDS, 2000: 2).

This chapter seeks to address the issue of aids orphan-hood as a social problem. Specifically it speaks to four points. Firstly, given the nature of the problem it focuses on how big the problem is. Second, it addresses the social emotional implications of rising statistics and difficulties faced by AIDS orphans. Thirdly it focuses on the rights of AIDS orphans. Finally, the chapter seeks to understand the threat the HIV/AIDS epidemic poses on AIDS orphans' skill development and to propose a strategy for curtailing this threat. To consider these issues it is first necessary both to define the concepts orphan and AIDS orphan.

3.2 DEFINITION OF CONCEPTS ORPHAN AND AIDS ORPHAN

Throughout history a child who has been deprived of natural framework for love, food, shelter, physical protection, learning, guidance, and preparation for adult life, has been seen as the world's most unfortunate creature. Ruiz-Casares (2001:1) argues that differences in orphan definition have programme and policy implications. It is therefore imperative that researchers explicitly state their own understanding and usage of the term orphan.

Ruiz-Casares (2001: 2) points out that those local terms for orphans vary from poetic to prosaic and definitions vary by age and whether one or both parents have died. Webb (1997: 3) argues that standardised definitions of orphans are still needed. This is because there are such issues as orphans reverting to non-orphan status when the surviving parent (usually the father) remarries. Also orphans themselves are likely to marry at an earlier age. There are always orphans who grow out of the age bracket used in definitions, such as reaching the age 18, yet in reality they will just be as vulnerable as the next child is. In some African cultures, there is no definite age barrier of an orphan as long as one is not yet married. The other concern is that the orphan status of girls below the age of 18 who themselves, become parents is unclear.

Hope (1999: 94) defines an orphan as a child who is motherless or who has lost both parents. UNAIDS defines orphans as children below the age of 15 who have lost either their mother or both their mother and father (Whiteside & Sunter, 2000: 80). These definitions contain two important elements and distinctions: on one hand, there is a child who may have lost one or both parents: on the other, there is an emphasis on maternal orphan hood, as it leaves infants in particularly vulnerable situation.

Saoke and Mutemi (1994: 3) suggest that an orphan is a child, not older than 18 who has lost either or both parents. This is because their findings indicated that orphans who had lost their father have immediate felt needs as those who had lost their mothers. The argument is that in the Africa cultural sense, there is no definite age barrier of an orphan as long as one is not yet married. Therefore this suggests that the

definition of and orphan should include any unmarried person who is not self supporting.

Nyandiya-Bundy (1997: 9) classifies orphans into three different categories. Maternal orphans are children under the age of 18 whose mothers have died. Paternal orphans are children under the age of 18 whose fathers have died. Double orphans are children under the age of 18 whose mothers and fathers have both died. According to Webb (1997: 187) the issue of paternal, maternal and double orphans is important in that the average conditions of the different orphans will vary and double orphans are potentially in the most vulnerable situation. Maternal and paternal orphans “graduate” into being double orphans since the death of a spouse usually followed by the other especially in AIDS cases (Nyandiya-Bundy, 1997: 13).

For the purpose of this study an orphan is defined as a child under the age of 18 who has had at least one parent die. A child whose mother has died is known as a maternal orphan; a child whose father has died is a paternal orphan. A child who has lost both parents is a double orphan.

Before 2002, UNAIDS defined AIDS orphans as children who before the age of 15 have lost their mother to AIDS. In 2002 UNAIDS changed their definition of AIDS orphans to children who before the age of 15 have lost either one or both parents to AIDS (Avert, 2003: 13). The definition was reviewed because if one parent is infected, it is likely the other will be infected too and will die soon. Furthermore, the exclusion of paternal orphans was seen as a great oversight, bearing in mind the large amount of absentee mothers for paternal orphans (Barnett & Whiteside, 2002: 200).

In the context of this study the term AIDS orphan refers to any child who before the age of 18 has lost parent/s due to AIDS.

The point is that definitions are important and there is no final way of deciding who is or is not an orphan, it is a social role and varies from place to place and culture to culture. Since the study is conducted in South Africa it is important to understand the African view of orphanhood and this will follow in the next section.

3.3 ORPHANHOOD: THE AFRICAN PERSPECTIVE

Hope (1999: 94) argues that the definition of an orphan in many African societies is the loss of the mother, as women are the primary care givers. Children are not considered to be orphans if they lose their father. This is due to the primary role of nurturing played by the mother. In most cases women are the producers of resources, which service the household. Children usually develop a greater amount of emotional attachment for their mother than they develop for their father. Hunter and Williamson (1996: 2) further state that the death of a mother has dramatic psychosocial consequences as children lose love and nurturing, whereas the loss of a father may mean loss of economic support only. This is in general recognition of the role the mother plays in taking care of the whole family. Even though the father may be there, his attention in all areas of childcare and upbringing may not be compared to those of a mother.

According to Avert (2004: 2) almost throughout sub-Saharan Africa, there have been traditional systems in place to take care of children who lose their parents for various reasons. Nyandiya-Bundy (1997: 6) states that there used to be no orphanhood in most traditional African societies. This is because paternal or maternal relatives customarily adopt orphans. A child in most African societies grows up being surrounded by “small and big fathers” and “small and big mothers”. The possibility that a child might exist for whom there were no parental substitute within the kin network was not entertained in African culture. This means the family in African culture remained the universally effective context for handling casualties connected with death within its ranks. Missionaries set up some orphanages and children’s homes in the colonial period, but they were not widely used nor usually perceived as relevant to the African social need (Kurewa, 1999: 41). Institutional care was viewed as unacceptable in most parts of Africa (Barnett & Whiteside, 2002: 207).

Avert (2004: 2) notes that the deep-rooted kinship systems that exist in Africa extended family networks of aunts and uncles, cousins and grandparents, are an age-

old social safety net for orphans, and it has long proved itself resilient even to major social changes. Throughout Africa, children orphaned have been absorbed into extended families. But the onslaught of HIV slowly but surely erodes this good traditional practice by simply overloading its caring capacity by the sheer number of orphaned children needing support or care. The capacity and resources are now stretched to breaking point, and those providing the necessary care, are in many cases already impoverished (Avert, 2004: 1-2; Robbins, 2004: 1; Barnett & Whiteside, 2002: 199; United Nations Children's Fund, 2003: 1).

HIV also undermines the caring capacity of families and communities by deepening poverty due to loss of labour, the high medical treatment and funerals (Avert, 2004: 2). According to UNICEF as quoted by Du-Venage (2002: 2) as well as Barnett and Whiteside (2002: 209) within the community there is reluctance to take in or help orphans because of the general economic climate and stigma associated with AIDS. Many people feel that they can barely feed, cloth and send their own children to school, let alone assume additional responsibility for orphans. Some fear that the orphans themselves may be infected with AIDS. They are rejected on the basis of the perceived immoral sexual habits of their parents coated with fear of contracting the disease. This has been brought about by what Overall and Zion (1993: 4) identify as the theory of "blaming the victim". This is whereby there is a tendency to identify other people as scapegoats who are then labelled as guilt and deserve the fate.

The HIV/AIDS epidemic confronts people with a new situation. Many people remain poor and will be further impoverished by the epidemic itself. The growth of the AIDS orphans' population is now a global phenomenon and is set to accelerate over the coming decades. The following section provides an overview of the extent of the situation.

3.4 THE EXTENT OF THE PROBLEM OF AIDS ORHANS

According to Avert (2004: 4) it is very difficult to estimate the number of children orphaned by AIDS each year, but whatever the figures, it is clear that there is an enormous problem. In the following paragraphs the extent of AIDS orphanhood is

reviewed worldwide, in Africa, in South Africa and in the North-West Province of South Africa.

3.4.1 World wide

The increase in AIDS orphaning is one of the major challenges facing many countries. According to North-West Population Trends and Development Report - HIV/AIDS Perspective (2004: 37) one of the worst consequences of AIDS is that large numbers of children are orphaned as a result of parents dying from AIDS. Some of these children are HIV-positive themselves – having been infected by their mothers either at birth or through breast milk.

Estimates show that by mid 1997 ten million children under the age of 15 had lost their mothers to AIDS worldwide. According to UNAIDS, by the end of 1999, 570 000 children were infected worldwide (Ruiz-Casares, 2003: 2). By the end of 2000, the HIV/AIDS crisis had created more than 13 million orphans worldwide (Deame, 2001: 1). At the end of 2001 the AIDS epidemic had left behind 13.2 million orphans worldwide (Barnett & Whiteside, 2002: 198; Laino, 2002: 3).

Presently it is estimated that there are 15 million children worldwide who have lost a parent or both parents to AIDS. More than 90 per cent of children orphaned by AIDS are in sub-Saharan Africa, and the numbers are increasing daily. In African countries that have already had long, severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope (Avert, 2004: 1-2).

For the moment, the rate of AIDS orphans continues to rise because there are still more newly infected individuals joining the pool of people living with HIV every year than there are people leaving it through death. According to Avert (2005b: 1) during 2004 some 4.9 million became infected with the human immunodeficiency virus and the year saw 3.1 million deaths from AIDS - a – high global total. The overwhelming majority of these people, some 95% of the global total, live in the developing world. This proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for

prevention and care fuel the spread. With infection rates projected to rise, so too are the number of AIDS orphans.

Deame (2001: 1) states that by 2010, the total orphan population in 34 African, Asian, and Latin American countries with severe HIV/AIDS epidemics is projected to reach 44 million. This is considered that it will create a child-care crisis never before seen in any war, famine, or other tragedy.

3.4.2 Africa

Children orphaned by AIDS are found in almost every country of the world. In some countries, there are only a few hundred or a few thousand. In Africa, there are millions. All have suffered the tragedy of losing one or both parents to AIDS (UNAIDS, 2001: 1). AIDS orphans in Africa are regarded as the largest and fastest growing category of children in difficult especially circumstances. These children have also been labelled “children in distress” or “children on the brink” (UNAIDS, 2003). They grow up in deprived and traumatic circumstances without the support and care of their immediate family. As the number of adults dying of AIDS rises over the next decade, an increasing number of orphans will grow up without parental care and love and will be deprived of their basic rights to shelter, food, health and education (UNAIDS, 2003).

As already mentioned the area in Africa south of the Sahara desert, sub-Saharan Africa is regarded as the region hard-hit by HIV/AIDS. The emergence and rapid spread of HIV/AIDS has been phenomenal by any standard and the region has one of the highest rates of infection in the world. The region has just over 10% of the world’s population, but is home to over 60% of all people living with HIV. An estimated 3.1 million adults and children became infected with HIV during the year 2004 and AIDS killed approximately 2.3 million people in the same year (Avert, 2005: 1).

Presently AIDS is the leading killer in sub-Saharan Africa and therefore more than 90% of AIDS orphans live in sub-Saharan Africa (Avert, 2004: 1; Barnett & Whiteside, 2002: 198; Deame, 2001: 1; Hope 1999: 93). AIDS has already orphaned

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more than 12 million African children. These numbers are projected to increase since millions more children currently live with sick and dying parents (Robbins, 2004: 1). By 2010, this number is expected to climb to more than 18 million (Laino, 2002: 3; UNAIDS, 2004: 1). It is further expected that in many African countries by 2010 orphans will make up 15% of all children under 15 year old (UNICEF, 2003: 2). Botswana, Namibia, Swaziland, Zimbabwe, Central African Republic and South Africa are expected to have the highest proportion of children orphaned as a result of parental deaths caused by AIDS. This is expected to create a child-care crisis never before seen in a war, famine or other tragedy (Deame, 2001: 2; UNICEF, 2004: 1).

According to UNAIDS (2000: 1) before the onset of AIDS about two percent of all children in developing countries were orphans. In 1998, wars in Africa killed 200 000 people whereas AIDS killed 2 million people on the continent (Ruiz-Casares, 2003:2). By 1997, the proportion of children with one or both parents dead as a result of AIDS in some parts of Africa had increased to 7% and in some cases reached an astounding 11% (Barnett & Whiteside, 2002: 198). By 1999, ten percent and more children were AIDS orphans in some African countries. At the end of 1999 the estimated numbers of orphans living in some of the worst affected countries were 211 000 in Burkina Faso, 90 000 in Ethiopia, 58 000 in Namibia, 97 000 in Nigeria, 371 000 in South Africa, 447 000 in Zambia and 623 000 in Zimbabwe (UNAIDS, 2000: 1). At the end of 2001 the total number of AIDS orphans in Africa was 11 million (UNICEF, 2003: 2).

At the end of 2003 there were, for example, an estimated 1.8 million orphans living in Nigeria, 650, 000 in Kenya and 980,000 in Zimbabwe. These numbers are expected to increase as the epidemic develops. According to a report issued by UNICEF (2003: 1) the staggering number of African children already orphaned due to AIDS is only the beginning of a crisis of gargantuan proportions, and the worst is yet to come. It has been estimated that the number of children orphaned by AIDS in Africa will rise dramatically in the next 10-20 years especially in southern Africa (Avert, 2004: 1).

Zambia is one of the countries that have hit the hardest by HIV/AIDS. According to Online News hour (2002: 1) “It is very hard to find a family in Zambia that hasn’t

been personally touched. It's very hard to find a child that hasn't seen or witnessed a death related to HIV/AIDS". The estimated number of children orphaned because of AIDS in Zambia at the end of 2003 was 630 000 and it has also been estimated that the number of orphans will rise to nearly one million by the year 2014 (Avert, 2004: 2; Saluseki, 2003: 1).

According to Barnett and Whiteside (2002: 208) the majority of orphans in Botswana are children whose parents have died from AIDS-related infections. UNAIDS have estimated that 120 000 children in Botswana, had lost their parents to AIDS by the end of 2003 (Avert, 2004: 6). Malawi has been struggling with high levels of HIV infection which is made worst by extreme poverty. The AIDS crises has had a crippling on the country's children and UNAIDS estimated that Malawi had 500 000 children orphaned by AIDS at the end of 2003 (Avert, 2004: 7). Zimbabwe has one of the worst AIDS epidemic in the world and it has so far left behind an estimated 980 000 orphans (Avert, 2004: 3). It is believed that the worst affected children are those in rural areas, where there have also been shortages of drugs, food and other resources. According to Boseley (2002: 1) Zimbabwe had an orphan rate of 17.6% with more than three-quarters due to AIDS. It is further estimated that by 2010, 21% of children will be orphans and 89% will be due to AIDS.

Already there are, for example one million orphans living in Nigeria and 890 000 in Kenya (Avert, 2003: 1). These numbers will increase as the epidemic develops. It has been estimated that the number of children orphaned by AIDS will rise dramatically in the next 10-20 years, especially in southern Africa. In Lesotho more than a quarter of all the children will be orphaned – four out of five from AIDS (Boseley, 2002: 1). Hall (2005: 3) notes that about four out of every ten adults in Swaziland are HIV-positive. In this country about 70 000 children are said to have lost their parents to AIDS.

According to McGreal (2001: 1) in countries afflicted by war, such as Sierra Leone, rape has fuelled the spread of the disease and the numbers of children left behind. In Rwanda, where close to one people died in genocide, nearly 250 000 children were already been orphaned by AIDS in 2001. Many of the children left behind are themselves HIV- positive, although few know it.

The above statistics reflect that a serious situation exists in Africa. The epidemic has vastly increased the numbers of orphans in Africa. AIDS is generating orphans so quickly that family structures can no longer cope. Caring for them within the extended family is desperately hard. Levels of care are variable, and some end up on the streets of the cities while others are drawn into soldiering (Barnett & Whiteside, 2002: 211; Robbins, 2004: 1). In either case these lives are hardly a preparation for the future as a member of a household or a community, least of all as a citizen. As these orphans grow into youth and adulthood, there are serious implications for the societies in which they will live their lives. These implications will be discussed later in this chapter.

3.4.3 South Africa

According to UNAIDS (2004: 2) some countries have yet to experience the full impact of parental deaths as a result of AIDS. Barnett and Whiteside (2002: 210) state that there will be a boom in South Africa's Aids orphan population during the next decade. South Africa currently has a high proportion of children who are not continuously cared for by either parent, and very high rates of care by aunts and by grandmothers (Avert, 2004: 1; UNICEF in Du-Venage, 2002: 1; Whiteside & Sunter, 2002: 2). Presently there are about 250 000 AIDS orphans in South Africa (Mesatywa, 2005: 1). This number is expected to rise to 1.5 million by 2010 (Avert, 2005: 1). In addition Medical Research Council Estimates showed that unless significant action is taken, by 2015, about 15% of all children under the age of 15 will be orphaned (Mesatywa, 2005: 1).

UNICEF as mentioned by Du-Venage (2002: 2) notes that in developing countries, the norm is about 2 percent of children to be classed as orphans however; in South Africa that figure is more than 17 percent. This is due to the history of displacement of people to implement the racially segregated society envisaged during the years of apartheid, combined with the migrant labour system. The epidemic inserts itself into this already fragile family environment, and one of its worst consequences is the creation of AIDS orphans.

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Whiteside and Sunter (2000: 80) state that South Africa is witnessing the emergence of child headed households and the conversion of facilities designed for early childhood education into de facto residential homes. According to them it has been estimated that Kwazulu-Natal for instance will face nearly 500 000 AIDS orphans by the year 2010. Briefing the Media at parliament on Monday, 07/03/05 Mike Waters of the Democratic Alliance social development said there were an estimated 83 000 child-headed households in South Africa, run by children under the age of 18 (Mesatywa, 2005: 1).

According to Tshukudu as quoted by Irin News (2003:1) when the parents die of HIV/AIDS, in African culture it is the duty of the extended family to care for children left behind. Within the South African traditional society there is a certain standard of care that is expected, but people are no longer willing to do that. The care that the children receive is unacceptable and most of the time the family members use these children to benefit from the government orphan packages (Irin News, 2003:1).

Furthermore, UNICEF notes that in South Africa, many relatives are often reluctant to take in the children of AIDS victims because of the stigma attached to the disease (Du-Venage, 2002: 2; Barnett & Whiteside, 2002: 209). Although the government offers some additional support for orphans, carers are sometimes reluctant to accept this assistance particularly if acceptance may identify the dead parent as having died of AIDS; or it may suggest that the family cannot cope-another stigma (Barnett & Whiteside, 2002: 209). Government officials concede that they are overwhelmed by the enormity of the problem. South Africa which has the highest number of people with HIV will have to cope with millions of children orphaned by AIDS by the end of the decade (Du-Venage, 2002: 2).

Since the study is conducted in the North-West Province of South Africa, a brief discussion of the situation of AIDS orphans in the province is reviewed in the next section.

3.4.4 North-West Province

According to North West Population Trends and Development Report – HIV/AIDS Perspective (2003: 37) about 15 728 children in the North-West Province were newly orphaned in 2002. A total of 10 745 of these new orphans were as a result of AIDS.

The projected number of orphans expected in the North-West by 2021 as estimated by Demographic Information Bureau according to a low and high impact scenario will be 515 378 000 and 764 328 000 respectively (North West Population Trends and Development Report – HIV/AIDS Perspective, 2003: 37). In both scenarios there is a drastic increase in the number of orphans by 2021. This means that whatever the magnitude of orphans due to AIDS, the real problem is already known and it will be much greater. Table 6 presents a projected orphan population in the North West 2001-2021 (North West Population Trends and Development Report HIV/AIDS Perspective, 2003: 37).

Table 6: Projected orphan population in the North-West Province 2001 – 2021

Impact	2001	2006	2011	2016	2021
Low	22.468	67.540	119.310	341.359	515.378
High	28.766	86.464	150.467	436.568	764.328

Although statistics are high UNAIDS (1996: 1) notes that statistics do not capture the misery that HIV/AIDS can bring to children. There are children who face the trauma of watching their parents grow sick and die. Furthermore, there are children who themselves are abandoned or orphaned, often become in turn –street children. For many neither money nor time is available for normal schooling to continue. However, opting out for school may help with short term needs bit the long term, it entrenches the household’s poverty and the children at greater risk of becoming infected with HIV. The result is a vicious circle linking poverty, food insecurity and HIV/AIDS. The following section is devoted to the specific issues around difficulties faced by AIDS orphans.

3.5 THE SOCIO-EMOTIONAL IMPLICATIONS OF THE RISING STATISTICS OF AIDS ORPHANS AND DIFFICULTIES FACED BY AIDS ORPHANS

The consequences of the escalation of AIDS are serious for the children and the society at large. Many children are left parentless by AIDS. These orphans and the communities to which they belong face a heavy financial and emotional burden. HIV/AIDS may cause extreme poverty, lack of social networks, as well as lack of sufficient psychological and economical support. There is a concern that AIDS orphans might come to constitute a “lost generation” of young people who have been marginalized and excluded for much of their lives (Avert, 2004: 3). The fact that children orphaned by AIDS are more vulnerable than children orphaned in other ways will become clear in the detailed discussion of the following implications of this social problem.

3.5.1 Poverty

According to UNAIDS (1999: 2) the onset of AIDS, in many developing countries, marked the beginning of a transition from poverty to complete destitution. Factors such as loss of household incomes, the cost of treating HIV-related illnesses, and funeral expenses frequently leave orphaned children destitute. The reality is most bleak in the worst affected areas of sub-Saharan Africa, where over 50% of the population lives below the poverty line. Of the many vulnerable members of society, young people who have lost one or both parents are among the most exposed of all (Avert, 2003a: 4). Orphans generally are often thought to run a greater risk of being malnourished, stunted or not receiving the care they need than children who have parents to look after them. In communities where adult deaths are high, food supplies often dwindle. Many face the constant difficulties of living with poverty and deprivation (Deame, 2001: 2; Doka, 1994: 36; Newsweek, 2000: 15; Robbins, 2004: 1; UNAIDS, 2004: 3; UNICEF/UNAIDS, 1999: 4; UNICEF, 2003: 2).

Barnett and Whiteside (2002: 201-202) state that AIDS-affected households tend to be poorer, consuming less food and with smaller disposable incomes; it is hardly

surprising that children in these households are usually less well-nourished and have a greater chance of being wasted. Resources available in AIDS-affected households decrease because of the deaths of productive members and the increased demand for household expenditure – medicine and food. The World Bank study in Kagera, Tanzania showed that even in ‘richer’ households 50% of orphaned children were wasted and had a very low weight for their height (Barnett & Whiteside, 2002: 201).

A new UNICEF report (2004: 1) shows more than half the world’s children are suffering extreme deprivations from poverty, war and HIV/AIDS conditions that effectively deny children a childhood and hinder the development of nations. The report offers an analysis of seven basic deprivations that children feel and that powerfully influence their futures. UNICEF concludes that more than half the children in the developing world are severely deprived of one or more of the following necessities essential to childhood:

- 640 million children do not have adequate shelter
- 500 million children have no access to sanitation
- 400 million children do not have access to safe water
- 300 million children lack access to information
- 270 million children have no access to health care services
- 140 million children have never been to school
- 90 million children are severely food-deprived

The State of the World's Children also makes clear that poverty is not exclusive to developing countries. In 11 of 15 industrialized nations, the proportion of children living in low-income households during the last decade has risen (UNICEF Report, 2004: 1).

Illness and loss of a parent may reduce the capacity of families to provide for the children most basic needs (Hope, 1999: 98). In rural areas this could be the inability to produce crops and in urban and rural areas to generate income. According to Irin News (2003: 1) in Malawi for instance the AIDS crises has led to many orphans having little food, few clothes, no bedding and no soap and as a whole community care. Lack of administrative capacity at the National level coupled with inadequate resources has made it difficult for the government to keep up with the growing

epidemic. The Malawian government for instance has acknowledged that its support has been grossly inadequate and the condition of orphans is made worse by extreme poverty and the erosion of extended families (Africa Recovery, 2001: 1). Poverty is a huge problem in Malawi and is estimated that 65% of the people live below the poverty line (Avert, 2003b: 8).

In 1995 Uganda had 1.2 million AIDS orphans. Based on the number of AIDS deaths and other factors there could have been 1.5 million AIDS orphans in 2000, but there were only 1.1 million. That is, Uganda was missing 400 000 AIDS orphans. According to UWESO's Ntambirweki as quoted by Newsweek (2000: 15) either the babies were born HIV positive, or died from neglect and poverty. These children may have been deprived of proper nutrition and care which results in poor physical condition and compromised immune system.

A study of the situation of AIDS orphans in relation to poverty in Tanzania sums up their circumstances (Conroy et al., 2001 in Barnett & Whiteside, 2002: 212). This survey looked at the lives of AIDS orphans and ordinary orphans and found that:

- Child-headed households are more frequently found among AIDS orphans than among others.
- AIDS orphans attended school less frequently than did other orphans.
- AIDS orphans are more likely to drop out school than others.
- Numbers of orphans are swamping household and community ability to cope.
- In a sample of 2, 786 AIDS orphans, there were 128 incidents of attempted suicide; in a sample of 2, 420 other orphans there were none.

Children whose parents have already died are disadvantaged in numerous and often devastating ways. Many of the orphans live where poverty, malnutrition, and lack of water, sanitation, and basic health and education services already make children's lives risky. In addition to the trauma of witnessing the sickness and death of their parents worsen their situation. They must grapple with the stigma and discrimination so often associated with AIDS, which often deprives them of basic social services. Many people are unable to take on the responsibilities of extra children because they

are already strained (Barnett & Whiteside, 2002: 212; Robbins, 2004: 1; UNAIDS, 2004: 3).

The unmeasured consequences for the AIDS orphan generation are of great concern. According to Avert (2004: 7) more action and money are needed for the care and provision of basic needs for AIDS orphans.

3.5.2 Pressure on the extended family

The second socio-emotional implication of the rising statistics of AIDS orphans is the pressure on the extended family. According to Avert (2004: 2) in most African societies, children did not belong to the nuclear family into which they had been born, but to the whole clan, which had the responsibility of ensuring that when orphaned, they were brought up and cared for. The deep-rooted kinship systems that exist in Africa extended – family networks of aunts and uncles, cousins and grandparents, are an age-old safety net for such children, and it has long proved itself resilient even to major social changes. After the death of a second parent, orphaned children would be shared out among relatives or kept together under the guardianship of grandparents, aunts and uncles. In this way the extended family system provided an effective safety net for the small number of orphans in society, especially in rural areas. Fostering and adoption by families without a blood tie was uncommon in Africa. Orphaned children remained in the extended family system at all times (Avert, 2004: 2; Deame, 2001: 2).

Before the AIDS epidemic in the 1970s, there were, effectively no orphans in Africa. However, a number of authors Avert (2004: 2), Barnett and Whiteside (2002: 199) Deame (2001: 2), Robbins (2004: 1), Van Dyk (2001: 334) as well as UNICEF (2003: 1) have noted that in recent times, the strands of the safety net provided by the extended family system have become increasingly frayed. The extended family is no longer able to continue with its traditional care-giving role. It is unable to offer the mechanism for coping with the approaching crisis of mass orphanhood as AIDS has orphaned more children than anywhere else.

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According to UNICEF (2003: 1) extended families are already caring for 90% of all orphans. Overstressed and in many cases already overwhelmed, these networks will face ever-greater burdens as the number of orphans continue to spiral upward. Capacity and resources are now stretched to breaking point, and those providing the necessary care are in many cases already impoverished, often the elderly and have often him or herself depended financially and physically on the support of the very daughter or son who has died (Avert, 2004: 2- 4, Robbins, 2004: 1; UNICEF, 2003: 1).

Fleshman (2001: 9) state that in Zambia, one of the countries hit the hardest by the HIV/AIDS epidemic, the traditional mechanisms for the care of vulnerable children, the extended family, has started to break down under the twin pressures of poverty and AIDS. Often the members of the extended family are elderly and find looking after and bringing them up a huge challenge. Avert (2004: 9) mentions that for many Zambian children the loss of parents brings hardship, an end to schooling and stigmatisation by other people.

In Botswana like all other African countries, traditionally the orphaned children have been cared by the extended family. However, this practice is rapidly unravelling as people are no longer willing to do this. It has been found in Botswana that the level of care the orphans receive is unacceptable and sometimes the family members use the orphans to benefit the government orphan packages (Avert, 2004: 7).

UNAIDS (1997: 14) notes that even before the AIDS epidemic, this traditional social security system was already being pushed to a breaking point. This may be due to a number of reasons. Firstly, migration from rural to urban areas has weakened the sense of mutual obligation between clan members. This has led to the emergence of individualism or nuclear family where people are considering themselves first. Secondly, population pressure on limited agricultural land has reduced the capacity of many households to provide food, clothing, shelter and education for the children of the deceased relatives. Lastly, AIDS deaths are highest among the age group of people who in the past would have been most likely to accept the orphans into their own homes.

According to Deame (2001: 2-3) without a traditional family support system, the problems for orphans mount quickly. In some countries, children in AIDS-affected households may be more likely to drop out of school because remaining family members cannot afford to pay fees or buy books, or child may be needed to care for other relatives, or to work. When families can no longer absorb more orphaned relatives, orphans may end up on the streets. Many suffer social isolation, and some are pressured by poverty into prostitution (Barnett & Whiteside, 2002: 207-212; Deame, 2001: 2; UNICEF/UNAIDS, 1999: 5; Van Dyk, 2001: 334-335).

Barnett and Whiteside (2002: 207) in conclusion state that it is necessary for communities and government to find ways to care for orphans within family and household systems that have been increasingly stretched, using institutional care as a last resort.

3.5.3 Aging parents caring for AIDS orphans

According to Avert (2004: 2) typically, half of the people with HIV become infected before they are aged 25, developing AIDS and dying by the time they are aged 35, leaving behind a generation of children to be raised by their grandparents. Avert (2004: 2), UNAIDS (2004: 3), UNICEF (2003: 1) and Hope (1999: 96) as well as Barnett and Whiteside (2002: 218) highlight that increasingly, grandparents are raising the infected and uninfected offspring of their own children who have died of AIDS. These grandparents care for their own children, who are sick, then they bury them and eventually they become surrogate parents to their bereaved grandchildren, often with few resources. AIDS in Africa is therefore often referred to as “the grandmother’s disease” as it is in most cases elderly women who have to attend to ailing children and provide care and support for grandchildren. A study of 300 orphans in Zimbabwe found that nearly half of caregivers of orphans were grandparents and most were already generally poor (Ruiz-Casares, 2001: 3).

For instance in South Africa’s Alexandra Township, “The Go-Go Grannies” are a group of grandmothers who help and encourage each other as they raise their orphaned grandchildren. They have lost their own children to AIDS and are now

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finding it difficult to cope, both emotionally and physically. The Grannies are part of the Alexandra AIDS orphans Project, which runs support-group programmes for children and caregivers living with, and affected by, the epidemic. The project currently provides psychosocial, financial and material support to 30 grandmothers. This includes one-time building grants to ensure adequate shelter for their growing families, as well as seeds and fertilizers so the women can start their own gardens to bring in food and income for their families (UNAIDS, 2004: 4).

Lewis (2003: 1) and Avert (2004: 3-4) note that it has become a common situation that the grandmothers are the caregivers for orphans in most African States. Many of the elderly are caring for the ill children and grandchildren with inadequate knowledge and understanding of AIDS and this leads them to spend resources trying to find a cure. They may sell their few belongings and go in search of a cure so that by the time their child dies they are left with grandchildren without sufficient funds and hence worsen their situation.

In some cases HIV/AIDS causes urban to rural migration, the opposite of the regular patterns. As a result orphaned children born and brought up in urban areas are sent to grand parents in the rural villages. Therefore, elderly grandparents increasingly have to bear the burden of caring for large numbers of orphaned grandchildren with little or no support from the surviving members of the extended family or other sections of society. Caring for a grandchild or grandchildren may be an unwanted or difficult burden, an intrusion into family life. The grandparents may be unprepared to take on the burden of total care for an orphan. Often, these grandparents do not have an income of their own and are progressively less able to adequately provide for the children in their care. They would normally count upon their sons to provide for their old age (Chachkes & Jennings, 1994: 84; Hope, 1999: 96; UNICEF, 2003: 1).

In a study that was carried out in Zimbabwe, it was found that many older people who care for their HIV- infected adults' children or orphaned grand children face the harsh realities of stigma attached to the disease. The study recommended that the older people should be recognised as carers and should be offered adequate support (Avert, 2004: 3; WHO, 2003: 1).

Sometimes these elderly grandparents are the only relatives left as AIDS largely affects the most economically active age group, the 15-45 year olds. These grandparents have to take on the responsibility of caring for their orphaned grandchildren. Barnett and Whiteside (2002: 218-219) as well as Black (1991: 34) identified problems associated with this. For example, grandparents typically lack the energy to work long and hard in the fields, so the range of food available to them and their dependents becomes smaller and household nutritional status falls. Without adequate material, economic and nutritional support the children are vulnerable to malnutrition and infectious diseases.

Looking after children may mean preparing regular meals, treating minor illnesses, and taking children to under five clinics, preventing household accidents and providing the children with stimulating environment and to discipline them. All the above responsibilities, but especially discipline are extremely difficult when large numbers of children live with one elderly grandparent. All this may prove to be very difficult to the elderly grandparent and the effects of such a situation are summed up by Barnett and Whiteside (2002: 219) as:

- High school drop rates
- Poor health
- Poor nutrition
- Lack of discipline.

3.5.4 Child-headed households

As AIDS creates generations of orphans it is redefining family structure and roles in many communities. AIDS disrupts social roles, rights and obligations. Since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, children are far more likely to lose the remaining parent. For the orphaned child there is often a premature entrance to burdens of adulthood, all without the rights and privileges – or the strengths – associated with adult status (Barnett & Whiteside, 2002: 206).

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According to Barnett and Whiteside (2002: 206) 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 the loss of a parent but also with the long-term care which that parent failing may require. When AIDS takes a parent, it usually takes childhood, too, for if no other relatives' step in, the oldest child becomes the head of the household.

Van Dyk (2001: 337) states that households headed by adolescents (sometimes as young as 12 years old) who care for their younger siblings are often seen in many communities. Children often find themselves taking the role of a father or mother or both, doing the housework, looking after the siblings and caring for ill or dying parent(s). In other cases, the young orphans must leave school as they struggle to make a living and take care of themselves and at times their younger siblings. Most of these children are plunged into economic crises and insecurity by their parent's death and struggle without services or support systems in impoverished communities (Tracey, 2005: 1; Newsweek, 2000: 13; Avert, 2004: 3). A study conducted in Ethiopia for instance found that the majority of child domestic workers in the capital city Addis Ababa are orphans (UNICEF, 2003: 25).

The following studies indicate that many children are already raised by other children. A study in Zambia of child-headed households found that in some homes, children were headed by children as young as 11 years of age (Ruiz-Casares, 2003:1). In Swaziland, as many as one in 10 households are run by orphans (UNICEF, 2003: 2). Avert (2004: 10) states that child-headed household, once a rarity in Zambia, are now increasingly common. Further, reports of children-headed household in countries such as Uganda, illustrate a phenomenon to many is inconceivable – children caring and providing for children through the maintenance of domestic and family structures (Hope, 1999: 98). The emergence of orphan households headed by siblings is an indication that the extended family is under stress.

World Bank (1997) describes a family as a social institution whereby social norms are organised in order to preserve societal values. Marriage provides the basic family group referred to as nuclear family, which is a unit made up of mother, father and children. However, with the advent of AIDS the idea of a family as it has always

been known will definitely change. As already mentioned there have been a growing number of households headed by children in their early teens because relatives are either unwilling or unable to accept them into their own homes. In most cases the AIDS orphans have become “an unwanted community within a community” (Webb, 1997: 183). According to UNAIDS (1997: 15) most orphaned households are left in the hands of grandparents at the death of the parents. The death of a grandparent then may leave the situation where there is no one else in the extended family willing to care for the children, giving rise to orphan households headed by older siblings.

Growing under conditions of orphanhood and child-headed households raises serious concerns about the quality of life of these children and the prospect that they will themselves experience HIV infection at the time they are sexually active. Kalumba (1997: 4) has raised concerns over the situation at home where HIV-infected children are likely to face serious health care orphan’s problems being taken care of by siblings without the supervision of grownups. Often the elder siblings who take charge are too young to provide care for their younger brothers and sisters.

According to Nyandiy-Bundy (1997: 10) the child headed household phenomenon exacts negative pressure on AIDS orphans. Children assume roles too young an age. They miss out on their childhood and they are too young for adult responsibilities. The executive director of UNAIDS Peter Piot in Boseley (2002: 1) notes that the impact of HIV/AIDS on the lives of children is one of the most tragic aspects. With the loss of their parent(s), these children have few resources to help them deal with bereavement and its repercussions. In many countries there is nothing that is in place to assist AIDS orphans to effectively deal with the trauma brought about by the extended illness and death of the parent(s) due to HIV/AIDS. They face the reality of family disruptions, and major problems with the loss of financial and emotional support and possible separation from siblings.

3.5.5 Children’s social and emotional development

Nyandiy-Bunddy (1997: 15) and Barnett and Whiteside (2002: 206) state that in taking care of the dying parent, the roles of parent and child become reversed as the

young children take on the responsibility of supporting and caring for their parents and this has serious consequences for a child's development. When parents die, their children often act out their feelings of anger resentment in anti-social behaviour towards their guardians, teachers and friends. Some may be angry with God. According to UNICEF (1998: 3) if there is no opportunity for children to express these emotions, then the psychosocial issues lie buried, only to be displayed at a later date, often in distorted and/or destructive way.

Black (1991: 10) argues that the deepest and most irreplaceable loss experienced by any orphaned child is the loss of parental love. Many doctors and social scientists have warned against assuming that children recover quickly from bereavement simply because they start to play and smile again. The fact is children experience grief and depression, which are hidden and in time they may find expression in behavioural disturbance. If discipline is taken against them, it compounds secret grief and leads to further disturbed behaviour.

According to Mukoyogo and Williams (1991: 8) the quality of childcare also suffers as AIDS invades the family, for example, the mother is less able to prepare food for the children even if the food is available. Inevitably children also suffer from lack of guidance and affection which are vital for their social and emotional development. Fontes and Hillis (1998: 347) discovered that in Rio de Janeiro, the common trend is that children who are orphaned by HIV/AIDS are displaced and many are abandoned due to the death of the primary care giver. The death of the parent(s) due to HIV/AIDS has meant that these children face deteriorating family conditions that hinder personal development and successful integration into society as productive citizens.

Like all children, AIDS orphans need to acquire the cultural values and behavioural norms necessary for their integration into society. But because of lack of supervision, neglect from relatives and community may result in early marriage especially for girls, child prostitution to meet basic needs and drug and alcohol abuse. Webb (1997: 4) has come up with evidence from Uganda that indicates that sexual activity generally starts earlier in orphans than in non-orphans. Kalumba (1997: 6) notes that these children respond more to peer pressure to turn into delinquent behaviour for

survival. They are subject to less stringent socialisation pressures, which could lead to deviancy and vulnerability to HIV infection.

Parental loss at early childhood creates negative social pressures. Children may find their way into the streets where they are exposed to a number of risks. Barnett and Whiteside (2002: 212) as well as UNICEF (2003: 2-3) argue that AIDS orphanhood will lead to a rise in the number of children living on the streets, begging, scavenging and descending into a life of crime. These streets are themselves at high risk of HIV infection. They are vulnerable to sexual exploitation. According to Webb (1997: 181) the growing number of street children in urban Kenya can be attributed to the increase in AIDS, who are forced to live, due to either ostracizing and/or the lack of community support in their home areas. Therefore, it can be seen that the relaxation of family ties and lack of adult guidance, parental upbringing and sense of identity contributes to the failure of many orphans to develop personal, moral and self-protective behavioural code which are essential for personal growth.

3.5.6 Education

According to Tracey (2005: 1) education is regarded as one of the ways that can be used to help battle the AIDS crisis at the grassroots level. However, resources may be lacking for children to continue or enrol in school or in formal training. The presence of HIV/AIDS in the family has devastating impact on school-going children. As the parent with HIV/AIDS progresses with illness, children are likely to drop out of school temporarily or permanently and some might not even start because their parents cannot afford to pay the fees and other expenses. They will therefore work full time in the home to help sick parents. These children's earnings are needed to help support the rest of the family (Avert, 2004: 7; Hall, 2005: 1; Robbins, 2004: 1; UNICEF, 2003: 2; UNICEF, 2004: 1; Van Dyk, 2001: 153).

AIDS orphans are less likely to have proper schooling. According to Barnett and Whiteside (2002: 202) the death of a prime age adult in a household will reduce a child's attendance at school. The household may be less able to pay for schooling. Hope (1999: 98), Tracey (2005: 1) and UNICEF (2004: 1) mention that orphans are

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likely to be forced to leave school as they struggle to make a living and take care of themselves. Many may be required to find employment to compensate for the loss of their parents labour. For instance a study conducted in Kwa-Zulu Natal on the plight of AIDS orphans revealed that some children drop out of school temporarily so that they could work full time to raise money for school fees and uniform. Some were working only part-time during weekends and school holidays and others had dropped out of school permanently, but intended to return if their circumstances changed (Mturi & Nzimande, 2002: 3).

Another recent study conducted by the Khmer HIV/AIDS NGO Alliance and Family Health International in Cambodia found that about one in five children in AIDS-affected families reported that they had to start working in the previous six months to support their family. One in three had to provide care and take on major household work. Many had to leave school, forego necessities such as food and clothes, or be sent away from their home. All of the children surveyed had been exposed to high levels of stigma and psychosocial stress, with girls more vulnerable than boys (UNAIDS, 2004: 4).

Orphan learners may face enormous financial hardship and have great difficulty in paying for school fees, uniforms and books. For instance, Hall (2005: 1) notes that in Swaziland many orphans are dropping out of school because of lack of finances. At the heart of the problem lies the fact that schools fear taking on students who are unable to pay fees. Swaziland's Ministry of Education set aside just over three million dollars to subsidise the schooling of these children – an amount that later had to be raised to almost 6.4 million dollars (Hall, 2005: 2).

Research in Zimbabwe showed that 48% of the orphans of primary school age who were interviewed had dropped out of school usually when their parents became too sick to look after themselves or when their parents died. Not one orphan of secondary school age was still in school (Van Dyk, 2001: 154). Studies in Uganda suggest that after the death of one or both parents, the chance of orphans going to school is halved and those who still attend school spend less time there (Deame, 2001: 2). A study in Kenya found that 52% of the children orphaned by AIDS were not in compared to 2% of non orphans (Avert, 2004: 3). In another study of orphans in Kenya, 64% of boys

tended to cite economic reasons for leaving school while 69% of girls made mention of pregnancy and marriage (UNAIDS, 2000: 29).

According to Barnett and Whiteside (2002: 202) in Zambia there is evidence of a fall of numbers of children attending primary school. Nearly one out of three urban orphans and two out of three rural orphans don't attend school, which is significantly worse than attendance rates for non orphans (UNICEF/UNAIDS, 1999: 17). Furthermore, Ruiz-Casares (2001: 1) mentions that in rural areas of Zambia, 64% of orphans are not enrolled in formal school compared with 48% of non-orphans. In Zambia's Copperbelt – an area badly affected by HIV/AIDS it found that 44% of the children of school-going age were not attending school, but with proportionately more orphans (53%) than non-orphans (42.4%) not attending (Barnett & Whiteside, 2002: 202). A similar pattern was apparent in a rural area in the eastern part of the country where only 38% of the orphaned school age children were attending school, compared with the provincial average of 51%. More data show that 32% of orphans of school going age were not enrolled and in rural areas the situation is more severe with 68% of rural orphans not enrolled (Barnett & Whiteside, 2002: 202; Webb, 1997: 189).

UNICEF (2003: 2) stresses that children who drop out of school are vulnerable to substandard education and reduced chances for life success. This has devastating effect, as these children who do not go to school lack the vocational skills needed to earn a decent living and support their younger brothers and sisters. They also lack information about how they can look after their own health, and especially about how they can protect themselves from HIV/AIDS and other sexually transmitted diseases (Avert, 2004: 7; UNAIDS, 2004: 3).

Even those children, who are taken in by remaining extended relatives, still remain at risk. Caring for children has costs. AIDS orphans increases demands on household resources. Many extended families that have accepted orphans cannot afford to send all their children to school, and orphans are often first to be denied education and are required to work for the upkeep of the family. Since virtually everywhere in Africa governments charge school fees, when the family cannot raise up the fees, the children suffer the consequences (Barnett & Whiteside, 2002: 204; Irin News, 2003: 1; Newsweek, 2000: 15; UNAIDS, 1997: 15). In Zambia, a study cited by the

UNAIDS report (2002: 1) found for instance that one third of urban children with parents enrol in school, but only one quarter of orphans do.

According to Van Dyk (2001: 153) there is evidence that emotional difficulties suffered by AIDS orphans combined with social stigma tend to block their ability to learn at school. They often have little ability or motivation to contribute to their educational development. In a study in Nasaka district in Uganda, UNICEF/WHO (1994: 37) identified some of the common sources of psychological stress among AIDS orphans. One fact that came out was that children felt that school teachers are unsympathetic to their difficulties and are often too ready to punish them for being late or ill equipped without looking for explanation.

However, in Zambia, a scheme under the Zambia Open Community Schools has initiated programmes, which attempt to help children deal with their grief and their fear. Teachers are trained on child psychology and the skills needed to address the situation. After a loss of a parent or a family member, teachers encourage children to tell or write stories or draw pictures dealing with death. Eventually, this leads to children to open up and talk about their feeling related to loss (UNAIDS, 1997: 24).

HIV/AIDS has also a devastating impact on the education system holistically. Avenstrup (1999: 8) observes that AIDS is changing the whole education context. AIDS increases teacher deaths and it may be difficult to replace particularly in deprived, rural or otherwise remote communities. Teacher's illness is of particular importance. Classes remain untaught for extended periods and replacement is difficult while staff members are on sick leave. The standard of education that a child receives may be low (Barnett & Whiteside, 2002: 202).

UNICEF Report (2004: 1) also highlights that HIV/AIDS is not only killing parents but is destroying the protective network of adults in children's lives. Many teachers, health workers and other adults on whom children rely are also dying. And because of the time lag between HIV infection and death from AIDS, the crisis will worsen for at least the next decade. For instance UNAIDS (2000: 29-30) reported that the Central African Republic in 2002 was already experiencing a 33% shortage of primary school teachers. Now because of staff shortages in the Central African Republic, 107 schools

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have closed and only 66 have been able to remain open. It is estimated that more than 71 000 children between the ages of 6 and 11 will be deprived of a primary education by the year 2005 in the Central African Republic (Van Dyk, 2001: 153). Furthermore, it has been noted that in the Caprivi region in Namibia, HIV/AIDS is severely disrupting schooling. Over the last three years it is reported that the region lost 15 out of 90 life science teachers to AIDS. One teacher commented that “The teacher who is sick can not prepare or teach well. Teachers have to go for funerals every second day so they have no time to teach” (The Namibian, 1999: 1).

Schools are taking more and more orphans and in some schools (for example in Zambia) up to 35% of the school children are AIDS orphans. But the education system is threatened by teacher absenteeism and deaths. The provision of quality education is hampered by the fact that teachers, principals and education administrators are also dying of HIV/AIDS (UNICEF, 2003: 2).

Another major problem identified by Avenstrup (1999: 9) is that of the particular risk faced by schoolgirls. Since men retain the false belief that sex with girls will cure them of HIV/AIDS, many men invent cultural tradition in order to have sex with girls. The male teachers may in turn abuse the schoolgirls as a self-fulfilling prophesy, yet these are the people who are left to become the main role model for the children.

According to Avert (2004: 3), UNAIDS (2004: 4) and UNICEF (2003: 2) keeping orphans at school is crucial for the future. Staying in school offers orphaned children the best chance of escaping extreme poverty and its associated risks. It can provide education that can work as a safety net in the child’s life. Schooling can also help to break the cycle of poverty. Offering children free basic education, giving them a safe and viable option for earning a living can mean that many orphans can have a bright future.

3.5.7 Health care

Orphanhood has serious implications for child health. Increasing AIDS related poverty causes a degradation of the family’s immediate environment, multiplies

health risks, and reduces its ability to access health services. AIDS orphans are often at greater risk of illness, abuse and sexual exploitation. Furthermore, they may not receive health care they need, and sometimes this is because it is assumed they are infected with HIV and their illnesses are untreatable. Orphans are also generally thought to run a greater risk of being malnourished and stunted than children who have parents to look after them (Avert, 2004: 5; Hope, 1999: 98; Robbins, 2004: 1).

Mukoyogo and Williams (1993: 12) point out that AIDS diminishes the family's capacity to grow food and earn money to buy food even while both parents are alive. The death of a parent exacerbates the situation still further. As a result children consume less food and also eat less nutritious food. Barrett (1997: 5) has come up with evidence that indicates that orphanhood, particularly caused by the death of a mother, often entails the deterioration in the health of the child. This evidence shows that in many families in South Africa, a mother is the primary health care worker whose responsibility includes family health-care. Therefore AIDS orphans are often prone to malnutrition and infections and are less likely to receive health care than any other children. Lewis (2003: 1) also argues that these children are likely to suffer deep psychological wounds because many would have watched their parents die painful, lingering deaths.

Discrimination in accessing health care is a major form of social exclusion faced by AIDS orphans. The fact that is often unknown and ignored is that not all AIDS orphans are infected. UNAIDS (1997: 13) has come up with evidence that two thirds of children born to HIV-positive mothers do not contract the infection and grow up to be as healthy as any other child in the community. The evidence also suggest that children orphaned by AIDS may be at greater risk of dying of preventable diseases and infections because of the mistaken belief that when they become ill it must be due to AIDS and therefore there is no need to seek medical help.

Very little attention has been given to the health needs and developmental problems of children whose parents die of AIDS. Webb (1997: 189) points out that hospital initiated home-based care programmes, have generally failed to go beyond the medical attention of the AIDS patient to look at the health care needs of the affected

children. However, the counselling and support of affected children remains a priority since they also go through the trauma caused by the bereavement.

3.5.8 Emotional trauma and stigma associated with HIV/AIDS

The death of a parent is certainly a profound psychological and social crisis for a child, especially when the parent dies from AIDS. The process of losing parents to HIV/AIDS for the children often includes the pain and the shame of the stigma and the fear that the disease carries in most of the societies. The illness and loss of a parent is very traumatic for a child and lack of consistent nurture can have serious developmental effects. Orphaned children are more likely to suffer damage to their cognitive and emotional development and to be subjected to the worst forms of child labour. The vulnerability of children orphaned by AIDS and that of their family starts well before the death of the parents. The emotional suffering of the children usually begins with their parents' distress and progressive illness. This intensifies as HIV/AIDS cause drastic changes in family structure resulting in a heavy economic toll, requiring children to become caretakers and breadwinners (Avert, 2004: 5; Chachkes & Jennings, 1994: 80; Doka, 1994: 40; Hope, 1999: 98; UNICEF, 2003: 2; UNICEF, 2004: 1).

Eventually the children suffer the death of their parent(s) and the emotional trauma that results. According to UNICEF (2003: 2) and UNAIDS (2004: 3) depression and alienation become common. Any death, especially the death of a parent, raises questions for the child. Questions such as "Why did this happen?" "Why did it happen to me?" and "Why did he/she or they have to die?" While any death raises profound question of meaning, AIDS related death may be particularly problematic. The children have to adjust to a new situation, with little or no support at all (UNICEF, 2003: 2).

The tremendous fear and stigma attached to AIDS generate a context where children find it difficult to seek support either from peers or from adults. They may personally experience the stigma of AIDS related illness, as they are teased by classmates or ostracised by peers and other parents (Avert, 2004: 5; Doka, 1994: 35).

According to UNAIDS (2004: 3) even people who work with orphaned children struggle to understand the emotional anguish a child experiences as he or she watches one or both of his or her parents die. When one parent is HIV-infected, the probability is high that the other parent is as well. Therefore, children often lose both parents in quick succession.

Barnett and Whiteside (2002: 206) note that successive orphaning is not unknown. An orphan's caregivers may also succumb to AIDS, with the result that children may suffer multiple bereavements. The child's suffering is often compounded by being separated from his or her siblings. For example, in a report from Zambia, separated siblings said they see each other less than once a month (Family Health International, 2002 in UNAIDS, 2004: 3). Many experience depression, anger, guilt and fear for their futures. This experience can lead to serious psychological problems such as post-traumatic stress syndrome, alcohol and drug abuse, aggression, and even suicide (UNAIDS, 2004: 3).

Avert (2004: 5) and Robbins (2004: 1) note that children grieving for dying or dead parents are stigmatised or ostracised by society through association with HIV/AIDS. Often children who have lost their parent to AIDS are assumed to be infected with HIV themselves. The distress and social isolation experienced by these children, both before and after death of their parents(s) is strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma, and often-irrational fear surrounding AIDS these children may be denied access to schooling and health care (Avert, 2004: 6; Barnett & Whiteside, 2002: 202). This further stigmatises the children and reduces their opportunities in the future. Peter Piot, the executive director of UNAIDS made this sad statement "if your father died in war, you are a hero. If he died of AIDS you are an outcast (Ruiz-Casares, 2001: 2).

Grodny (1994: 137-138) identified the following as common socio-emotional reactions amongst children who lost parents (s) to AIDS:

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- Anger: Children who are old enough to understand the ways in which HIV is transmitted may be extraordinary disappointed in and angry with the parent for engaging in the behaviour.
- Fear of death: The death of their parents may cause children to begin to view their world as unpredictable. They can respond with a heightened sense of vulnerability, often marked by fears of recurrent tragedy.
- Guilt: Many children are guilt-ridden and feel they have caused their mother to get sick.
- Loss and abandonment: Children experience a great deal of anxiety about who will care for them if their parent(s) die.
- Depression: Depression is regarded as the most common reaction to the announcement of a parent's HIV infection, AIDS and death. The features of this are withdrawal from family and social activities, isolation, moodiness, below-or above-average appetite, sleep disturbances, and inability to concentrate.
- Suicidal ideation and gestures: Children have also been known to have suicidal ideation after the death of a parent. This ideation is clearly an identification with the parent who has died from AIDS.

According to Doka (1994: 38) it is critical that the child have support. Each child should have a supportive adult whose main function is to maintain the child's emotional comfort. This person can answer questions and provide nurturing. The child needs to be assured that he or she is not responsible for the illness or death.

3.5.9 Children's exploitation and HIV infection

As highlighted earlier some children live on their own at a young age as result of their parents dying from AIDS. According to Avert (2004: 5) orphans enduring the grave social isolation that often accompanies AIDS when it strikes a family and they are at

far greater risk than most of their peers of eventually becoming infected with HIV. Often emotionally vulnerable and financially desperate, orphans are more likely to be sexually abused and forced into exploitative situations, such as prostitution, as means of survival. Girls are also in greater risk of becoming infected at a younger age than boys, because they are biologically, socially and economically more vulnerable (Avert, 2004: 5; Robbins, 2004: 1).

According to Van Dyk (2001: 154) sexual initiation may occur at a very early stage for some children, especially in marginalized communities where sexual abuse and rape are relatively common. A survey of 1600 children in four poor areas of Zambia Capital Lusaka for instance showed that more than 25% of children aged 10 had already had sex. In South Africa, 10% of respondents in a study in six provinces indicated that they had started having sex at age 11 or younger. Another study conducted in Kwazulu-Natal reported that 76% of girls and 90% of boys are sexually experienced by the time they are 15 or 16 years of age.

Child sexual abuse has become a subject of worldwide concern. In Africa, newspapers and other forms of mass media frequently report about the increasing cases of child sexual abuse. According to Hope (1999: 41) there are many theories that explain why men abuse children. Firstly, there is the prevention theory, which is based on the assumption that all sexually active are likely to be HIV/AIDS infected. If an individual is uninfected and wishes to engage in safe sexual activity this can only be done with a partner who is uninfected and in this case children less than 12 years. Secondly there is the cleansing theory, which suggests that by engaging in sexual relations with children HIV/AIDS can be passed from the infected individual to his or partner (Hope, 1999: 41). However, regardless the underlying motive for childhood sexual abuse, these children are at increased risk of exposure to HIV/AIDS.

In Uganda, focus groups discussions revealed that girls orphaned by AIDS were especially vulnerable to sexual abuse in domestic housework (UNICEF, 2003: 2). Girls carry a larger burden of domestic responsibility than boys and are more likely to be kept out of school. In Zambia, a study conducted by the International Labour Organisation in several districts, shows that the majority of children in prostitution are orphans (UNICEF 2003: 1-2).

Without the protective environment of their homes, orphaned children face increased risk of violence, exploitation and abuse. They may be ill-treated by their guardians, and dispossessed of their inheritance and property. Those living with foster families are more likely to be malnourished, underweight, or short for their age in comparison to non-orphans. In worst-case scenarios, orphaned children may be abducted and enrolled as child soldiers or driven to hard labour, sex work, or life on the streets (Barnett & Whiteside, 2002: 212; Robbins, 2004: 1; UNAIDS, 2004: 4).

3.5.10 Loss of family security and identity

According to Ruiz-Casares (2001: 1) as well as Siegel and Freund (1994: 54) not only do children carry the emotional burden of watching a loved one suffer and die, but they also experience the trauma of the family unit collapsing. A family illness and death necessitate changes in responsibilities, routines, living conditions, and even place of residence. Such extensive environmental change can deprive children of the feelings of security and comfort they derive from familiar routines and settings. According to Doka (1994: 36) these children, given their environment, may experience developmental or behavioural problems. They may find it difficult to trust or to bond with adults.

Children deserve a childhood filled with comfort, security and hope. Unlike most diseases, HIV/AIDS generally kills not just one, but both parents. Once AIDS has claimed the mother or father, children are far more likely to lose the remaining parent. When parents fall sick and die a child's identity falls apart. One of the concerns revealed by several focus group discussions and interviews held with orphaned children and community members from a rural area near Mutare in Zimbabwe, is feeling different from other children because many lack family support and hence suffer more frequently from malnutrition, illness and abuse (Ruiz-Casares, 2003: 1).

Doka (1994: 36) notes that AIDS orphans may have to struggle with issues of multiple losses. Many of these may have lost both parents through AIDS, abandonment, and inability of others to care for them. As already noted they may have experienced the loss of other family members. They may have been separated

from their siblings, friends, neighbours, and classmates. Losing a parent is considered hard to handle however it is even more difficult to cope with multiple losses. Relocation that requires a change of neighbourhood or school can disrupt supportive friendship networks that could buffer the loss (Doka, 1994: 36; Siegel & Freund, 1994: 55).

Consequently, even if such disruptions are unavoidable caregivers are encouraged to try to maintain as much stability and consistency in the child's environment as possible. Even maintaining such simple routines as having meals at a certain time or going through an established bedtime ritual can reassure the children that all has not changed. Growing up in communities disrupted by the epidemic; orphans are more likely to cope if they can live in surroundings that are familiar, stable and as nurturing as possible. Many believe that orphans should be cared for in family units through extended family networks, foster families and adoption. At the very least, siblings should not be separated (Avert, 2004: 5; Siegel & Freund, 1994: 54).

3.5.11 A bleak future and life of crime

A generation of orphans threatens to undermine economic development, for children without parents can seldom afford education. School is a place where children can acquire knowledge and skills to prepare for the future. According to Dr Peter Piot of UNAIDS many AIDS orphans end up roaming the streets and prime targets for gangs (Bartholet, 2000:13). Growing up without parents, and badly supervised by relatives, this growing pool of orphans will be at greater than average risk to engage in criminal activity. These children are often much more likely to being swallowed by crime as it is viewed as a means of survival especially in the streets (Barnett & Whiteside, 2002: 210). According to Lewis (2003: 1) the children live traumatised and unstable lives, robbed not just of their parents but their child hood and future.

According to Barnett and Whiteside (2002: 212) in extreme cases, which are all too common orphans turn to the street where physical needs and financial desperation make them more vulnerable to crime, sexual exploitation and substance abuse. This

places a significant number at risk of contracting HIV through virtually inescapable income-generating prostitution.

This section has established that as the number of adults dying rises over the next decade, an increasing number of orphans will grow up without parental care and love and will be deprived of their basic rights to shelter, food, health and education. According to UNICEF (2003: 2) many of the most severely affected countries in sub-Saharan Africa have no national policies to address the needs of orphaned children, including children orphaned and made vulnerable by HIV/AIDS. The ongoing failure to respond to the orphan crisis will have grave implications not just for the children themselves but for their communities and nations. The following paragraphs specifically review legal implications and ethical aspects of the socio-emotional problems faced by these orphans.

3.6 THE RIGHTS OF AIDS ORPHANS

According to Barnett and Whiteside (2002: 211) orphanhood threatens many aspects of children's lives. Hunter and Williams (2000: 215-216, 236-237) state that the hardships faced by AIDS orphans have been documented for more than a decade, and many African governments are trying to develop and implement solutions. Some countries have created new laws and policies to protect children and to help children defend their inheritance and rights to property while others have not. The 2003 report on progress in meeting the 2001 UN Declaration of Commitment on HIV/AIDS goals notes that 39% of countries with 'generalized epidemics' have no national policies to provide orphaned and vulnerable children with essential support. Some 14% of these countries are developing policies, but 25% have no plans to do so (UNAIDS, 2004:5).

According to The State of the World's Children 2005, "Childhood Under Threat," as mentioned by UNICEF (2004: 1) more than 1 billion children are denied a healthy and protected upbringing as promised by 1989's Convention on the Rights of the Child, the world's most widely adopted human rights treaty. The report stresses that the failure of governments to live up to the Convention's standards causes permanent damage to children and in turn blocks progress toward human rights and economic advancement. "Too many governments are making informed, deliberate choices that

actually hurt childhood," said UNICEF Executive Director Carol Bellamy in launching the report at the London School of Economics (UNICEF, 2004:1).

UNAIDS (1997: 14) states that the relation between HIV/AIDS, impoverishment and denial of human rights is apparent in the impact of the epidemic on children who have been orphaned by AIDS. Ennew and Milne (1989: 12) argue that children have not always been on the human rights agenda as a separate group. For years they were regarded as a residual category of persons, lacking full human rights. Furthermore, they have observed that in many countries children are not given the opportunity to vote, do not contribute to election campaigns, and do not make policy decisions. The development and implementation of social policy for children rests with adults. Therefore, children cannot choose, but have to accept the choices made for them by adults. Social rights emerge from needs and provide framework for social policy development, therefore, as problems faced by AIDS orphans become visible, social policies emerge.

The South African Constitution (Act 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The Bill of rights within the constitution sets out a number of rights, which protect children. However, the most comprehensive document containing the rights of the child is the United Nations Convention on the Rights of the Child (UN CRC, 1990), which was adopted by the United Nations General Assembly in November 1989 and entered into force in September 1990. The above-mentioned document sets out a wide range of political, civil, cultural, economic and social rights of children. It is based upon four broad principles that are essential in all matters affecting the child. These principles are; protection, participation, survival and development, and non-discrimination. Every child has a right to education, to the highest attainable standard of health, to seek, receive and impart information and ideas of all kinds, to special protection and assistance if deprived of his or her family environment, to non discrimination and privacy, to express opinion and freedom from drug trafficking, prostitution, sexual exploitation and sexual abuse (UN CRC, 1990).

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This United Nations Convention on the Rights of the Child Document (UN CRC, 1990) in principle provides a protective framework for children. It accords them the following rights which are to be protected by signatory governments.

- To be cared for by his or her parents (Article 7)
- To preserve identity, nationality, name and family relations (Article 8)
- To maintain regular contact with parents if separated (Article 9)
- To freedom of expression (Article 13)
- To freedom of association (Article 15)
- To be brought up by parents or guardians whose basic concern is his or her best interests (Article 18)
- To protection from physical or mental ill-treatment, neglect or exploitation (Article 19)
- To conditions of living necessary for his or development (Article 27)
- To education (Article 32)
- To rest, leisure, play and recreation (Article 31)
- To protection from economic exploitation and performing any work that interferes with his or her education or is harmful to his or her mental, spiritual or social development (Article 32)
- To be protected from all forms of sexual exploitation and sexual abuse (Article 34)
- To be protected from abduction, sale or trafficking (Article 35)
- To be protected from torture or other cruel, inhuman or degrading treatment or punishment (Article 37)

Barnett and Whiteside (2002: 212) state that in normal circumstances many of these rights are violated; HIV/AIDS increases the number of children at risk.

When AIDS invades homes, family possessions such as livestock, furniture and even land may be sold off to obtain cash for treatment of the parents. In extreme cases money is borrowed from relatives and friends. Van Dyk (2001: 334) points out that after the parent's death, children often lose their rights to the family land, property and house. The inevitable death of the parents, cause unscrupulous relatives and friends sometimes succeed in claiming land and other property that orphaned children

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are legally entitled to inherit from their parents. Speaking at a launch of regional orphan care initiative, Land and Housing Minister Margaret Nash of Botswana was reported as saying that relatives often tried to take over deceased parents' homes as well as their cars and bank accounts (Irin News, 2003: 1).

Further, Avert (2004: 6), Barnett and Whiteside (2002: 206) as well as Robbins (2004: 1) highlight that once parents die, children particularly in case of girls, may be denied their inheritance and property. In some instances land, home, and possessions may be appropriated by banks, leaving children homeless and with no protection by customary laws of inheritance. Du- Venage (2002: 1-2) has evidence to show that in urban areas other investments like mortgaged houses are also at risk of being repossessed and auctioned due to non-repayment. In South Africa for example it has been noted that banks are left with unpaid debts because mortgage holders have died from AIDS (Du-Venage, 2002: 1). Loss of income or inability to repair and maintain the home can result in shelter being lost or becoming inadequate and the children left without a home. It has been argued that in theory the law is usually on the side of the orphan but in practice the enforcement of the law is very difficult unless the child receives legal assistance (Du- Venage, 2002: 1-2).

A study in Zambia reported that 46 percent of families affected by AIDS had been forced to move to poor premises with fewer facilities (Hope, 1999: 98). After the death of parents the children may find themselves living with various caregivers. Some children are taken in by relatives, others by the neighbours or found a bed in one of the few orphanages. For the rest there are only the streets of cities, where children lacking adult supervision and a stable environment, survive by begging and petty crime (Avert 2003a: 10; Doka, 1994: 36).

Van Dyk (2001: 335) mentions that some relatives take in orphans in order to entitle them to land claims or foster grants and become "self appointed trustees" ending up expropriating the children's land, or money or manipulating land boundaries in their own favour. In such cases they may reject male orphans for fear that they will rightfully claim back their land. According to Irin News (2003: 1) in Botswana for instance there are a lot of cases reported of property grabbing where the family members divide it among themselves and leave the children with nothing. Because

these children no longer have access to education and because they lack work skills and family support of any kind they often end up living on the streets (Van Dyk, 2001: 334-335).

In Africa, orphaned children have relatively few legal or customary rights to property or to decision making about their future, unless the parent has made specific provision for them in the will. UNICEF (1998: iii) has come up with evidence that in a research in Namibia, the vast majority of the dying parents had not a will providing for the transfer of their property or responsibility for their children.

Some forms of exploitation are open for example, in case where the orphaned child is accepted into an extended family as a domestic servant. Ennew and Milne (1998: 53) came up with evidence that in Jamaica orphan girls are taken in as domestic servants by relatives. The conditions under which live are generally far poorer than those of their “new” family. Some were discovered to be sleeping under kitchen tables and they usually dine on scraps of leftover food. The hours of work were exceptionally long and many were on call 24 hours a day. The study concluded that these children are living in virtual slavery. Salazar and Glasinovich (1998: 12) agree with this by producing evidence that in Guatemala orphans working as domestic servants have psychological problems due to discrimination, isolation and disdain. It was disclosed that these children cannot leave the house and are not paid adequately. Even though there were difficulties in reaching these children for survey, evidence pointed out that there was physical, mental and sexual abuse.

Many children are not aware of their legal rights and to pursue these rights in courts needs money, skills and self-confidence that these children lack. UNAIDS (1997: 15) has noted that grandparents also find it difficult, without necessary legal information and support, to defend the inheritance rights of their grandchildren against the claims of the children’s greedy relatives.

UNAIDS (1997: 6) states that AIDS orphans are vulnerable to infection through sexual abuse, coercion and commercial exploitation which stems from failure to respect their rights. The majority of them do not have the rights to information, education and services. Taylor-Brown et al (1998: 140) have come up with evidence

that these children mistrust and fear the legal system or other government intervention. This is because, while legal rights are by definition enforceable, the AIDS orphans have been afforded few or no rights.

According to Avert (2004: 5) there is much that can be done to ensure the legal and human rights of AIDS orphans. Many communities are now writing wills to protect the inheritance rights of children and to prevent land and property grabbing (an adult attempting to rob orphans of their property once the children have no parents). The State of the World's Children argues that bridging the gap between the ideal childhood and the reality experienced by half the world's children is a matter of choice (UNICEF, 2004: 1). The quality of a child's life depends on decisions made every day in households, communities and in the halls of government. The report further emphasizes that people must make choices wisely, and with children's best interests in mind. If people fail to secure childhood, the nations will fail to reach larger, global goals for human rights and economic development. As children go, so goes the nation (UNICEF, 2004: 1).

Because of the preceding premise describing challenges and shortcomings of AIDS orphans the question of skills development becomes indispensable. As a matter of fact there is a demise of skills which culminates in far reaching results as detailed below.

3.7 IMPACT OF AIDS ON SKILLS DEVELOPMENT

As already mentioned in this chapter every year tens of thousand of children lose their parents to AIDS reflecting a lost generation of children with no hope and no future. AIDS orphans frequently suffer many losses including parent(s), sibling(s), school, home, neighbourhood, friends and social supports. Until now, most orphan-support interventions have been piecemeal and have not matched the scale of the problem (UNAIDS, 2004: 5).

According to Mike Waters of the Democratic Alliance, South African National Government Policy for the care orphans of the AIDS epidemic is terrible. The process of rolling out antiretroviral drugs which would keep many parents alive for

longer, is excruciatingly slow hence many children are left orphaned as their parents succumb to AIDS. He said further, there was a shortage of more than 6 500 social workers, representing a 72% vacancy rate at the Department of Social Development (Mesatywa, 2005: 1). This leads to a lack of support for AIDS orphans and this lack of support makes it difficult for children to have normal development.

A parent's death deprives the child the learning and values they need to become socially knowledgeable and economically productive adults. Recent research suggests that this breakdown in intergenerational knowledge may play a part in a country's economic decline. This has devastating effect, as these children who do not go to school lack the vocational skills needed to earn a decent living and support their younger brothers and sisters (Avert, 2004: 7; Bell et al., 2003 in UNAIDS, 2004: 3; UNAIDS, 2004: 3).

Another significant issue is that traditional skills may not be passed by parents because of premature death. Education can empower the children and give them the skills and hope for the future. Otherwise, if insufficient action is taken, there is a danger of a huge generation of uneducated youths and adults. Education and information are fundamental human rights, and young people may not be denied the basic information and skills they need to protect themselves (Avert, 2004: 7).

According to Grodny (1994: 133) the needs of adolescents who are surviving parental death from AIDS have not received sufficient programmatic attention. Although these children may seem invisible, the multiple traumas they have faced and their vulnerability make it imperative that programmes be developed that attend to their needs. He further notes that programmes to empower these children are generally limited hence these young orphans usually grow up in communities blighted by drug use, poverty, and violence. Absence of basic knowledge and life skills contribute to the vulnerability and exploitation of orphans.

Anderson and Okoro (2000: 2) note that the only solution will be to purposefully employ a continuous positive preventive approach in order to stabilise or change the life-styles of the youth. These programmes must have the potential to provide self-

empowerment to these children. They should offer them necessary assistance that will enable them to survive and take part in their future (Grodney, 1994: 133).

Avert (2004: 3) states that empowering affected children means regarding them as active members rather than just victims. Many AIDS orphans already function as heads of households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of HIV/AIDS in their families and communities. Hunter and Williamson (2000: 2) state that programs to help AIDS orphans must be able to be implemented quickly, given the speed with which the orphan problem is growing, be sustainable for several decades, and be able to adapt to the epidemic's growing and changing impacts.

Life skills are widely recognised as an effective method of intervening. They promote abilities that contribute to positive health behaviour, positive interpersonal relationships and physical as well as mental well-being. The promotion of mental and physical well-being contributes to people's motivation to look after themselves and others, hence the prevention of health and behaviour problems. Particular emphasis is placed on behaviour change via values-oriented education accurate information and intervention that foster self-respect. This support will ensure that children grow up safely without experiencing exploitation and themselves falling prey to HIV (WHO, 1997: 17; Anderson & Okoro, 2000: 6-7). Consequently the focus of this study is directed towards the development and empirical testing of a life skills programme for AIDS orphans.

3.8 CONCLUSION

The AIDS orphan crises worldwide and specifically in South Africa is a daunting challenge for the country. It is very difficult to estimate the number of children orphaned by AIDS each year, but whatever the figures, it is clear that there is an enormous problem. Millions of children worldwide have already lost at least one parent to the epidemic, and millions more will do so in the years to come. Some thousands of people will die of AIDS today and some thousands will die tomorrow, and the next day. For the children the tragedy is only beginning.

This chapter has established that most of the children orphaned by AIDS come from socio-economically disadvantaged families. Parental death may be one in a series of significant stressors that they have had to confront. Others may be poverty, crowded living conditions, poor education and health care. These children may face discrimination and rejection with their extended families and communities. Thus these children constitute a very vulnerable population. With the relentless toll of AIDS reducing the ability of families and communities to support and care for children countries are now facing troubling scenarios: grandmothers struggling to care for orphans, households headed by children, many of them primary-school age, who are caring for younger siblings, and worse, children with nowhere at all to turn.

The extraordinary challenge and difficulties that these children (mostly adolescents) experience expose them to risky habits detrimental to their health. The AIDS epidemic threatens the viability, perhaps the very existence, of this generation. A healthy productive generation of adolescents today will ensure that South Africa has the healthy generation of adults needed in the 21st century. Specifically the next chapter serves to understand adolescence as a stage to help in understanding the nature of adolescence and the developmental processes which are involved. Once this understanding is developed, focus can be on developing a program which is specifically designed to parallel the adolescent developmental process.