CHAPTER THREE

SOCIO-EDUCATIONAL STUDIES OF THE IMPACT OF HIV/AIDS ON ADOLESCENTS ORPHANED BY AIDS IN FOREIGN COUNTRIES

3.1. AIM OF THE CHAPTER

"More than 113 million school-age children are out of school in developing countries, two-thirds of them are girls. Of those who enter school, one out of four drops out before attaining literacy. At least 55 of the poorest countries seem unlikely to achieve EFA (Education for All) by 2015, and 31 of these countries are also among the 36 worst affected by HIV/AIDS" (The World Bank 2002:xvi).

The aim of this chapter is to provide a detailed situational analysis of the socio-educational impact of HIV/AIDS upon orphans in selected countries throughout the world. Countries selected are those where orphans of AIDS are experiencing notable sociological, educational and psychological problems and where the situation is particularly of international concern since the prevalence of HIV/AIDS is high. However, it must be noted that as a result of a scarcity of available information on child-headed homes worldwide, the ideas in this chapter pertain predominantly to orphans of AIDS in general. Various prominent academics working in this field are quoted and the efforts of non-governmental organizations especially those in Africa are highlighted.

In the discussion that follows, it will become apparent that statistics and information pertaining **specifically** to adolescent AIDS orphans and especially those in child-headed households are difficult to come by (Aggleton & Parker 2002:5-6; UNAIDS/WHO 2002:31). The reasons for this may vary from the fact that families do not readily admit

to having AIDS or that people are unaware that deaths have been caused by HIV/AIDS to the fact that State Departments are reluctant to conduct statistical research for fear of exposing victims to the stigma and bigotry that follow such disclosure (Aggleton & Parker 2002:5-6). Another reason is that very little research has been conducted on HIV/AIDS adolescent orphans in child-headed homes and the educational and social conditions under which they live (UNAIDS/WHO 2002:31). It should also be borne in mind that the statistics in this regard are constantly changing even on a daily basis (UNAIDS/WHO 2002:5). Research (Ainsworth & Filmer 2002:8) has revealed that although there is a stark parallel between orphan rates and HIV prevalence (the percentage of people living with AIDS) there is also a vast discrepancy between the two since orphan rates depend upon AIDS through "*cumulative AIDS deaths*", while HIV prevalence depicts the percentage of the population that is "*infected and is still alive*" (Ainsworth and Filmer 2002:8).

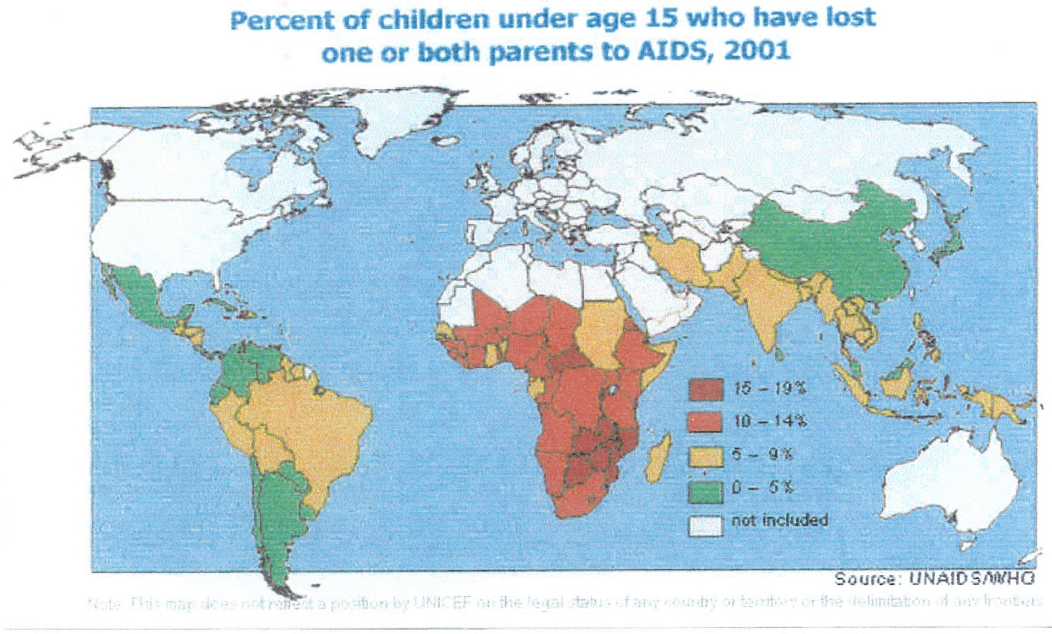
3.2. INTRODUCTION

In order to fully appreciate the catastrophic effect of HIV/AIDS upon the adolescent orphan, UNAIDS as well as WHO (UNAIDS/WHO 2002) regard it imperative to consider the global statistics regarding present and projected adult deaths. This is crucial since millions of adult-deaths are the reason that children, worldwide, (The World Bank 2002:16) are left abandoned and compelled to adopt adult roles prematurely.

This devastating pandemic has spanned over three decades depriving many countries such as Uganda, India, Rwanda, Zimbabwe, Botswana and South Africa of valuable resources and powerless children of their able-bodied parents. With reference to this study, by the year 2002 the statistics indicated that the adults living with AIDS (37 million), the newly affected adults with AIDS (4.2 million) and adults who have died of AIDS (2.5 million) are especially important since these have an indisputable bearing upon the children who remain behind and are adversely affected socially, educationally and psychologically (UNAIDS 2002:6). This is a particularly significant statistic since it

will have a positive influence upon the number of children who become orphans as a result of the pandemic (UNAIDS/WHO 2002:28) as the following map denotes:

FIGURE 3.1: Percent of children under age 15 who have lost one or both parents to AIDS, 2001



Source: UNAIDS/WHO (2002)

Figure 3.1 verifies that orphans of AIDS make up a major component of the millions of children below the age of 15, who have lost a mother or both parents. The above representation also depicts the dire situation in especially sub-Saharan Africa where the percentage of children under 15 orphaned by AIDS ranges from ten percent to as high as nineteen percent. The issue of the greatest humanitarian concern at present is that the majority of 14 million children presently orphaned by AIDS live in sub-Saharan Africa (Fahlen 2002:7). East Asian and South American countries follow (5-9%) and the pattern is that HIV/AIDS is gaining momentum in these areas. By the year 2010, the pandemic will almost triple the number of orphans in sub-Saharan Africa, who will have lost both their parents (UNAIDS/UNICEF 2002:6). Statistics supplied by Barnett and Whiteside (2002a:197-198) indicate that although as many as 95% of the worlds AIDS orphans

appear to live in Africa, startling figures are becoming evident even in Asia and America. The authoritative standpoint (Fahlen 2002:7) is that even widely successful preventative measures and a fall in the rate of infections at this stage, will not prevent most people who are already infected from dying of the related diseases. Consequently millions more children will be deprived of their parents in the future.

Ainsworth and Filmer (2002:7-9) assert that in countries where HIV has escalated swiftly but where there is a definite decrease in AIDS mortality, there is understandably an insignificant impact upon orphan rates. However, in countries such as Uganda where the pandemic is advanced, HIV prevalence may have waned or is constant but orphan rates are nevertheless high (UNAIDS/UNICEF 2002:9).

3.3. THE SOCIAL AND EDUCATIONAL EFFECTS OF HIV/AIDS UPON CHILDREN IN FOREIGN COUNTRIES

Apart from the worsening economic circumstances, which may include the loss of inheritances, the children orphaned by AIDS, suffer severe social and emotional stress in the form of anguish over the bereavement of the parent, panic about what is yet to come, prejudice, shame, isolation and physical and sexual mistreatment (UNAIDS/UNICEF 2002:9).

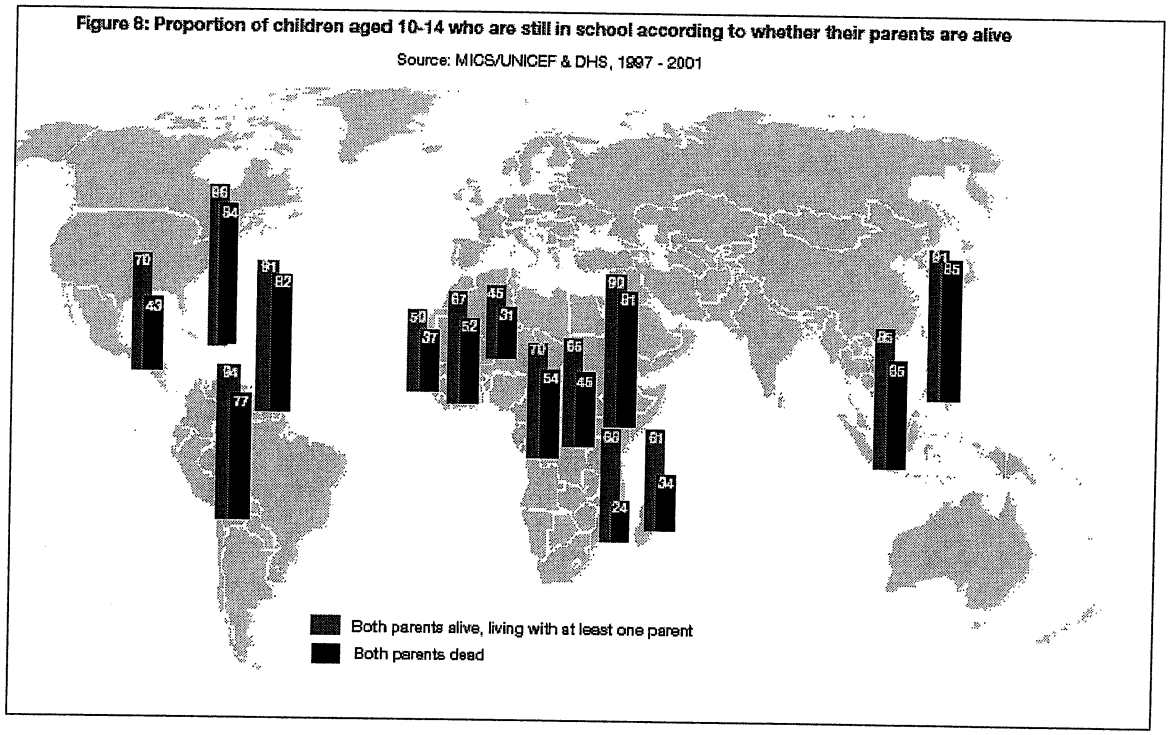
Adolescent AIDS orphans are abruptly exposed to all sorts of disturbances in their young lives – their societal functions, their privileges and obligations are all altered considerably (Barnett & Whiteside 2002a:206 Bennell, Hyde & Swainson 2002:1-2). No more are they reliant children but they have to prematurely don the cloaks of adulthood which help them to cope with the additional stresses in their young lives (UNAIDS/UNICEF 2002:9). A UNAIDS report (UNAIDS/UNICEF 2002:9) argues that vulnerable children worldwide are forced to take on further responsibilities ranging from finding new ways of generating income and taking care of ailing family members. Furthermore, financial restraints result in the orphans of AIDS being deprived of the security of education and

social services and being unable to handle the unexpected psychosocial stresses (UNAIDS/UNICEF 2002:10).

Researchers from different parts of the world, in the field of HIV/AIDS, such as Ainsworth & Filmer (2002), Ayieko (1998), Desmond & Gow (2002), Phiri & Webb (2002) and Kelly (2002) all agree that AIDS has had the most devastating effect on the safety, education, social life, health and survival of all children in affected areas worldwide. These devastating effects could lead to psychosocial distress, deepening poverty and severe material hardship. Barnett and Whiteside (2002a:197-198) maintain that the survival mechanisms of previously resilient communities, is beginning to fold under the immense strain of the pandemic. Hence, the perspective of these researchers is that orphans are struggling to survive on their own in child-headed households (Barnett & Whiteside (al 2002a:206). For the adolescent orphan in a child-headed household, the pandemic has brought with it the trauma of watching helplessly as first one parent then the other grows ill and dies (UNAIDS/UNICEF 2002:9).

Bellamy (2001:1) asserts that the disease impacts negatively not only upon the child's endurance, welfare and development but especially upon the being of the society that the said child stems from. The observation of Coombe (2002b:10) is that the greatest deprivation in the lives of adolescent AIDS orphans is the lack of formal education. Coombe (2002b:10) further stresses that, countries such as Botswana, South Africa, Swaziland, Zimbabwe and Zambia have accumulated evidence to indicate that pupils' enrolment at school is being hampered directly or indirectly by HIV/AIDS. The figure below highlights the (worldwide) proportion of children aged between 10-14 who are still in school according to whether their parents are alive. As a result of the United Nations definition it is difficult to acquire information with reference specifically to the age group 13-18, however for the purposes of exhibiting the gravity of the situation pertaining to AIDS orphans, the statistics on the next page shall be utilized to substantiate the cause for extreme concern worldwide:

FIGURE 3.2: Proportion of children aged 10-14 who are still in school according to whether their parents are alive:



Source: UNAIDS/UNICEF 2002: 10

The diagram aptly illustrates the discrepancy between school-attendance of orphans versus non-orphans. The above statistics for children attending school display that the percentages of children whose parents have passed on are much lower than those for children whose parents are **still** alive. This indicates that the presence and influence of the parents contribute to positive school attendance. Considering the percentages made available, data for the South American states and the sub-Saharan African countries are of singular concern. If one were to analyze these statistics from an HIV/AIDS perspective it could be concluded that the reason for this could be the orphans' lack of funds to pursue further schooling, the agony of the shame associated with the disease, the absence of parental support or the liability of domestic chores that hamper progress (Coombe 2002b:5).

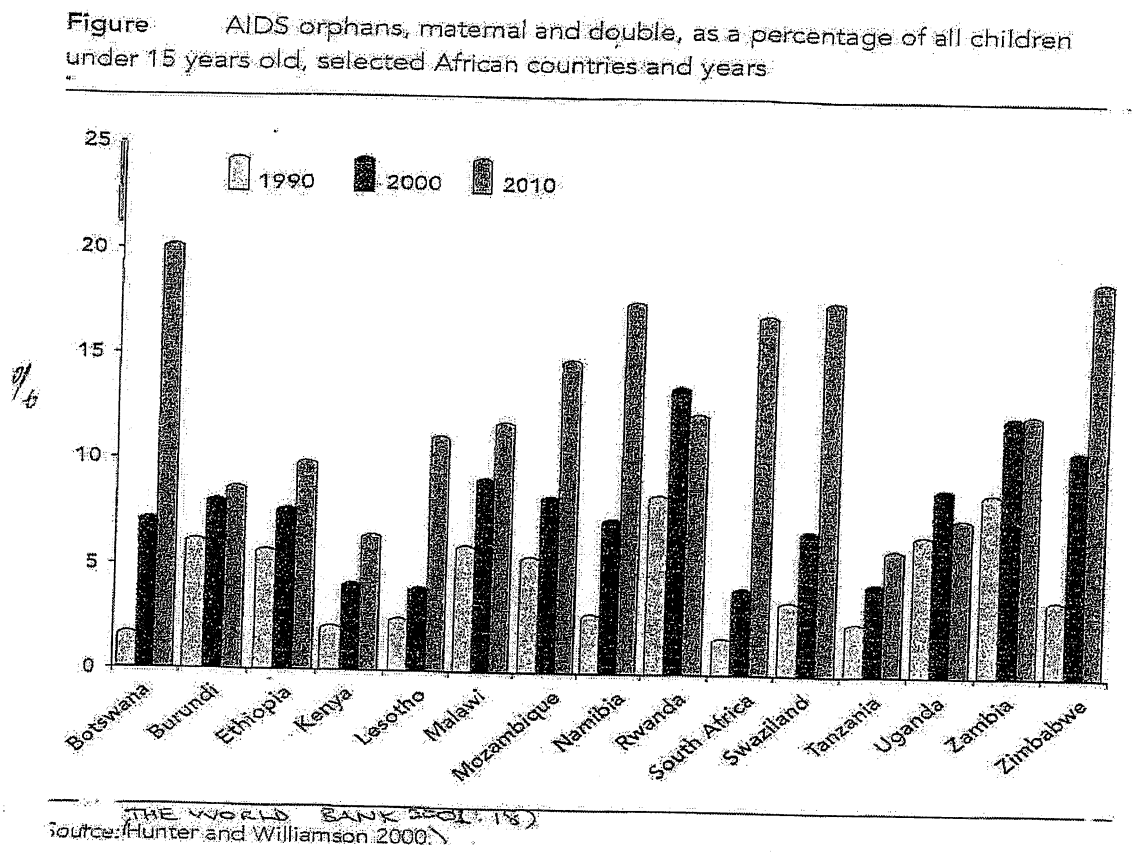
Researchers (Coombe 2002b:10, Ayieko 1998, Booysen, Van Rensburg, Bachmann, Engelbrecht & Steyn 2002:3 and Desmond & Gow 2000:14-15) agree that some of the factors that affect education and social welfare among adolescents are likely to be decreased resources, high parental death rates that precipitate poverty, inadequate funds to pay for schooling and the need to take care of the ailing. A study by UNICEF (UNAIDS 2002:10), which explored the effects of orphaning upon labour and education, revealed that "*In all countries, children aged 5-14 who had lost one or both parents were more likely to be working more than 40 hours a week*".

Williamson and Hunter (2002:2) also report that AIDS is altering the entire social image in the most affected countries and giving rise to unique child welfare dilemmas. Children are compelled to abandon their schooling in order to care for ill parents or get jobs in order to support their families (Associated Press 2002:2).

3.4. AFRICA

The table below provides an indication of the statistics related to orphans generally in various groups and countries in the African regions. These distressing statistics reveal the need for desperate action to facilitate effective methods to address the educational and social welfare issues with special reference to orphans:

FIGURE 3.3: AIDS orphans, maternal and double, as a percentage of all children under 15 years old, selected African countries and years:



Source: The World Bank (2002:18)

Figure 5 reveals shocking **anticipated 2010** statistics of AIDS orphans as a percentage of all children under 15 years old in countries such as Botswana (over 20%), Namibia and Swaziland (almost 20%), South Africa (almost 18%) and Mozambique (+15%). Regardless of what is to come the dramatic increase in percentages in these countries from 1990 to 2000 is just as great a cause for concern and ought to have initiated constructive programmes towards combating the virus and its effects. The discrepancy in the Rwandan statistics from under 10% in 1990 to almost 15% in 2000 might have been aggravated by the genocide in that country but lower percentages are predicted in 2010. According to the diagram, the percentage of AIDS orphans below 15 in Zambia moved from below 10% to between 12% and 15% but is expected to stabilize as a result of the positive steps being taken to stem the tide of the pandemic. Uganda foresees an even

more optimistic future in that percentages in this country are expected to fall by the year 2010. However, the same cannot be stated about Zimbabwe where the staggering increase from below 5% in 1990 to above 10% in 2000 is forecast to jump to almost 20% in 2010.

The crisis in sub-Saharan Africa (a term which refers to all the countries south of the Sahara Desert) denotes that the number of children orphaned by HIV and AIDS is escalating resulting in more orphans who are destined to survive in child-headed households (Cohen 1999:4). Bennell, Hyde and Swainson (2002:49) suggest that the number of orphans in conflict-affected areas has increased dramatically as a result of HIV/ AIDS. Orphans *"already exceed 20% of the under 15 population in at least six countries (Malawi, Rwanda, Uganda, Zambia and Zimbabwe)"* (Bennell et al 2002:49).

Research by Barnett & Whiteside (2002a:197-8) pointed out that of recent the extended families in sub-Saharan Africa and Southern Africa (Coombe 2002b:5-6) have been unable to attend to the needs of the child survivors of the pandemic for economic and material reasons. Children have been caste out, having to fend for themselves or being left in the care of extremely ill or old grandparents. According to Coombe (2002b:11) too many HIV/AIDS-affected learners cannot continue with school because of their poor physical and financial conditions. Orphans often have to quit school in order to become decision-makers taking on the responsibilities of supervising younger siblings and providing an income for the family (Lyons 1998:5). The coping skills of these orphans in either case, is questionable (Krift & Phiri 1998:1-2).

3.5. ZAMBIA

The current HIV/AIDS predicament in Zambia is considered to be one of the worst epidemics in the world. A UNICEF report (1997: 2) estimated that in excess of 7% of Zambia's 1 905 000 households were without an adult member, being headed by children, that is, a boy or girl aged 14 or less. Epidemiological Fact Sheets compiled by

UNAIDS, UNICEF and the World Health Organization (2004:2) place the statistics for Zambians by the end of 2001 as follows:

TABLE 3.1: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN ZAMBIA

ADULTS AND CHILDREN	**1 200 000**
Adults (15-49)	**1 000 000**
Women (15-49)	**590 000**
Children (0-15)	**150 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**120 000**
ESTIMATED NUMBER OF ORPHANS	**570 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

A paper delivered by M.J.Kelly at the XIth International Conference on AIDS & STDs in Africa (ICASA) gives prominence to the fact that *"Zambia is currently experiencing the worst HIV/AIDS epidemics in the world, one result being that between one third and one quarter of the children aged below 15 have lost one or both parents"* (Kelly 1999:1). The burden of the children is a key issue requiring urgent attention. Geoff Foster of the Family AIDS Caring Trust in Zimbabwe (UNAIDS 1997:3) has stated that the demise of the orphan's grandparent creates the situation where there is no-one else

in the extended family to take care of the children and this gives rise to orphan households headed by older brothers and sisters.

It is apparent that chiefly the formal education sector is suffering. Studies (Kelly 1999:3) in the Copperbelt – one of the areas most severely affected by HIV/AIDS in Zambia – illustrate that the principal reason for inferior school attendance and enrollments was the lack of funds to pay school fees. This was a direct result of fixed earnings being halted or being channeled towards "palliative" care of the ailing parent/s. A 1996 UNICEF report confirms the close association between school attendance and AIDS by stating that the sudden break in attendance is the consequence of the child being unable to afford school anymore (Kelly 1999:4).

By and large orphans are less likely to have access to a suitable education as a result of various mitigating circumstances such as the lack of funds for school fees, the need for the adolescent orphan to work in order to supplement the income and the shame and embarrassment to face others. Research (Barnett & Whiteside 2002a:202) in Zambia illustrates that there is a dramatic drop in the numbers of children of school-going age who are **actually** attending school. This state of affairs can be attributed in large part to the AIDS pandemic but is also prejudiced by the mediocre standard of education in the country, the effects of indigence and levels of unemployment.

Kelly (1999:3-4) verify the theory that orphans from AIDS-affected homes are more likely than non-orphans to drop out of school. Evidence (Kelly 1999:3-4) indicates that in two high-density areas in Lusaka it was "*found that of 1,359 children aged 18 and below, 67% had lost one or both parents*" and approximately 7% of them had abandoned their schooling in the 12 months before the study (Kelly 1999:4). However, in Zambia orphans are not differentiated against and it is believed that when NGO workers and researchers begin to ask to count AIDS orphans they are introducing a stigma that never existed prior to then (Barnett & Whiteside 2002a:122).

3.6. ZIMBABWE

In Zimbabwe The National AIDS Council (Phiri & Webb 2002:20), assesses that over 900 000 children have lost one or both parents as a result of HIV/AIDS thus far. By the end of 2001 the following statistics were available regarding AIDS:

TABLE 3.2: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN ZIMBABWE

ADULTS AND CHILDREN	**2 300 000**
Adults (15-49)	**2 000 000**
Women (15-49)	**1 200 000**
Children (0-15)	**240 000**
ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**200 000**
ESTIMATED NUMBER OF ORPHANS	**780 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

With 200 000 AIDS-related deaths and 780 000 children having lost at least one parent as a result of an AIDS-related illness, there are various associated problems relating to the educational, social, financial and psychological lives of AIDS orphans in Zimbabwe. Many orphans are left on their own in child-headed households having to take care of themselves while others are cared for by NGO's. The AIDS Orphan Trust has been

taking care of a particularly **small** group of approximately 1500 children allowing them to remain in their homes where they are visited by trained caregivers who teach them survival techniques. Orphan support in the form of the FOCUS project in Zimbabwe is a programme of Family AIDS Caring Trust (FACT). By recruiting women from the villages and people from church groups, they identify, monitor and assist orphans of AIDS. The volunteers are able to recognize the deficiencies in the children's lives and afford emotional and spiritual support. Abuse and exploitation of the children appear to decrease when there are frequent visits by the monitors and caregivers (Phiri & Webb 2002:20-21).

The educational circumstances in Zimbabwe expose the fact that 99% of children attended school before the death of the mother but the percentages fell dramatically on the mother's death to 80% in urban areas and 93% in rural areas. The burden of domestic and farm chores seemed to fall upon these adolescent orphans and if they did continue with their schooling they were unable to attend regularly (Barnett and Whiteside 2002a:204).

3.7. MALAWI

As the following statistics indicate, the catastrophic effect of extremely high levels of HIV, have overwhelmed Malawi:

TABLE 3.3: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN MALAWI

ADULTS AND CHILDREN	**850 000**
Adults (15-49)	**780 000**

Women (15-49)	**440 000**
Children (0-15)	**65 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**80 000**
ESTIMATED NUMBER OF ORPHANS	**470 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

As at 2001 there were 470,000 children orphaned by AIDS (AVERT.ORG 2002b:6) of which 400,000 were below 15 years of age (UNICEF 2003c:1), Believing that the community would be able to focus on and assist to alleviate this critical situation, the Government established the National Orphan Task Force in 1991 and the National Orphan Care Guidelines in 1992.

Despite the fact that orphans in Malawi have extended families on both sides, that is, maternal and paternal relatives, they are sometimes forsaken, poverty-stricken children with nowhere to go and are subjected to further emotional trauma by having to struggle with adult roles (Ali 1998:2). In most cases the only options available to them are to drop out of school, to look for casual labour or sometimes to marry earlier than they normally would so as to support the younger siblings (Ali 1998:7). They lack proper care and counselling to be able to handle hardship and grief.

Coombe's research (2002b:11) for this country depicts that for 1999 the percentage of children at school who had lost one or both parents increased from 12% to 17%. The study provides additional data to state that a third of the children were absent from school since they had to care for the ill and double the percentage for those who had lost both

parents. In addition, children who had lost both parents were twice as likely to drop out of school (17%) during 2000 while the average age for these pupils was approximately six months older than the average age for that grade (Coombe 2002b:11).

Research (Ali1998: 2) in Malawi indicates that more children orphaned by AIDS, were found in the rural rather than the urban areas. This could be attributed to the fact that the children return to their home village to be cared for by the extended families on the deaths of their parents.

Orphans of AIDS are often exposed to unfamiliar cultural practices for example the imposed right of the husband's family to take property belonging to the orphans' family; hence, the orphans are left destitute (Ali 1998:6) (Khonyongwa 1998:1). The orphans are also subjected to the law that gives the paternal uncle the right to decide whom they will reside with after the demise of their parents. Apart from this the uncle, is entitled to conduct the property sharing at his discretion. Unfortunately, where there is a surviving wife, she is not automatically entitled to an inheritance.

According to Ali (1998:12-13) families in Malawi do not appreciate the significance of providing for the educational and psychosocial needs of the child orphaned by AIDS. Hence, the children who are compelled to live on their own, battle with acceptance of the parents' deaths as well as the loss of support (Ali 1998: 12-13; Krift and Phiri 1998:3). Results from a study by Ali (1998:7) reveal that child-headed households are more apparent as a result of the following:

- The demise of the parents;
- Relatives refuse to take care of the orphans because of the stigma attached to the latter or since their relationship with the relatives have not been pleasant;

- Immediately after they lost their parents, children were sometimes taken in by their relatives but moved out on their own after they were abused (Ali 1998:7).

Once they are abandoned, the beleaguered orphans battle to eke out a living and frequently drop out of school to engage in chance employment to support themselves and their siblings.

The Community based options for protection and Empowerment (COPE) of Save the Children (US) in Malawi can be credited for the creation of effective programmes that lend a hand to communities that assist children affected by HIV/AIDS to pay school fees and run their homes. This programme is a forerunner in the creation of effective methods by using already established social and community structures in order to assist children affected by HIV/AIDS (Phiri & Webb 2002:22-23).

3.8. UGANDA

As early as in 1998 the view of Fiala (1998:6) was that there were in excess of 3 million children already being subjected to the effect of the pandemic in Uganda alone.
Most recent studies indicate that over 1,5 million children have been orphaned since the pandemic began in Uganda but the tide has turned with the combined effort of political commitment and the involvement of all sectors of society to assist in the reduction of HIV infection rates (UNAIDS, UNICEF & WHO 2004:2).

Statistics provided by UNAIDS, UNICEF and WHO (2004:2) for the period up to 2001 present the following picture:

TABLE 3.4: ESTIMATED NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV/AIDS IN UGANDA

ADULTS AND CHILDREN	**600 000**
Adults (15-49)	**510 000**
Women (15-49)	**280 000**
Children (0-15)	**110 000**

ESTIMATED NUMBER OF ADULTS AND CHILDREN WHO DIED OF AIDS	
DURING 2001	**84 000**
ESTIMATED NUMBER OF ORPHANS	**880 000**

(Children who have lost their mother or father or both their parents to AIDS and who were alive and under age 15 at the end of 2001)

Source: UNAIDS, UNICEF & WHO (2004:2)

If one were to consider the number of adults (510,000) living with AIDS and the number of women (280,000), it is simple to deduce that the situation regarding orphans of AIDS in Uganda is a serious challenge to the resources of the country. Estimates of recent suggest that 2314 per million people were living with AIDS as at 2002 (Bukenya 2002:2). Far more critical than this statistic, is that the substantial number of parental deaths has intensified the unfortunate situation of the orphaned children who were still living as at 2001 (880,000) in this country. A Swiss-American Foundation, the Association Francois-Xavier Bagnoud (FXB) (Monk 2000:7) that is assisting orphans in the area has found that in a place called Luweero in Uganda over half of the children had lost their fathers and that their mothers were absent (Barnett &Whiteside 2002a:98).

Children in this country have been found to experience anguish some time prior to the deaths of their parents as a result of the seriousness of the AIDS-related diseases (NADIC

2001:4). After the traumatic death of their parents, these children experience a general lack of "*family guidance and emotional support, limited access to education, inadequate socialization, nutrition, material and financial support*" (NADIC 2001:4). Studies indicate that the extended families are now unable to absorb the burden of the considerably excessive numbers of orphans since care costs more than these families can afford (Barnett & Whiteside 2002:204-205 & 207).

The pandemic has already created the phenomena of child-headed households (Fahlen 2003:7). As a result of parental deaths, children have no protection and little status or rights in the community (Bukenya 2002: 2). A study by Monk (2000:12) of the orphan situation in Uganda emphasizes the severe educational, sociological, financial and psychological effects of the pandemic upon paternal orphans in particular. Poverty, school fees and general uneasiness (that is disruptive) have led to low literary levels (Bukenya 2002:1-2). It is less probable that orphans will be able to afford the privilege of appropriate education and the death of a parent invariably diminishes the chances of the child being able to attend school at all (Barnett & Whiteside 2002a:16). The psychosocial stress experienced by children orphaned by AIDS and struggling to survive in child-headed households in Uganda is further aggravated by the stigma associated with HIV/AIDS.

3.9. KENYA

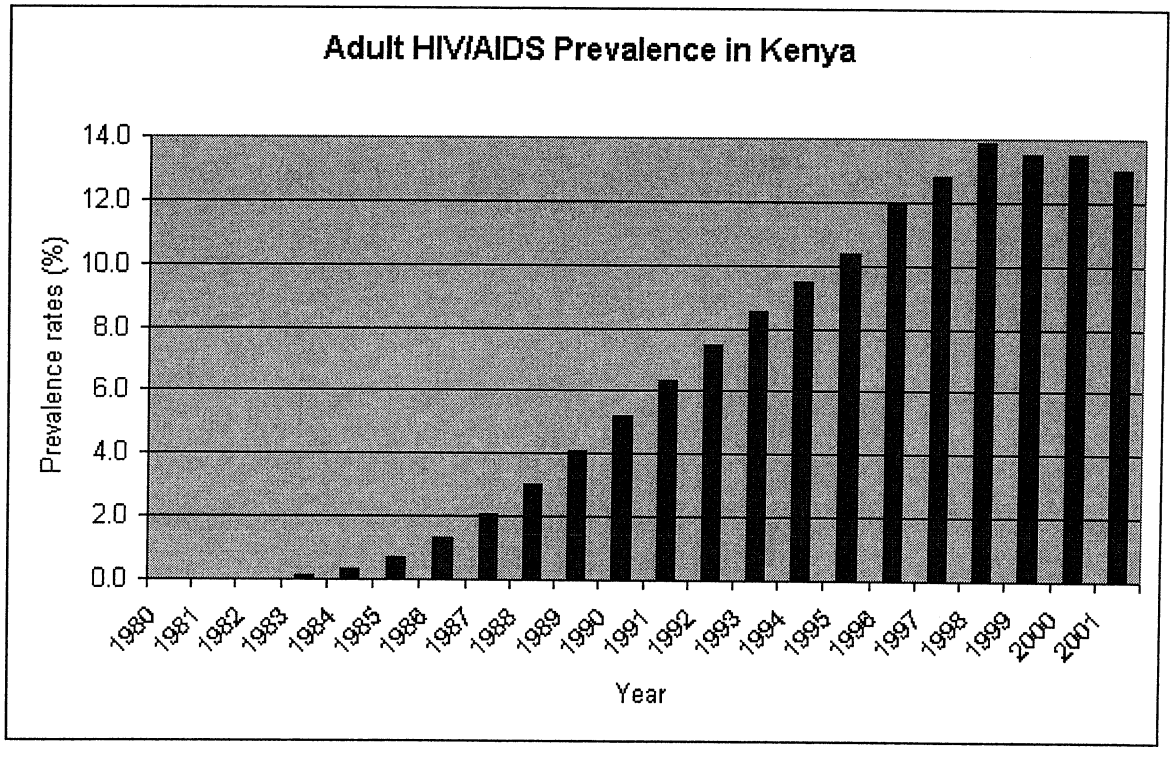
In Kenya, HIV/AIDS has given rise to more or less one million orphaned children (Francais 2001:1) and contributed to the increase in the number of street children in urban areas (Human Rights Watch 2001:3). The outcome of this critical situation is that children in Kenya are facing psychological trauma, separation, hazardous labour and neglect. In addition to this the children are forced to act as the primary care-givers of their dying parents and siblings left in their care (Human Rights Watch 2001:6-7; Harmon 2001:2-3). Harmon (2001:2-3) is of the view that these orphans must be afforded free school, counselling, healthcare and training to help them cope in their parentless

environments. Since the beginning of the epidemic in 1984 (UN 1999), there were approximately 730,000 children under the age of 15 who had lost their mothers or both their parents as a result of AIDS by 1999.

When Kenyan President Moi had declared HIV/AIDS a "national disaster" in 1999, it was estimated that one person out of every nine was already infected with HIV (Human Rights Watch 2001:2). Consequently, the National AIDS Control Council (NACC) was established to control the spread of the virus in conjunction with UNICEF and WHO.

The statistics (Computervisions:2) below verify the need for constant update of intervention, investigation as well as treatment:

FIGURE 3.4: Adult HIV prevalence in Kenya

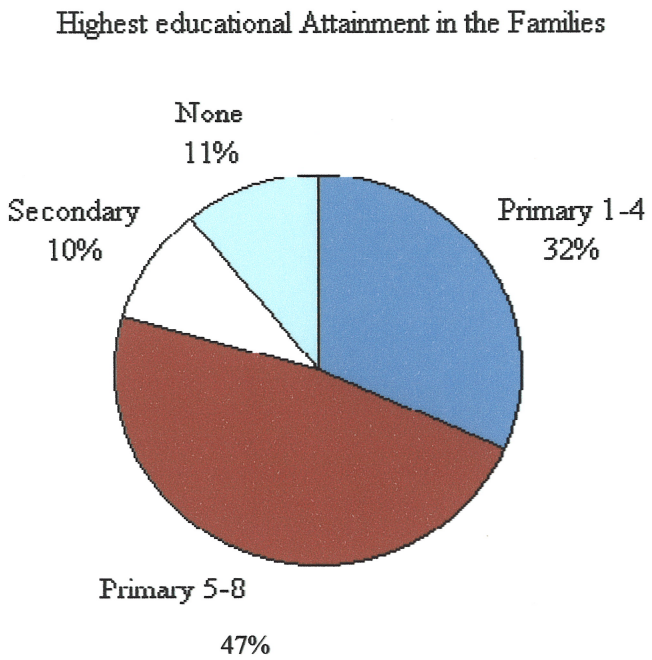


Source: Computervisions:2

It is apparent from the above figure that there has been a steadily alarming increase in HIV/AIDS prevalence each year. The rate of prevalence appears to have peaked between 1998 and 1999 and then started to lessen thereafter. The reduction in the number of adults infected with HIV was not instantaneous but can be attributed to the fact that early commitment by Kenyan authorities brought on constant intervention and investigation together with proper treatment in order to fight the rapid spread of the HIV/ AIDS pandemic. The high percentage of adult HIV/AIDS prevalence in the graph is indicative of the high mortality rate among adults and the high numbers of orphans and children in child-headed households.

The figure below illustrates that children orphaned by AIDS achieved minimal levels of education:

FIGURE 3.5: Highest educational attainment in the families



Source: AYIEKO (1998:10)

For the purposes of this study the above data is important since it demonstrates that too many adolescent orphans are not able to achieve their academic ambitions. It is important to note that the percentage of adolescent orphans that manage to achieve secondary school level is a paltry 10%. This is indicative of the fact that orphans are not permitted to go on to the secondary school level in a vast number of cases. The highest (47%) that most orphans achieve is the Primary 5-8 level which forms the major portion of the graph. The research revealed various reasons for the above trend:

- Poverty
- Lack of funds
- Malicious caregivers who prevent orphans from going to school in order to impede their future earning potential
- Embarrassment at the way in which their parents died
- Being stigmatized as AIDS orphans
- Believing that their parents had been bewitched as a result of their superior education
- A lack of parental supervision and back-up
- Arduous domestic chores
- School attendance was not seen as a priority in many families
- Education costs from standard 8 and form 4 are too costly and school necessities are unaffordable.

Since there are numerous parental deaths, the extended family reinforcement system, already weakened by droughts, famine and civil unrest is being tested to the limit and incapable of offering any more support to orphans. Harman (2001:2) reports that Tobias Odero, a counsellor with the Baltimore-based Christian Children's Fund (CCF), is adamant that the children who are orphans of AIDS ought not to be institutionalized since the process only adds to the already harrowing ordeal of having to cope with the death of

their parents. Hence, his contribution to the system is to visit these children in their homes daily in order to assist with finances and morale. As a result of the high daily death rate (500 per day), the relatives who would traditionally take care of these orphans are basically weighed down (Harman 2001:2).

The orphan of AIDS becomes the innocent victim of this lack of shared liability. The age-old tradition of the spirit of caring among relatives is dissipating from the pressures of major financial needs and the primal intuition to take care of one's own. Soaring funeral expenses and medical bills restrict the relative's ability to offer further assistance to members beyond the immediate family. The already burdened extended family is often unable to afford further school fees and related educational expenses for the orphans of AIDS placed in their care. This leads to high drop-out rates of children orphaned by AIDS in Kenya.

An in-depth study (Ayieko 1998:1) into the phenomenon of child-headed households in Kenya by Ayieko verifies the premise that the concept of child-headed households is becoming more numerous in rural areas. The report (Ayieko 1998) states that in most cases where appropriate subsistence measures are not made before the parents pass on, the orphans are left with inadequate or no means at all. Hence children who are compelled to bear the brunt of such dispossession are deprived of their childhood and often their right to a proper education.

3.10. TANZANIA

Statistics provided by Barnett and Whiteside (2002a:212) indicate that between one-third and one-fifth of children in Tanzania have lost one or both parents to AIDS. An offshoot of this is that such children face the acute stress of having to deal with educational, psychological as well as social problems such as social insecurity and the lack of

confidence in general. A survey based on statistics regarding AIDS orphans in Tanzania exposed that child-headed households are more common among orphans of AIDS than among any other orphan (Barnett and Whiteside 2002a:212).

Projections (Fox 2001:26) with reference to HIV/AIDS in Tanzania reveal that by the year 2010 there will be 4,2 million orphans. Statistics in relation to AIDS supplied to UNAIDS (Fox 2001:25) were as follows:

TABLE 3.5: HIV/AIDS STATISTICS FOR HIV/AIDS IN TANZANIA

• **HIV positive adults**	**1.3 million**
• **AIDS-related deaths**	**140 000**
• **Children who have lost at least one parent to an AIDS-related illness**	**1.1 million**

Source: Fox (2001:25)

The above statistics present a bleak picture of Tanzania, suggesting that with the AIDS-related deaths of 140,000 people, 1.1 million children have been orphaned. It would stand to reason, therefore that the demise of the 1,3 million already infected adults will result in a social catastrophe of unimaginable magnitude. USAID predicts (Madorin 2000:1) that by 2010 there will be 4.2 million orphans in Tanzania if an effective yet inexpensive treatment is not developed in the near future, but judging by the above figures, this disaster is not too far of.

Many orphans in Tanzania have to deal with the responsibilities that other children with parents would have to face much later in their lives (Madorin 2000:1). These AIDS orphans are facing material impediments in the form of unpaid school fees, other related expenses such as the cost of uniforms and the costs of food and clothing. Older children orphaned by AIDS and living in child-headed homes, have more demanding

responsibilities, which require them to be of assistance to their siblings to survive as well (Madorin 2000:2).

The HUMULIZA (Novartis Foundation: 1-3) has embarked on a fourteen-week program for sets of orphans, in order to attempt to alleviate the children's psychological and social problems by applying the "child-to-child" approach. In this way the children are able to exchange ideas, discuss similar experiences and lose some of their bitterness and sorrow by recognizing that there are many others like them. This project aims at training teachers, members of NGO's, churches and women's social groups who will be able to assist the children who are orphaned by HIV/AIDS. The project also joins forces with UNICEF Tanzania while the latter is creating an experimental undertaking supporting orphans and creating better educational opportunities for the adolescent orphans in this country (Novartis Foundation: 2-3). Consequently it is anticipated that school attendance and educational progress will be positive.

Within the course of their research in Tanzania, Phiri and Webb (2002:30) uphold that households, community members and families are taking the initiative to look after orphans by paying attention to their needs and providing the necessary educational and psycho-social support. However, these researchers (Phiri & Webb 2002:30) deem that such programmes should be sustained and that resources should filter down to the communities effectively. On the other hand it is imperative that well-meaning organizations do not create the impression that the resources will provide **certain** solutions to **all** the problems of the desperate communities. Funding and ability structuring should work hand-in-hand in order to provide the necessary structures that will lead to these efforts to create better learning opportunities and psychosocial support for the orphans of AIDS.

3.11. BOTSWANA

Botswana is a sub-Saharan African country with a population of 1.6 million that has had the highest per capita incidence (Brigaldino 2002:1) of HIV/AIDS in that, at the end of 2002 an approximate 330 000 of the adult population is infected with HIV (AVERT.ORG 2003e:1). As a result of these adult deaths there will be a multitude of sorrowful AIDS orphans struggling to survive under the most trying circumstances (Daniel 2003:2). Daniel (2003:2-3) extends the assertion upholding that the relatives, who under normal circumstances ought to take care of these children, have abandoned them. Further, these orphans of AIDS are excluded and marginalized (Daniel 2003:2) by the communities they live in, sometimes sexually abused and often lose their properties and belongings. Their profound emotional and mental distress is intensified by the ensuing sense of bleakness from which there appears to be no escape after their parents pass on.

At the end of 2001 estimates indicated (AVERT.ORG 2002b:5) that 69,000 children had lost their parent/s to the pandemic but projections are that the number will exceed 200, 000 by 2010 (Brigaldino 2002:1). The statistics below provide evidence of the HIV prevalence rate in Botswana, which is the highest thus far worldwide. The life expectancy in this country is 39 years and would have been 72 years had there been no AIDS in the country (Fredriksson & Kanabus 2003:1).

TABLE 3.6: ESTIMATED NUMBER OF ADULT AND CHILDREN LIVING WITH HIV/AIDS DURING 2001 IN BOTSWANA

Adults and children:	**330,000**
Adults (15-49):	**300,000**
Women (15-49):	**170,000**
Children (-15):	**28,000**
Adult rate (%)	38.3%

Estimated number of orphans

Estimated number of children who have lost their mother or father or both parents to AIDS and who were alive and under age15 at the end of 2001:

Current living orphans: **69,000**

Source: UNAIDS/WHO 2002:1

A study in Botswana (Barnett & Whiteside 2002a:204) exposed that normally orphans began to perform poorly at school immediately after the death of a parent. Orphans from the poorest communities and socio-economic backgrounds displayed signs of poor nutrition, poor care and neglected education. Coombe (2002b:34) and Daniel (2003:3) are of the view that the most recurrent justification for orphans of AIDS becoming school drop-outs or under-achievers, was that they lacked the material means to meet fundamental requirements (Coombe 2002b:34). Teachers and schools in Botswana have begun to provide a range of services such as supplying essentials, networking with children within AIDS-affected households in order reduce stress on children, keeping an eye on orphan welfare, assisting with emotional needs and behaviour disturbance (Coombe 2002b:34).

Various NGO's, government departments as well as the private sector established a National Orphan Programme in April 1999 to accommodate and cater for these orphaned children (AVERT.ORG 2002b:5). These interested organizations work with the intention to evaluate and form guidelines, foster the capacity of established institutions, make available communal welfare services, encourage a cooperative spirit in proposals and supervise and appraise activities. One key objective of the Programme was to set up a comprehensive National Orphan Policy, which was based on the Convention on the Rights of the Child. Measures have been taken to remedy this tragic situation by providing food, clothing and uniforms for school to destitute orphans (Daniel 2003:3). These steps were introduced by the Botswana Government by means of the 'Short Term Plan of Action on the Care of Orphans in Botswana' (STPA), which had been extended to last until 2003 (Daniel 2003:4). The government of Botswana appears to have obviated

the problems of orphans to a significant degree in that children are kept at school and they are able to attain satisfactory grades (Coombe 2002b:34).

The Bobirwa Orphan Trust is made up of community volunteers and local extension staff from government who identify and register orphans. They then establish the kind of assistance that each orphan needs, helping local groups to purchase food, clothing and blankets as well as paying for school fees, uniforms and other educational requirements (AVERT.ORG 2002b:5). UNDP is also providing the necessary funding for local communities in Botswana to assist AIDS orphans. The House of Hope project in Palapye district and the Maun Orphan Care programme in the Nqamiland district provide home-based care for the terminally ill and education, training and welfare services for the orphans of AIDS (UNAIDS 2002:3).

3.12. INDIA

Boseley (2002:1) is of the opinion that the largest number of AIDS orphans around the world – 1.2 million in 2001- emanates from India (Boseley 2002:1). The report declares that these shocking figures are set to increase in five years to 2 million and to 2.7 million in ten years. Debatably, below 1% of the population **have** HIV/AIDS (Step Forward 2003:1), however, if one were to consider that this adds up to probably 4 to 5 million people who are HIV-positive, then India certainly has great cause for concern. The tragedy of Indian statistics is that the maximum proliferation of HIV/AIDS is among the sexually active and most industrious individuals of the age group 15-44 years (Verma, Ravi, Salil, Mendoca, Veera, Singh, Prasad & Upadhyaya 2002:3).

By the end of 2001 (UNAIDS, UNICEF & WHO 2004:2) the following statistics in relation to HIV/AIDS in India were available:

TABLE 3.7: ESTIMATED NUMBER LIVING WITH HIV/AIDS

ADULTS AND CHILDREN	**3 970 000**
Adults (15-49)	**3 800 000**
Women (15-49)	**1 500 000**
Children (0-15)	**170 000**

Source: UNAIDS, UNICEF & WHO (2004:2)

The following statistics (Step Forward 2003:2-4) substantiate the above and provide an accurate view of the path of the pandemic in India:

- In India, the quality of education as well as the pupil enrollment has always been a disconcerting issue. AIDS has certainly intensified the problem given that unexpected financial pressures and psychosocial concerns often do not allow children to complete their schooling.
- The Indian government has released statistics that indicate that from 1994-1995 merely 62% of boys and 47% of girls had enrolled at primary schools in the country.
- The **300 million poverty-stricken** Indians in that country have no access to basic needs such as food, shelter and clothing. This grave state of affairs is aggravated by the physical, economic and emotional impacts of HIV/AIDS.
- In India alone approximately 1,600 people become newly infected and about 1,000 die of AIDS-related diseases **each day**.
- Unfortunately, almost one-third of all people living with HIV/AIDS in India are **women**.
- It is envisaged that by the year 2005, 5-10% of children in India below the age of 15 will lose their parents to AIDS.

It is particularly crucial to take into consideration the number of orphans who will be left behind, thus affecting the social and educational resources of this country. Proportionately the number of children orphaned by AIDS is lower in this country when seen against figures provided for sub-Saharan Africa **but** Capua (2002:1) condemns India for neglecting this HIV/AIDS issue as the African countries had previously done. De Capua believes that eventually the situation will deteriorate to having "tens of millions of orphans within the next decade"(De Capua 2002:1).

According to Coombe (2002:39), the impact of the pandemic upon education in countries such as India, where the prevalence of AIDS is low, will not be uncovered in the very near future since comparatively minimal percentages of learners and educators are affected by AIDS. If one were to take into consideration that for every nine persons around the world who is HIV-infected, one comes from India, together this does not constitute even 5% of the total Indian population and an even smaller proportion of the education community itself. In the same vein, Boseley (2002:1) contends that the proportion AIDS orphans is lower than in some sub-Saharan African countries where the basic constitution of the family is breaking down because of the demise of a generation of parents. Nevertheless, Countess du Boisrouvray (De Capua 2002:1) is of the view that HIV is "*running silently*" in India and the leaders could learn valuable lessons from Africa and take the necessary steps in order to obviate a disaster.

3.13. CONCLUSION

"Despite a widespread belief that orphans are well-served by AIDS care organizations, there is a growing realization that such care is inadequate and that children orphaned by AIDS are in reality often a neglected group" *(UNAIDS 1997:5).*

It is quite apparent that in a country like Uganda where the issue of HIV/AIDS was restricted early in its progression the state is still faced with the problem of orphans of AIDS despite the necessary steps that were taken. This could be attributed to the fact that the progression of HIV was restricted but the after-effects of AIDS will take decades to overcome. Other countries around the world ought to take a leaf out of this book in order to realize that even if a cure for AIDS was discovered at this stage, the psycho-social and educational problems of orphans and child-headed households will persist for decades to come.

An important observation is that in all countries around the world, especially in third world countries, orphans in child-headed households are faced with fundamentally the same problems, which are financial restraints, poverty, stigma and discrimination, social and emotional stress, unfamiliar adult responsibilities, loss of inheritance, panic regarding the future, isolation, absenteeism, dropping out of school and physical and sexual abuse.

The pandemic has consciously affected countries - whether first or third world – but the difference in prevalence, and incidence within each has been dependent upon the economic infrastructure and the manner in which social, welfare and educational state organizations have handled the crisis. Each country will execute initiatives according to their own educational, social and welfare structures in conjunction with that countries traditional and cultural background. The support offered by external organizations such as UNICEF and UNAIDS will therefore have to be mindful of this.