CHAPTER 4

THE SOCIO-EDUCATIONAL IMPACT OF HIV/AIDS ON ORPHANS OF AIDS IN SOUTH AFRICA

"Every child in South Africa will feel the impact of HIV/AIDS. For some, it will be far removed, while for others it will be within them destroying their immune system, and eventually leading to their death... Children are experiencing, and will experience at an increasing rate, the deaths of their parents, other family members, teachers and at times their peers. Deaths will affect the provision of services, education, health and welfare. Children will grow up in societies where death is a common experience, affecting them emotionally, economically and psychologically. The epidemic violates many of the fundamental rights of South African children" (Desmond and Gow 2002b:3).

4.1. AIM OF THE CHAPTER

The aim of this chapter is to elucidate the manner in which children orphaned by HIV/AIDS are affected in South Africa and in the province of Kwa-Zulu Natal. The latter is the province where the empirical research for this study on child-headed households will be conducted. This chapter will concentrate on Kwa-Zulu Natal in the hope that the information provided by the study will impart constructive elements to support and smooth the advancement towards the mitigation of the effects of the pandemic upon children, chiefly orphans of AIDS. However, it must be reiterated that research based on the socio-educational conditions of orphans in child-headed households is a neglected field of study since there is only anecdotal evidence of the phenomenon. Definitions provided in earlier chapters of this study will apply to this discussion on South Africa and Kwa-Zulu Natal.

4.2. THE IMPACT OF HIV/AIDS IN SOUTH AFRICA

4.2.1. INTRODUCTION

In South Africa, there are great demands upon social and educational structures as a result of the vast number of children orphaned by AIDS (Barrett 1998:4). However, for orphanhood, these are still early days of South Africa's AIDS pandemic since the appalling degree of orphan hood being experienced elsewhere in Africa is yet to come (Johnson & Dorrington 2001:5). What is disconcerting about the South African scenario is the fact that bearing in mind the approximately 6.5 million people (Giese & Meintjes 2003:1) who are infected with HIV thus far, there might just be far more orphans of AIDS in this country than in any other in times to come.

The enormous strain caused by HIV/AIDS upon the government resources; Non-Governmental Organizations (henceforth referred to as NGO's) and the extended family system make the future appear rather bleak (Barrett 1998:4). Kehler (2003:47), in an examination of the South African Draft Children's Bill to be tabled in Parliament, emphasizes the dramatic increase in child poverty and child-headed households in the country. The argument in Kehler's (2003:47) report illustrates that **six out of every ten** children in South Africa live in poverty. As indicated by McKay (2003:26) of Save The Children Fund in the UK, South Africa has approximately 100 000 child-headed families presently.

Children, who are the most vulnerable, lose their parents and caregivers, have to leave school to assume adult responsibilities and cannot afford school because breadwinners are too ill to work (Desmond 2003:4). According to Giese (2002b:1) the majority of children in South Africa do not benefit from their rightful claim to shelter, food, education, family care, health care and protection. Although the pandemic is not the

major reason it is nevertheless one of the primary causal factors why children live under such disastrous circumstances.

Orphan hood is not a unique social issue within the South African society. Nonetheless, the emergent orphans of AIDS have begun to weigh heavily upon the present social and educational institutions, evolving diverse family structures, especially in the form of child-headed households (Fox, Oyosi & Parker 2002). Some of these children will grow up without proper education, love, care and guidance towards proper basic social skills and cultural knowledge. They may even suffer the discrimination and stigmatization attached to HIV/AIDS (Fox et al 2002).

The National Children's Forum (NCF) arranged to bring together 90 HIV affected children from around South Africa in order to allow the children to share experiences (Giese 2002b:1). Some of the most significant findings pertinent to this study were:

- Children affected by HIV/AIDS were not being supported by the school system. Educators were often totally unaware that these vulnerable children could not afford fees, uniforms or even food, had to take care of ailing adults or siblings **and** were required to bring in an income. Hence, they found it more convenient to be absent for lengthy periods of time and eventually just to drop out of school since the added pressures did not allow them to continue.

- These affected children gradually began to believe that HIV is spread by touching since they were discriminated against in all facets of their lives including the schools where children kept away from them. The maternal orphans were particularly affected by their circumstances having to face extreme poverty and increased neglect and vulnerability to abuse.

- Child-headed households were growing in number and these courageous orphans of AIDS were compelled to take on the roles of caregivers and

providers relying mainly on the generosity of their neighbours and the services of NGOs and CBOs.

- Although the extended families were supposed to care for the orphans of AIDS, they were responsible to a significant degree for the mistreatment, inequity and disregard that the orphans were forced to undergo.

- The conference with the orphans also exposed the fact that poverty and HIV/AIDS had become inseparable when children wished that they could have provisions, clothing, water, school fees, medication, means of transport and love.

4.2.2. THE PREVALENCE OF HIV/AIDS IN SOUTH AFRICA

UNAIDS and WHO (2002:2) calculations at the end of 2001 estimated that there were 5 000 000 adults and children who were infected with HIV by that time. During the year 2003, the recorded rate of mortality in South Africa was 650 000 – 200 000 more deaths than there would have been had AIDS not been a factor (Keeton 2003:18).

Fox, Oyosi & Parker (2002:8) are of the opinion that antenatal surveys are indicative of the magnitude of the calamity of the HIV/AIDS pandemic facing South Africa. Their study revealed different estimates from those of UNAIDS and WHO (2002), which elucidate that:

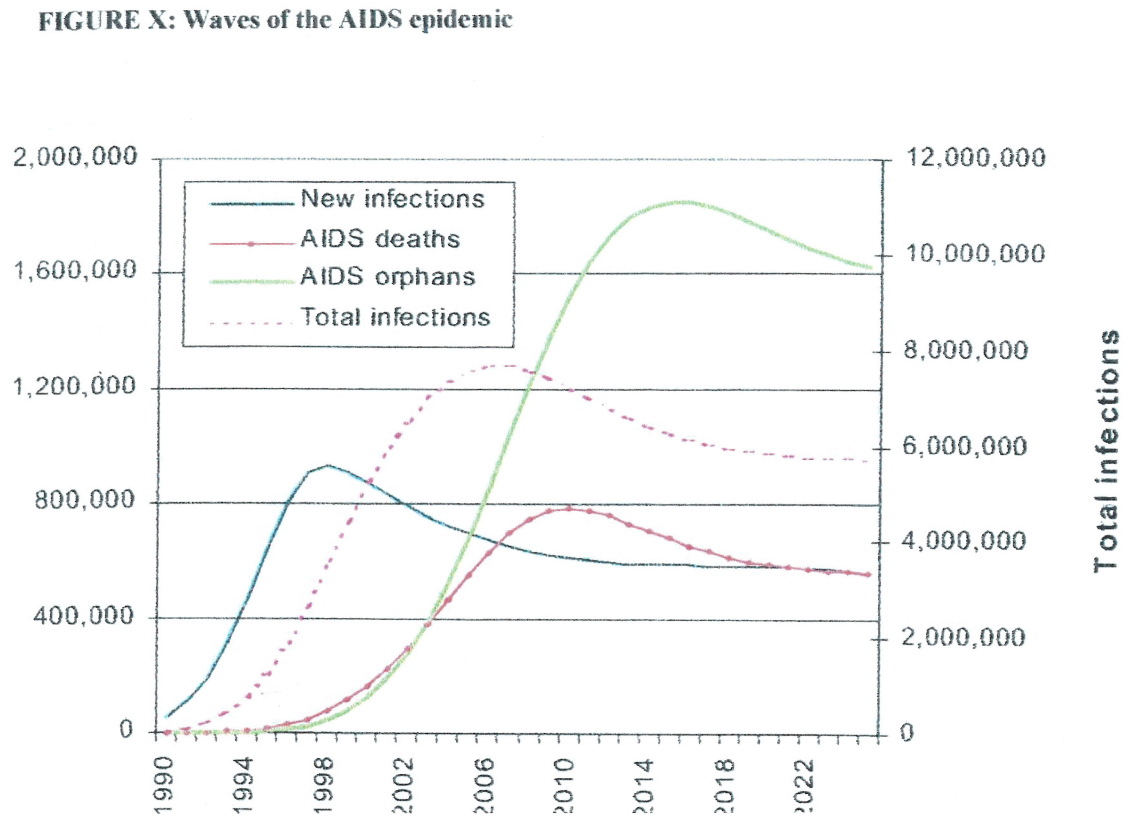
- About 4.7 million people were HIV infected by 2002; and
- Estimates of the rate of infection suggest that 2.5 million women and 2.2 million men between the ages 15-49 had become infected by 2002.

Giese and Meintjes (2003:1) consider that the following statistics have a significant influence upon the prevalence of AIDS in South Africa and the impact upon orphans of AIDS:

- 700 000 South Africans had died of AIDS as at July 2002;
- Approximately 6.5 million people (including 3.2 million women of child-bearing age – 15-49) were estimated to be HIV+ by 2003.

This standpoint will support the view that such statistics are surely influential upon the manner in which children are affected by HIV/AIDS. Fox et al (2002:8) maintain that in South Africa the epidemic is slowly intensifying since the greater part of HIV positive adults are still asymptomatic – hence the numbers of orphans are bound to increase dramatically over the years to come. It is significant to note that it is not relevant whether the children themselves are **infected,** but the **direct impact** – educationally, socially, materially, economically, and emotionally - upon the lives of millions is **central** to this study. According to Whiteside (2002:6) in 2002 there were approximately 300 000 orphans of AIDS in South Africa. Academics Rehle and Shisana (2003:7) in a paper discussing the Epidemiological and Demographic HIV/AIDS projections for South Africa, maintain that the projected numbers of orphans is 2.5 million by 2012. This is supported by the following illustration, which explicitly depicts future statistics:

FIGURE 4.1: WAVES OF THE EPIDEMIC



Source: Johnson & Dorrington (2001:6)

The above representation clearly depicts the South African situation with regard to HIV infections, AIDS deaths and orphans from 1990 together with future predictions of the path of the pandemic. The pictorial representation is indicative of the series of "waves" which demonstrate the long-term impact of the pandemic. It is apparent that the wave of new HIV infections reached the pinnacle in 1998 with approximately 930 000 infections in a year and the wave of total infections are set to reach a summit around 2006 at about 7.7 million infections. AIDS deaths, that are expected to peak soon after, approaching 2010 at about 800 000 deaths per annum, will be followed by the wave of AIDS orphans around 2015 resulting in almost 1.85 million children under the age of 15 whose mothers die of AIDS.

As indicated by the Children's Rights Centre in Durban (Gow & Desmond 2002:53), it is essential that more verifiable data about the location and condition of children orphaned by AIDS be made available. Researchers such as Dorrington & Johnson (2001 23-25) are of the opinion that there is a problem regarding the compilation of data and statistics of AIDS orphans in any country even South Africa. The data will depend on the number of AIDS deaths and these will depend on the statistics provided by health authorities (Keeton 2000). Secondly, the definition of the concept "orphan" needs to be uniform in order that all provinces should provide estimates based on the same definitions.

The Bambisanani Project (2001) cited by Fox et al (2002:10-11) validate that most of the children in this dire situation declare that their most vital needs were material in the form of food, clothing, bedding, medical care, money, grants, shelter and scholastic requirements like books and uniforms.

4.2.3. THE PREVALENCE OF ORPHANS OF AIDS IN SOUTH AFRICA

The discrepancies regarding the exact numbers of orphans of AIDS and the numbers of child-headed households in South Africa can be attributed to the fact that each group or individual researcher conducting the research applies definitions of these concepts as they see fit. With reference to this study one will find discrepancies with regard to the adolescent phase and age limits as well as the definitions of paternal, maternal and complete orphans – hence there are differences in the researcher's results even though they occur in the same time frame.

The following are some of the statistics supplied by *bona fide* studies:

- The inference by **UNAIDS** regarding the number of AIDS orphans in South Africa is that by 2005 there is likely to be approximately one million such children, a figure that is set to double by the year 2010 and reach 5.7 million by the year 2015 (**Dorrington & Johnson** 2002:47). **Dorrington & Johnson** (2002:47) further explain that statistics relating to the number of **paternal orphans** below the age 18 will be in excess of 4.7 million by the year 2015.

- On the other hand, **Whiteside** (2002:xi) proclaims that this is a situation of catastrophic magnitude since there were approximately 300 000 AIDS orphans in South Africa in 2002 – a figure that is set to increase almost 600 % to about 2 million by the year 2015. In comparison to the statistics provided by Dorrington and Johnson (2003:7) (4.7 million by 2015), Whiteside's figures are conservative.

- Contrary to others, **Mvulane** (2003:29) considered the number of orphans of AIDS to be 600 000 during 2003. Mvulane (2003:29) further stipulates that in 2002, 73% of the 204 000 children who had lost their **mothers**, had lost them to HIV/AIDS.

- **National statistics** also provided by Mvulane (2003: 29) suggest that as of July 2002 there were 885 000 children under the age of 18 who had lost a mother.

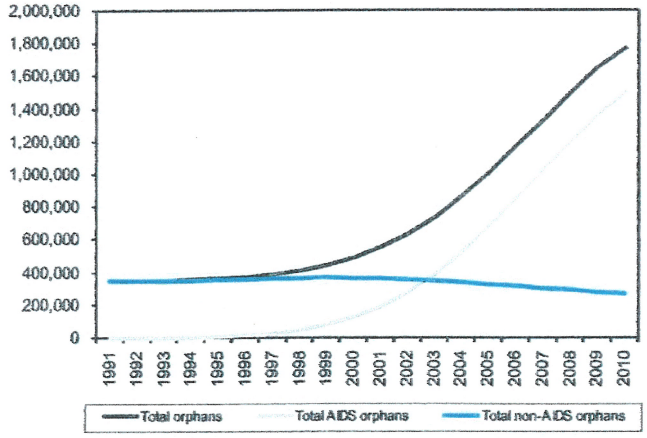
The information below provided by the Medical Research Council of South Africa (Dorrington, Bradshaw & Budlender 2002:29) supports the above projections of Whiteside (2002:xi), Keeton (2000:1) and Desmond & Gow (2002b:47):

FIGURE 4.2: Maternal orphans under 15 years, South Africa

South Africa

Maternal orphans under 15 years, South Africa

Year	Total orphans	Total AIDS orphans	Total non-AIDS orphans
1991	346 751	227	346 524
1992	347 701	581	347 120
1993	350 631	1 398	349 234
1994	355 642	3 162	352 480
1995	363 299	6 736	356 562
1996	373 229	13 469	359 760
1997	388 824	25 520	363 305
1998	412 435	45 799	366 635
1999	447 522	77 887	369 636
2000	493 846	124 989	368 857
2001	555 684	190 993	364 691
2002	636 876	279 102	357 774
2003	739 572	391 052	348 520
2004	865 216	527 054	338 162
2005	1 011 457	684 364	327 093
2006	1 172 985	857 201	315 784
2007	1 336 483	1 034 085	302 398
2008	1 499 424	1 208 646	290 777
2009	1 647 293	1 367 926	279 367
2010	1 770 870	1 502 457	268 413



Source: Dorrington, Bradshaw & Budlender 2003:29

The above statistics denote that, as at 2003 the total number of maternal orphans of AIDS (Dorrington et al 2003:29) is **391 052**, which is **more than half** of the total number of all the orphans in South Africa (636 876). According to the graph, the total number of orphans is set to soar as a result of the escalation in the number of orphans of AIDS in the years to come and will be roughly 1,8 million by the year 2010. In contrast, the number of non-AIDS orphans is predicted to decrease by the year 2010. Whiteside's results (2002:6) do, to some extent agree with what is stated by Dorrington et al (2003:29) in that the orphans of AIDS constitute almost half of the orphan population in South Africa.

It is apparent from the information given in FIGURE 4.1. and FIGURE 4.2. that the high prevalence of HIV in South Africa will lead to devastating circumstances for the

children left behind. Taking into consideration the UNAIDS definition of the term "orphan" (as mentioned in previous chapters) the predicted increase (according to FIGURE 4.2.) in AIDS orphans climbs dramatically from 124 989 in the year 2000 to 1 502 457 in 2010 (Dorrington et al 2003:29).

4.2.4. THE IMPACT OF HIV/AIDS ON AFFECTED FAMILIES IN SOUTH AFRICA

A number of children in South African households will find that their orphan hood is initiated even before the death of their parents (Johnson & Dorrington 2001:27). Once the parent becomes ill as a result of an AIDS-related disease, the income that the household relied on is no longer available. This sudden change in economic circumstances as well as having to watch their parents dying is exceptionally harrowing for the orphans (Johnson & Dorrington 2001:27).

Traditionally, within the South African context extended families coped with the increased burden of care whenever they were required to take on the orphans of their relatives. However, of recent the extended family system has displayed signs of flagging as a result of the exceptional number of orphans that are placing a strain on the extended family (McGregor 2002:2). Barrett (1998:5-6) reveals that the extended family's inability to cope results in child-exploitation and school-drop-outs as there is no money for school fees, hence children are being made to work to supplement household income.

Kalideen (2003:5), Gow & Desmond (2002:48) and Louw, Edwards & Orr (2001:4) find that families are affected in the following ways:

- The coping mechanisms of South African extended families and communities have become beleaguered with the increasing number of orphans of AIDS;
- Extended families are unable to absorb orphans into their communities;
- Families are overstressed;
- The stigma associated with HIV/AIDS and the orphans places undue stress upon the extended families;
- Orphans who do not live with adults, live in extreme poverty, are malnourished and drop out of school;
- Orphans of AIDS are psychologically disturbed because of watching their parents die; and
- The pandemic has resulted in many children taking on adult roles, being denied their right to education and being excluded by societies whose attitudes and policies are rooted in ignorance and discrimination.

A study (Beresford 2002:6) conducted on 771 households in four South African provinces by the Abt Associates and commissioned by Henry J. Kaiser Family Foundation displayed the following:

- 72% of the households were headed by women – one in five was a pensioner;
- 31% of the household heads were either AIDS sick or chronically ill which meant that this was the late undiagnosed stage of HIV;
- In excess of 20% of the children had been orphaned by AIDS;
- Of every 12 children, one (8%) looked after an AIDS sick adult;

- One in eight people said that monetary or physical pressure prompted them to send their children somewhere else to live that is plus 33% with another parent and 35% with grandparents;
- Girls were twice as likely to drop out of schools than boys were;
- Only 4% declared that they reduced expenses on school fees as a result of AIDS.

The South African situation displays a higher percentage of households that are headed by minors than those where there are **no** adults present (Desmond et al 2003:56). The **1999 October Household Survey** (Desmond et al 2003:57) indicated the following:

TABLE 4.1: 1999 October Household Survey (OHS)

	Child-headed households	Households containing no adults	Households containing only over 70's and under 18's
1999 OHS	**0.25%**	**0.19%**	**0.22%**

Source: Desmond et al 2003:57

The above are percentages of all households included in the Survey. However, the proportion of child-headed households appears to be much higher in the 1996 Census than the October Household Survey of 1999. Ziehl (Desmond et al 2003:58), who has worked with data from the 1996 Census, is critical of the authenticity of such data, stating that the report considered children under 4-years of age as heads of households in some cases. These discrepancies alone will indicate the difficulty that exists in the compilation of such data (Desmond et al 2003:58). These academics estimate that teenagers head the majority of child-headed households (Desmond et al 2003:58).

4.2.5. THE IMPACT OF HIV/AIDS ON THE EDUCATION OF ORPHANS OF AIDS IN SOUTH AFRICA

"The paradigm of education is shifting, and we must change our concepts and planning principles, or watch the achievements registered by EFA **(English For All)** ***being steadily undone. We must move from a narrow 'HIV education' curriculum campaign toward a broader 'HIV and education' paradigm"*** (Coombe 2002c:149).

There has been little empirical investigation into the socio-educational impact of HIV/AIDS on orphans of AIDS since the evidence thus far has been anecdotal (Ewing 2002:38). In addition, although these reports have exposed the impact of the pandemic upon orphans generally, no empirical research has been done specifically on the educational and social impacts of AIDS on orphans in child-headed households.

Coombe (2002c:129) and Rees (2000:3) are of the view that as a result of HIV/AIDS, there will be a dramatic reduction in the quality of education in South Africa. HIV/AIDS will lead to a reduction in general populations, thus there will be fewer pupils attending school (Kelly 2000a:11-15). Reduced school populations can also be attributed to poverty and the inability of children in child-headed households to pay their school fees as there will be no regular income or that money will be required to pay for medical care rather than education. Kelly (2000a:13) is of the view that orphans are more likely than non- orphans to drop out of school.

A sadly neglected segment of the AIDS arena is that of the manner in which children are getting by in the face of the trauma and the effect on the child's education (Coombe 2002b:19). Despite the South African policy of free education for all since 1994, the numbers of school-leavers has increased significantly (Gow & Desmond 2002:6). Children affected by AIDS are unable to attend school regularly because of the responsibilities at home where they are required to take care of sick parents and take

over adult duties. Gow & Desmond (2002:6) also see the urgent demand for suitable learning prospects to cater for the needs of those orphans who suffer confusion or seclusion, for those who care for younger children and for girls who are required to care for the sick.

A study by Booysen, Van Rensburg, Bachmann, Engelbrecht and Steyn (2002) in Welkom and Qwa-Qwa in the Free State Province, concentrated on the socio-economic impact of HIV/AIDS on households and communities. This research (Booysen et al 2002:3) also revealed that 8.9% of children between 14-18 were not attending school - 60.7% of these orphans were female indicating that female children especially were compelled to abandon their schooling on the death of their parents (Booysen et al 2002:3).

Within the South African context, HIV/AIDS is likely to increase the number of orphaned children, absenteeism and school dropout rates, produce declining school enrolment rates and deepen poverty (Coombe 2002c:131; Rees 2000:3). Coombe (2002c:131) continues with the contention by declaring that although South African population growth will be maintained, there will be greater evidence of school dropouts and non-attendance among those adolescents who become caregivers and those who have to work to support their families (Coombe 2002c:131).

The effect of the pandemic upon educators is also significant since their approach, practices and expertise can be instrumental in supporting orphans with their day-to-day problems (Kelly 2000a:13-15). Unfortunately, teacher mortality and the loss of productivity as a result of sick teachers are impacting negatively upon the education of orphans of AIDS. The system is unable to deal with the demand created by the loss of so many teachers who are victims of HIV and AIDS.

The successful functioning of the education system is challenged by the morbidity and mortality caused by HIV/AIDS. According to the Department of Education statistics in 2000 (Coombe 2000b:36), 12% of all educators (375 000 teachers, 5000 inspectors and advisors and 68 000 managers and support personnel) were HIV positive. This would mean that over 53 000 educators will die by 2010 or between 88 000 and 133 000 educators if there is a prevalence of 20%-30%. This would result in the loss of the most experienced senior teachers, managers, teacher educators and professors.

4.2.6. THE IMPACT OF HIV/AIDS ON THE RIGHTS OF ORPHANS IN SOUTH AFRICA

In any consideration of orphans in child-headed households it is imperative to take cognizance of the Rights of the Child within the South African milieu. In South Africa the constitution incorporates the fundamental rights of the child which include (Barrett 1998:3-4; UNAIDS 2003):

- **The right to equality and non-discrimination.** Children are especially affected in that:
  - Children who are diagnosed to be HIV positive and/or live in HIV households, are vulnerable to discrimination and rejection from relatives, schools and crèches;
  - If they are disabled and affected by HIV/AIDS, they are doubly discriminated against since there are no provisions made;
  - Refugee children whose parents have died of AIDS are in greater need of assistance because of their isolation from their extended families and own communities; and
  - The number of street children as a result of orphanhood is on the increase and they are at a greater risk of abuse, exploitation and a very poor standard of living.

- **The right to dignity.** Children are directly affected by HIV/AIDS and consequently:
  - They are more vulnerable to sexual exploitation and abuse;
  - Children are exposed to trauma and neglect long before their parents pass on;
  - The children have to contend with discrimination and the associated stigma of being a part of households affected by HIV/AIDS.

- **The right to life, including socio-economic rights for example basic education**. This right is being affected:
  - Children who are affected by HIV/AIDS are more likely to drop out of school as there is not enough money to pay for school fees, uniforms and books;
  - Children are being forced to sacrifice their schooling in order to take care of ailing parents;
  - There are few resources and facilities that promote healthy children in an HIV/AIDS positive environment especially for children from birth to six years of age;
  - There is no official policy and no assistance to help and provide community resources for the basic needs of young orphaned children;
  - There is an absence of a subsidy for food, water and shelter; and
  - Teachers themselves are untrained, overpaid and affected by HIV/AIDS.

- **The right to family care or parental care, or appropriate alternative care.** This will be influenced by:
  - The increased rates of children being orphaned;
  - Stressed families with decreased ability to cope with increasing demands;
  - Poor quality family life; and
  - Increased numbers of children being orphaned and decreased monitoring of children who are informally placed within the extended family system.

- **The right to basic nutrition, shelter, basic health care services and social services and the child's best interests are of primary importance in every matter concerning the child.** This right is being violated by:
  - Inadequate Legal Provision to address the changing nature of the basic needs of the children;
  - Inability of children who are orphaned to obtain access to social services because they cannot apply for such grants for themselves and they experience infinite impediments when they apply for identity documents;
  - Increased dispossession of inheritance of property, savings and insurance;
  - Increased mortality rates of orphans – death rates are higher among these children; and
  - Parents and caregivers who are sick and those who are orphaned are less likely to have preventative and curative health care provided.

The above Rights are certainly applicable in respect of the theme of this study in that researchers such as Giese (2002) and Proudlock (2002) are of the opinion that these Rights have been violated due to HIV/AIDS in this country. Orphans in child-headed households are tormented as caregivers to dying adults, as classmates of infected and affected learners and as onlookers to death from a myriad of painful AIDS-related diseases. They are eventually deprived of the comfort of family life, adequate protection, adequate shelter, equitable education and wholesome food. The only course towards the development of exceptional educational and social development for adolescent orphans of AIDS is via the advancement of these Rights of the Child (Reynolds 2003:8-10).

The South African Draft Children's Bill (Kehler 2003:50) that is in the process of being tabled in Parliament makes provision for children affected by HIV/AIDS and those in child-headed households. These children are defined as those 'in especially difficult circumstances' and requiring special attention. Kehler (2003:51) is of the view that the Bill *'places a legal obligation on all spheres of government and society to not only*

identify child-headed households but also to support and assist their functioning in communities'. This integrated and holistic approach will ensure that community-based structures are strengthened in order that the children's health and educational needs are taken care of.

4.2.7. THE SOCIAL EFFECTS OF HIV/AIDS ON ORPHANS IN SOUTH AFRICA

Booysen (2003:1) is of the view that most affected households are the victims of a 'vicious cycle of poverty and HIV/AIDS'. This is evident more especially if the particular household has suffered a recent illness or death and had to incur substantial medical or funeral expenses. It is quite obvious that the extended family system and caregivers are totally overcome by the pandemic, unemployment and poverty to be able to assist in the needs of orphans of AIDS (Martin 2003:37). Affected families undergo financial transformation in that regular income is decreased or that they are unexpectedly subjected to chronic destitution.

A recent report (Kalideen 2003:5) released by the United Nations Children's Fund (UNICEF) found that orphans live in increasing poverty once their parents have died. The report further claimed that the children were malnourished, dropped out of school, were increasingly used as child labour and were psychologically affected by the trauma of watching their parents die (Kalideen 2003:5-). The stigma attached to AIDS and fear of being landed with the burden of orphans affected by AIDS, prompt members of the extended family network to refuse to take over the responsibility of caring for these children (Sherriffs 1997:82). Hence, the orphans are traumatized by the abandonment. Further, trauma may result when they are compelled to live with strangers who abuse them.

Even prior to the death of a parent, the child is challenged by the psychosocial distress of this debilitating illness and becomes apprehensive about the future. Once the parent passes on, children orphaned by AIDS may have to cope with severe financial, educational and psychosocial difficulties (Marcus 1999:42-43). The Bambisanani Project (2001) in the Eastern Cape (Fox et al 2002:11) presents the view that the orphan's emotional welfare is threatened both prior to the parent's death and after. The children who were interviewed for the study believed that they were deprived of affection and attention when they themselves were sick, that they did not enjoy any leisure time nor were they privileged to have parental guidance and companionship.

Daniel (2003:2-3) reports that hidden psychosocial 'wounds' in the form of the stigma, discrimination and rejection that they experience, affect the educational achievement of the orphans. On account of the fact that stigma and discrimination foster further intolerance and social isolation children become victims of AIDS when they are sometimes refused admission to schools. Apart from the community, the relatives, who are expected to take care of these children on the death of the parent, abandon them for fear of being shamed themselves. This tribulation and the inept approach the orphans utilize to cope with it, traps them within an orbit of loss and despair with no prospect of escape. Children affected by the endemic disease are given no choice in the matter of having to deal with ailing dying parents, the strain of having to persevere in an environment demanding the maturity of adulthood, a predicament that is accompanied by prejudice and rejection, and the eventual calamity of parental death.

A study (Louw et al 2001:25) indicates that the ever-increasing number of orphans in South Africa is definitely going to impact upon the societies from which they come. Giese (Gow & Desmond 2002:66) is of the perception that children who grow up in environments devoid of parental supervision and support could create less productive adults who may display strong anti-social behaviour. In the long term the consequences are going to prove most detrimental to the progress of the country and the youth will be driven towards deviant behaviour.

Fox et al (2002:11) draw attention to the fact that studies in South Africa disclose that when financial support is provided, the less material needs in the form of the child's emotional and psychological welfare are neglected. An analysis (Fox et al 2002:14) of South African orphans and other vulnerable children presented conclusions that these particularly difficult psycho-social circumstances imposed by the HIV/AIDS pandemic brought on various divergent behaviour patterns – ways in which the children tried to cope. These could appear as minor acts of crime, rape, teenage pregnancy, immoral behaviour and a general lack of discipline. Fox et al (2002:14) refer to the Bambisanani Project (2001) declaring that children will develop as determined by the norms and values of their communities. Hence their view is that the South African situation displayed marginal community support systems that could prove beneficial to the well being of children in distress. Should there be more encouraging conditions for the children, pre- and post parental deaths, they will be able to cope more effectively after the ordeal (Fox et al 2002:14).

Adolescents in the family are required to take on adult roles and additional household tasks. Hence children (some even from the age of 12) are forced to take on "adult responsibilities". Apart from the trauma of suddenly becoming head of a household, some of these orphans are required to act as "guardians" to their younger siblings (Louw et al 2001:25). Therefore, researchers like Desmond & Gow (2002b:18-19), Coombe (2000a:15) and Fox et al (2002:9) expound that this actuality in the shape of child-headed households creates responsibilities and restricts their social life and access to education for orphans who would otherwise be adequately catered for by their healthy parents.

A report by Dorrington and Johnson (2002:48-49) further emphasizes the reality that extended families are now unable to cope with the growing number of children in need as a result of the extreme poverty. The once strong community-based support within the South African society is over-burdened by the large numbers of children orphaned by AIDS and the sudden appearance of child-headed homes is commonplace as a result of

the financial burden such children become for the extended family (Fox et al 2002:9; Dorrington and Johnson 2002:48-49; McGregor 2002:2; Barrett 1998:5-6). Fox et al (2002:9) also indicate that the orphans incorporated within the extended families are often subjected to blatant abuse and indifference, being exposed to arduous household tasks.

The Bambisanani Project 2001 (Fox et al 2002:10) disclosed that HIV/AIDS was one of the chief roots of orphanhood. The research findings (Fox et al 2002:10) revealed that the children reacted differently to the demise of their parents depending on whether:

- Children with other siblings and one surviving parent are in an insecure, apprehensive state.
- The impact of the pandemic is more pronounced if the children are aware that the virus is sexually transmitted and that the death of one parent is to be followed in time by the death of the other. Hence, the total loss of parental support, which is exacerbated if parents and family members do not make adequate preparations for later.
- Children whose needs are catered for and who are aware what their situations will be after their parents' deaths since wills are signed by the parents, move into orphanhood more comfortably. In sharp contrast others face the loss of home and other property to certain members of the community because their parents die intestate. This results in school dropouts and to social problems.
- Children who are deprived of an effective support system may be compelled to survive without any outside assistance at all.

Preliminary research to this study has revealed that children in households where there were critically ill and dying adults were notably more traumatized psychologically (Daniel 2003:2). Their previously secure lives are unexpectedly threatened by the sudden halt of the regular income that the parent/s were able to provide up to that time,

bigotry by those they had considered close to them and their having to watch over critically ill parents, caregivers or siblings. Such trauma results in the child's having to deal with dropping out of school, social isolation, taking on adult responsibilities, hunger and being deprived of adult supervision and care (Daniel 2003:15-16).

4.2.8. THE IMPACT OF POVERTY AND HIV/AIDS ON ORPHANS IN SOUTH AFRICA

"HIV is not a disease of the poor, but the poor are at higher risk of HIV infection, the poor are more vulnerable to HIV infection, and the disease makes the poor poorer." (Carol Coombe 2002c:122).

According to Giese (2002a:62), children who are part of infected households are all the more burdened because of the bias stemming from HIV as well as the associated poverty. Barnett & Whiteside (2002b:3) are of the opinion that AIDS exacerbates poverty, leading to *'financial, resource and income impoverishment'* and also emphasizes the social inequalities that already exist.

Guthrie (2003:16) concurs with Desmond and Gow (2002:65) in the assertion that the impact of HIV/AIDS and the concept of 'poverty' do not just relate to the insufficiency of income but also encompass the lack of income, lack of opportunities, lack of access to assets and credit, as well as social exclusion and the frustration of having to drop out of school.

Orphans of AIDS and children in child-headed households are found chiefly in societies where there are complex social problems such as destitution, abuse, lack of running water and essential food (McKay 2003:26). These extremely poor children are always mocked at and left out of social groups by their peers and other members of the

community. After the deaths of their parents, orphaned children are frequently abandoned in child-headed homes with no adult supervision and no source of income (Gow & Desmond 2002:36). They are deprived of the support of peers and educators once they forsake their studies for the reasons that there is restriction on funds available and there is no suitable adult control (Giese 2002:65).

It is evident that HIV/AIDS has lead to increased poverty among children in South Africa. Gow & Desmond (2002:36) make reference to ACESS (Alliance for Children's Entitlement to Social Security) 2001 in their assertion that as at 2002 approximately 12 million of the 17 million children in South Africa could be categorized as being poverty-stricken. A survey (Streak 2002:1) conducted by the Human Sciences Research Council (HSRC) in 2002 revealed that 75% of South African children aged from 0 to 17 lived below the poverty line of R400/month per capita and 57% below the poverty line of R200/month per capita in 1999. In comparison, in 2002, 11 million children aged from 0 to 17 years are severely poor in the sense that they are now living below the poverty line of R200/month according to the value of the Rand as at 1999 (which converts to R245-00 according to the value of the Rand in 2002). South Africa's poorest children emanate primarily from Kwa-Zulu Natal, Eastern Cape, Limpopo and North West provinces (Streak 2002:1).

South African statistics (Martin 2003:37) indicate that a minimum of R490 per month is required to meet the basic needs of children but the real situation in 2003 stood as:

- Roughly 14.3 million children (75%) live in poverty – on less than R490 per month;
- Nearly 11 million of the above children live in extreme poverty – on less than R245 a month;
- Orphans receive a child support grant of R140-00 per month from the Government but only 2,7 million children receive this state grant (Van der Westhuizen 2003:7).

Manicom and Pillay (2003:94-96) are most critical of the Child Support Grant for women and children, stating that the system does not provide acceptable financial assistance for those in need. They support the perception of ACESS in that 60 percent of South African children (0-17) live in the lower 40 percent of South Africa's households and that R140-00 is not sufficient to cover even the most basic wants of the children.

The standpoint of a researcher namely, Guthrie (2003:16) is that the socio-economic situation in South Africa has not been transformed since 1994 instead it appears to have deteriorated. Kath Defilippi (Keeton 2000:2), the executive director of the South Coast Hospice Association in Kwa-Zulu Natal proclaims that the extensive indigence in this region deteriorates into "horrific poverty" once families are affected by AIDS. Rising unemployment levels particularly in the Black population and the rural areas are the major force behind the epidemic. It is apparent that the child's poverty stems from the fact that the child's parents or caregivers who are sick or who have died, are unable to provide for the basic needs of the child and the onus therefore falls upon the state.

4.2.9. STRATEGIES TO MITIGATE THE IMPACT OF HIV/AIDS ON ORPHANED CHILDREN

Giese (2002b:1), an HIV/AIDS programme co-ordinator at the Children's Institute at the University of Cape Town, declares that South Africa is equipped with the perfect policies to make children the priority but it is unfortunate that there is constant infringement of the child's rights to shelter, food, education, family care, health care and security. Her view is that the pandemic is a major contributor to this adverse situation and that the services being offered by the State do not reach the majority of the resultant vulnerable children and orphans, above all, those in child-headed households. It is also apparent that the National Welfare system is buckling noticeably

under the strain of the thousands of children orphaned by AIDS (Mvulane 2003:29-30; Halkett 1998:10).

Thus far the South African Government has created the following strategy and policy documents to reduce the impacts of the pandemic upon this country's children (Giese & Meintjes 2003:42-43):

- **The National Integrated Plan (2002-2005).** This Plan which aims to form a partnership with all organizations, institutions, churches, communities and the private sector, is structured to deal with 'prevention, treatment, care and support, legal and human rights, research, monitoring and evaluation' of all people affected by HIV/AIDS;

- **The National Integrated Plan for Children Infected and Affected by HIV/AIDS** (NIP) (1999). This plan was initiated by the Directors General of the national Departments of Health, Education, Social Development and Finance in December 1999 specifically to provide for the needs of children;

- **The National AIDS and Children Task Team (NACTT) (2002)** was reconstituted as the National Action Committee for Children Affected by HIV/AIDS (NACCA) in order that there is teamwork between all the representatives from the different state departments, international development agencies and national NGO's to render the best possible service;

- **The Department of Social Development** and the **Nelson Mandela Children's Fund** assisted in the organization of a conference in June 2002 that brought about further changes when NACCA (above) was requested to develop action plans for children affected by HIV/AIDS with regard to housing, education and

recreation, food security, training and capacity building, database and communication, care and support, and social security and placements;

- **The Department of Social Welfare 2002 National Guidelines** for social services for children infected and affected by HIV/AIDS were formulated in order to assist service providers and government officials working with children and caregivers;

- The National project, **Circles of Support** that endeavors to work actively at eradicating the stigma and discrimination against children affected by HIV/AIDS and to promote community support for all vulnerable children, was established in 2002; and

- **The Child Support Grant** has of recent been increased from children under the age of 9-years to children under the age of 14-years, a strategy that is to be put into action gradually over the next three years.

The Draft Children's Bill that was presented by the South African Law Commission in 2002 (Kehler 2003:48) is due to replace the Child Care Act (No 74 of 1983). This document calls attention to 'primary prevention and early intervention services' with the aim of providing support and services to families at risk.

Despite the above-mentioned strategies that are implemented it still appears that many of the poor orphaned children are not being adequately assisted to deal with their bleak conditions. Makasi (2002:1) also emphasizes that in South Africa HIV/AIDS is not solely a health issue but a "*developmental issue*". The dire need for the support of orphans ought to be dealt with as a matter of some urgency considering the daily increase in the number of children who are affected by AIDS and the encumbrances

that face them. There is a need to preserve the family unit despite the catastrophe and for the Departments of Education and Social Welfare Services to aid these parentless children to deal with the their harsh conditions.

4.3. THE IMPACT OF HIV/AIDS ON KWA-ZULU NATAL

4.3.1. THE PREVALENCE OF AIDS ORPHANS IN KWA-ZULU NATAL

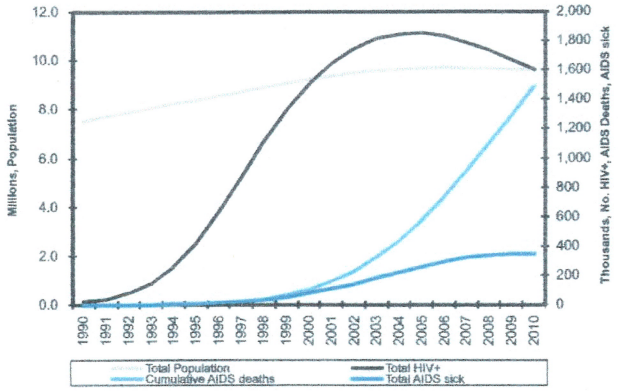
Research (HopeHIV 2002:1) highlights the fact that the province of Kwa-Zulu Natal is the hardest hit by the HIV/AIDS pandemic including the majority of South Africa's orphans who come from child-headed households. As at July 2002 approximately one third of the 700 000 South Africans who died of AIDS were from Kwa-Zulu Natal Giese & Meintjes 2003:1).

The high mortality rate in Kwa-Zulu Natal has left many children orphaned and in child-headed households. The perception of researchers and academics (Sherriffs 1997:82) in the World Health Organization and locally was that HIV thrives in unstable societies – hence the predicament in Kwa-Zulu Natal. As indicated by the illustration below, the statistics pertaining to the number of people who are HIV+, the number of cumulative deaths and the total number who are AIDS sick paint a grim picture for the Province:

FIGURE 4.3: Total population, number of HIV+ and AIDS sick people and cumulative deaths, Kwa-Zulu Natal:

KwaZulu-Natal

Total population, number of HIV+ and AIDS sick people and cumulative AIDS deaths, KwaZulu-Natal



Year	Total Population	Total HIV+	Cumulative AIDS deaths	Total AIDS sick
1990	7 514 578	18 614	104	168
1991	7 696 067	40 451	276	410
1992	7 879 173	81 336	677	943
1993	8 052 556	151 171	1 548	2 012
1994	8 223 087	261 854	3 319	4 020
1995	8 384 742	423 140	6 716	7 584
1996	8 529 882	633 695	12 839	13 417
1997	8 714 258	873 713	23 252	22 422
1998	8 890 733	1 112 987	40 352	36 528
1999	9 057 974	1 326 931	66 733	54 885
2000	9 211 922	1 504 196	105 340	79 238
2001	9 348 732	1 643 162	159 216	108 569
2002	9 464 671	1 745 490	231 265	143 222
2003	9 556 833	1 813 217	323 962	181 582
2004	9 623 198	1 848 217	438 910	222 153
2005	9 663 375	1 853 006	576 305	261 660
2006	9 678 981	1 831 347	734 535	296 928
2007	9 673 613	1 788 587	910 100	324 457
2008	9 652 692	1 731 160	1 097 978	342 129
2009	9 622 429	1 666 034	1 292 322	348 975
2010	9 589 177	1 599 512	1 487 357	345 949

Mortality rates for children and adults, KwaZulu-Natal

Source: Dorrington, Bradshaw & Budlender (2002:16)

The above table places the cumulative number of AIDS deaths for 2003 as being 323 962 and for 2004, 438 910 which in turn impacts upon the large number of orphans of AIDS that adult deaths will precipitate. It is also of particular relevance that although the number of people sick with AIDS will decrease, the number of cumulative deaths is still expected to escalate.

Kwa-Zulu Natal was estimated to have had between 197 000 and 278 000 orphaned learners under the age of 15 as a result of the pandemic (Louw et al 2001:25). Ebersohn & Eloff (2002:78) maintain that research in the area confirmed that there were about

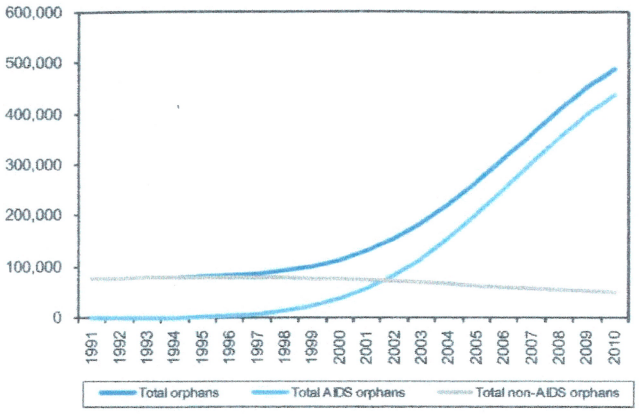
4570 child-headed households in the province of Kwa-Zulu Natal. However, statistics provided by the Durban Child Welfare Society (Mvulane 2003:29) in Kwa-Zulu Natal indicate that there has been an increase of 300% in orphan cases between 2001 and 2002. Just in Umlazi and Durban the increase in HIV/AIDS orphans is documented at 250%. By the year 2010 the total number of orphans of AIDS is likely to be in excess of 450 000 (Whiteside & Sunter 2000:71-72). The study by Dorrington et al (2002:17) (below) confers, to some extent, with this assumption:

FIGURE 4.4: Maternal orphans under 15 years, Kwa-Zulu Natal

KwaZulu-Natal

Maternal orphans under 15 years, KwaZulu-Natal

Year	Total orphans	Total AIDS orphans	Total non-AIDS orphans
1991	77 770	73	77 697
1992	78 601	188	78 412
1993	79 553	452	79 102
1994	80 724	1 013	79 710
1995	82 280	2 132	80 148
1996	84 558	4 228	80 329
1997	88 084	7 924	80 160
1998	93 603	14 042	79 561
1999	102 108	23 590	78 518
2000	114 732	37 683	77 049
2001	132 440	57 375	75 065
2002	156 048	83 501	72 547
2003	186 196	116 537	69 659
2004	223 023	156 412	66 611
2005	265 861	202 277	63 584
2006	313 039	252 370	60 669
2007	361 398	303 682	57 717
2008	408 367	353 445	54 922
2009	451 525	399 028	52 496
2010	487 920	437 651	50 269



Population pyramid in 2000 and 2010, KwaZulu-Natal

Source: Dorrington, Bradshaw & Budlender (2002:17)

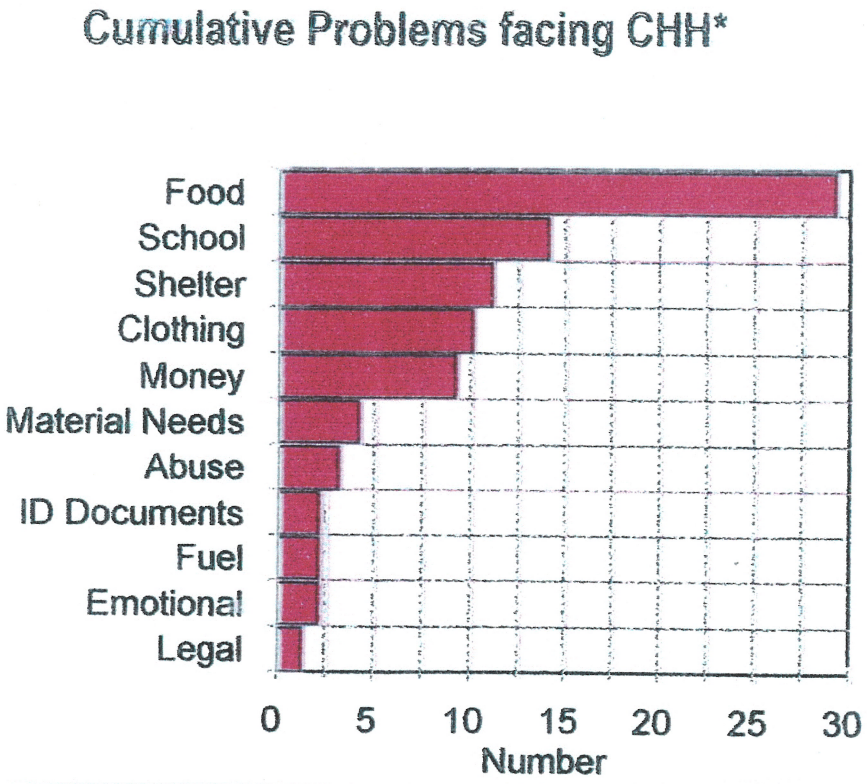
This study considers the projected figure of maternal orphans under 15 years of age at 437 651 in comparison to total numbers of non-orphans as 50 269 for the same period. The diagram is also illustrative of the fact that the number of AIDS orphans is set to spiral at an alarming rate – a situation that does not bode well for the Province with regard to the care and attention of such orphans.

4.3.2. THE PREVALENCE OF POVERTY AND THE EFFECT OF HIV/AIDS ON ORPHANS IN KWA-ZULU NATAL

Desmond, Richter, Makiwane and Amoateng (2003:56) consider the issue of child-headed households in Kwa-Zulu Natal to be *'an emotive and tragic story'*. Many teenagers are forced into adult roles, having to provide care and financial support after their parents or caregivers pass on. In a report on the effect of AIDS upon family life in Kwa-Zulu Natal (hereafter KZN), Clarke (2002:22) proclaims that orphans live in a world where poverty and trauma is rife, an austere world in which they are completely at sea in the campaign against hunger and death. A survey by the Human Sciences Research Council revealed that child poverty rates in KZN were 80% in 1999. If one were to analyze the needs of orphans of AIDS in the form of food, clothes, water and shelter, one will recognize that these are all poverty related, accentuating the correlation between poverty and HIV/AIDS in Kwa-Zulu Natal (Giese & Meintjes 2003:46; Booysens 2003:17).

The graph on the following page illustrates the results of a study conducted by the Thandanani Project by Strode (2003:42). This study places the necessities of the orphans of AIDS in order of importance:

FIGURE 4.5: Cumulative Problems facing Child-headed households



SOURCE: STRODE (2003:42)

The above illustration serves to emphasize that the most important basic necessity of food is lacking in almost every household (Strode 2003:42). Strode (2003:42) also confirms that the lack of any regular income makes it impossible for the orphans to fulfill any material needs - hence they are often unable to attend school since they are unable to pay school fees. As indicated above the orphans consider that they are also deprived of proper shelter, clothing and money. The issue of abuse of the orphans does not feature prominently within the context of this study.

Child poverty is a major concern in KZN and community care programmes such as Thandanani in Pietermaritzburg emphasize the need for the community and households to incorporate these orphans within their folds in order to assist the costs that the State will normally incur (Gow & Desmond 2002:52-53). The following tables reveal the

grim situation in the Province and the logic behind the view that the pandemic is spreading rapidly as a result of this state of poverty (Streak 2002:2; Gow &Desmond 2002:53-55):

TABLE 4.2:

CHILD POVERTY RATES, ESTIMATES OF POOR CHILDREN AND CHILD POVERTY SHARES BASED ON OCTOBER HOUSEHOLD SURVEY 1999 AND POVERTY LINE OF R400/MONTH CAPITA:

Province	Child poverty rate in 1999 (%)	Estimated number of children in 2002	Estimated number of poor children in 2002	Child poverty share in 2002 (%)
KZN	**80.0%**	**4 106 547**	**3 286 470**	**23**

Source: Streak 2002: 3

TABLE 4.3:

CHILD POVERTY RATES IN 1999 AND ESTIMATED NUMBERS AND SHARES OF POOR CHILDREN BASED ON OCTOBER HOUSEHOLD SURVEY 1999 AND A POVERTY LINE OF R200/MONTH PER CAPITA:

Province	Child poverty rate in 1999 (%)	Estimated number of children in 2002	Estimated number of poor children in 2002	Child poverty share in 2002 (%)
KZN	**62.9**	**4 106 547**	**2 584 250**	**23**

Source: Streak 2002:4

The above assessments are based on the view of Booysen (2003:10) who upholds that the poverty line provides a standard of the extent of poverty within certain communities. Table 4.3 confirms that the child poverty rates in Kwa-Zulu Natal are about 80% and that the estimated number of poor children (column 4) which is 3 286 470 is the highest in South Africa (Streak 2002:3). This is emphasized in the last column of the figures, which highlights that Kwa-Zulu Natal has a 23% child-poverty share in South Africa – the highest in the country (Streak 2002:3). Table 3 identifies that the child poverty rates for a poverty line of R200/month is still 23%.

Case (2003:1-2) upholds the theory that orphans of AIDS in Kwa-Zulu Natal face financial ruin and deprivation since they need to cope with a sudden loss of regular income that had been provided by the afflicted member of the family. In order to take care of medical bills and funeral expenses they may have to sell furniture and other household belongings. School dropouts are a common feature among orphans of AIDS who will be unable to afford school fees and purchase schoolbooks and stationery. It becomes more important for them to buy food rather than go to school. Once orphans in child-headed households are unable to pay school fees, they are most likely to abandon their studies (Strode 2003:63). The heads of these child-headed households lacked the emotional stability to devise the necessary means whereby they could access education. Orphans in child-headed households affected by HIV/AIDS are more likely to be shunned by communities and eventually social events do not include them.

4.3.3. STRATEGIES TO MITIGATE THE IMPACT OF HIV/AIDS ON ORPHANED CHILDREN IN KWA-ZULU NATAL

Spain (2000a:1) is of the view that children who have been abandoned, orphaned or displaced are at risk of being alienated or deprived as a result of the stigma attached to the virus. In order to inhibit any dysfunctional development, the Cindi-network works tirelessly to ensure that the children they are able to assist, develop socially, educationally and intellectually (Spain 2000a:2). Orphans of AIDS are identified and supported using the most inventive measures since financial assistance is dependent upon the contributions of important sponsors.

A major part of the work of the Thandanani Association includes the care and education of AIDS Orphans (Fox et al 2002:15-16) since the Foundation believes that it is a child's right to education. They are currently assisting communities in Pietermaritzburg and Richmond to access social grants in order that the vulnerable are able to alleviate some of their financial burdens and ensure definite schooling for the children (Thandanani 2003). However, sponsors and donations enable the project to assist the children to pay school fees and purchase uniforms. Statistics for April 2002 to March 2003 highlighted the following:

- 212 children were assisted with food parcels;
- 609 children were helped to pay school fees for 2002/03 and 2003/04;
- 123 children's cases were opened by the social worker;
- The Thandanani Bursary Programme assisted 264 children in 46 different schools to pay their fees in 2002 and was rewarded with a pass rate of over 80%.

The Sinosizo Project is a home-based care programme that works with some 900 families by seeing to the needs of children between the ages 9 and 14 who are the primary caregivers of their parents and younger siblings. Children in the area faced

many problems that others like them did not normally have to - finding ways of disposing of soiled bandages and incontinence pads, look for sustenance and prepare food for their families, fetch water for drinking, cooking, bathing and washing clothes and carry smaller children on their backs. The children are given the responsibility of administering medication to their parents but often there is none to give to their dying parents – hence the children are party to their parents' deaths (Coombe 2002c:135).

The Ingwavuma Orphan Care project was set up in June 2000 (Barnard 2003:29) and has at present the highest number of orphans of AIDS in the country. Statistics for the region as at September 2002 were:

- 865 orphans (both parents dead)
- 228 children living with dying parent(s)
- 107 abandoned children.

Basic social problems include the lack of access to clean water, toilets and electricity. The customary extended family is still evident in this area but is unable to cope with the catastrophic effects of the pandemic. Hence, orphans, hunger and child-headed households are widespread, with orphans totaling almost 2000 (Kehler 2003:47-51;Morin 2004:15). Children from homes affected by HIV/AIDS often cannot afford to pay mortuary fees and bury their parents in their own back yards (Kehler 2003:47-51;Morin 2004:15). The problem with applying for foster-care grants is that there is no regional office for the Department of Home Affairs and there are protracted delays in the processing of birth and death certificates (Kehler 2003:47-51;Morin 2004:15). The welfare office in this region is inundated with the demands for further food parcels and is unable to process any more foster grants because of time-restraints (Mvulane 2003:30).

Academics affirm that the abject poverty and hardship that such orphans face can be equated to that of protracted incurable afflictions where the family generally finds it

difficult to handle the psycho-social and economic tribulations that accompany the illness (Gow & Desmond 2002:53). They point out the views of the Child Rights Centre in Durban that there is far too little confirmation available about child-headed households and anecdotal evidence does not suffice. There is a pressing need for there to be more consistent records about the location and living conditions of orphaned children to be able to offer funding and address the issue of the children's vulnerability.

4.4. CONCLUSION

If one were to analyze the information provided in this chapter, the statistics pertaining to the percentage of HIV/AIDS adult deaths at the given moment and that which is anticipated in this country will reveal that this will invariably lead to an unprecedented increase in the number of orphans in years to come. As a result, such a picture ought to merit greater awareness and action towards the care and protection of the most vulnerable victims – the orphans in child-headed households.

These are children who lack the adult supervision and guidance and financial stability that would have, under normal circumstances, assisted them to become steady, competent members of their communities. Many orphans in child-headed households in South Africa are deprived of an effective support system and are compelled to survive without any outside assistance at all. In the light of the above, more research is needed to mitigate the impact of HIV/AIDS on the adolescent in the child-headed household. In order to obviate the disaster of having dysfunctional adults in future societies as a result of poor psychosocial and educational development, it is incumbent upon government, social and education departments and NGO's to make a concerted effort towards ensuring that adequate psycho-social, educational and financial support is afforded to orphans of AIDS in child- or adolescent-headed homes.