CHILDREN ORPHANED BY AIDS

Front-line responses from eastern and southern Africa

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Front cover: Maritas Shaba, with six of the nine grandchildren she has cared for since they were orphaned by AIDS, in the compound of her household in Malawi.

Back cover: A brother and sister, who were orphaned by AIDS two years previously, in Lusaka,Zambia.

The AIDS pandemic is the world's most deadly undeclared war, and Africa has so far borne its brunt.

In 1998 in Africa, where some 200,000 lives were lost as a result of conflict and war, AIDS killed 2.2 million people. The disease, now the leading killer in sub-Saharan Africa, has taken the lives of 16.3 million people since the epidemic began. Most, by far, have died in Africa.

Yet as shocking as these deaths are, the impact of HIV/AIDS does not end with them. Because those dying from AIDS are mainly people in the prime of their lives who are often parents, a less well-known and calamitous effect of AIDS is the vast numbers of children orphaned by the disease. These children endure overwhelming and largely unmitigated losses, living as they do in societies already weakened by under-development, poverty and the AIDS epidemic itself. According to projections, by the end of the year 2000, a cumulative total of 13 million children will have lost their mother or both parents to AIDS, and 10.4 million of them will still be under the age of 15.

And the worst is yet to come, in numbers both of deaths and children left behind. The lives already claimed by the epidemic are just a fraction of those that lie ahead, in sub-Saharan Africa and many other countries of the world. According to estimates by the joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), 12.2 million women and 10.1 million men were living with HIV in sub-Saharan Africa at the end of 1999, with infected women actually outnumbering infected men – a pattern not seen on other continents. Globally, the figure is 33.6 million people, and they are joined each year by millions of the people newly infected.

In its human and social ramifications, AIDS constitutes a global emergency: It is a growing threat to stability, exacerbating inequalities within and between countries, undermining previous gains in development and harming children. As the projects described in this report make clear, stronger commitments and sustainable efforts are urgently needed by the families, communities and children on the front line of this epic struggle.

By the end of the year 2000, a cumulative total of 13 million children – the majority in Africa – will have lost their mother or both parents to AIDS. A Ugandan boy talks to some of his 15 cousins, all orphaned by AIDS, outside their grandparents' house where they live.

UNICEF/96-1494/Pirozzi

The crisis: Unique for children left behind

Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatized by society through association with HIV/AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without services or support systems in impoverished communities. The following characteristics make their crisis especially acute.

The scale of the problem. More children have been orphaned by AIDS in Africa than anywhere else. The deep-rooted kinship systems that exist in Africa, extended-family networks of aunts and uncles, cousins and grandparents, are an age-old social safety net for such children that has long proved itself resilient even to major social changes. This is now unravelling rapidly under the strain of AIDS and soaring numbers of orphans in the most affected countries. Whereas before AIDS, approximately 2 per cent of children in developing countries were orphaned, in 1997 rates in some countries were 7, 9 and even 11 per cent. Capacity and resources are stretched to breaking point, and those providing the necessary care in many cases are already impoverished, often elderly and might themselves have depended financially and physically on the support of the very son or daughter who has died.

An AIDS-weakened infrastructure. The impact of the epidemic is felt throughout communities and societies, as teachers and farmers, trained health care personnel and workers from all parts of the economy have died and continue to die in enormous numbers. National budgets are strained by the demands: By 2005, the health sector costs for treatment, care and support related to HIV/AIDS are expected to account for more than a third of all government health-spending in Ethiopia, more than half in Kenya and nearly two thirds in Zimbabwe.

As those dying are usually in their most productive years, many schools, hospitals, private industries and civil services are short-staffed. In the private sector, AIDS-related costs – including those connected to absenteeism from work, insurance and the recruitment and retraining of replacement workers – are estimated to consume as much as one fifth of all profits. Economists at the World Bank conservatively estimate the impact on countries with high HIV rates as a loss of 1 per cent of gross domestic product growth each year.

The effects also reach deeply into the daily lives of families caring for someone with the disease, where resources quickly evaporate. Studies in urban households of Côte d'Ivoire, for example, show that when a family member has AIDS, average income falls by 52 to 67 per cent, while expenditures on health care quadruple.

Why the crisis is unique for children

The huge scale of the problem.

An AIDS-weakened infrastructure.

The vulnerability of orphans.

Grief before death and the tragedy of losing both parents.

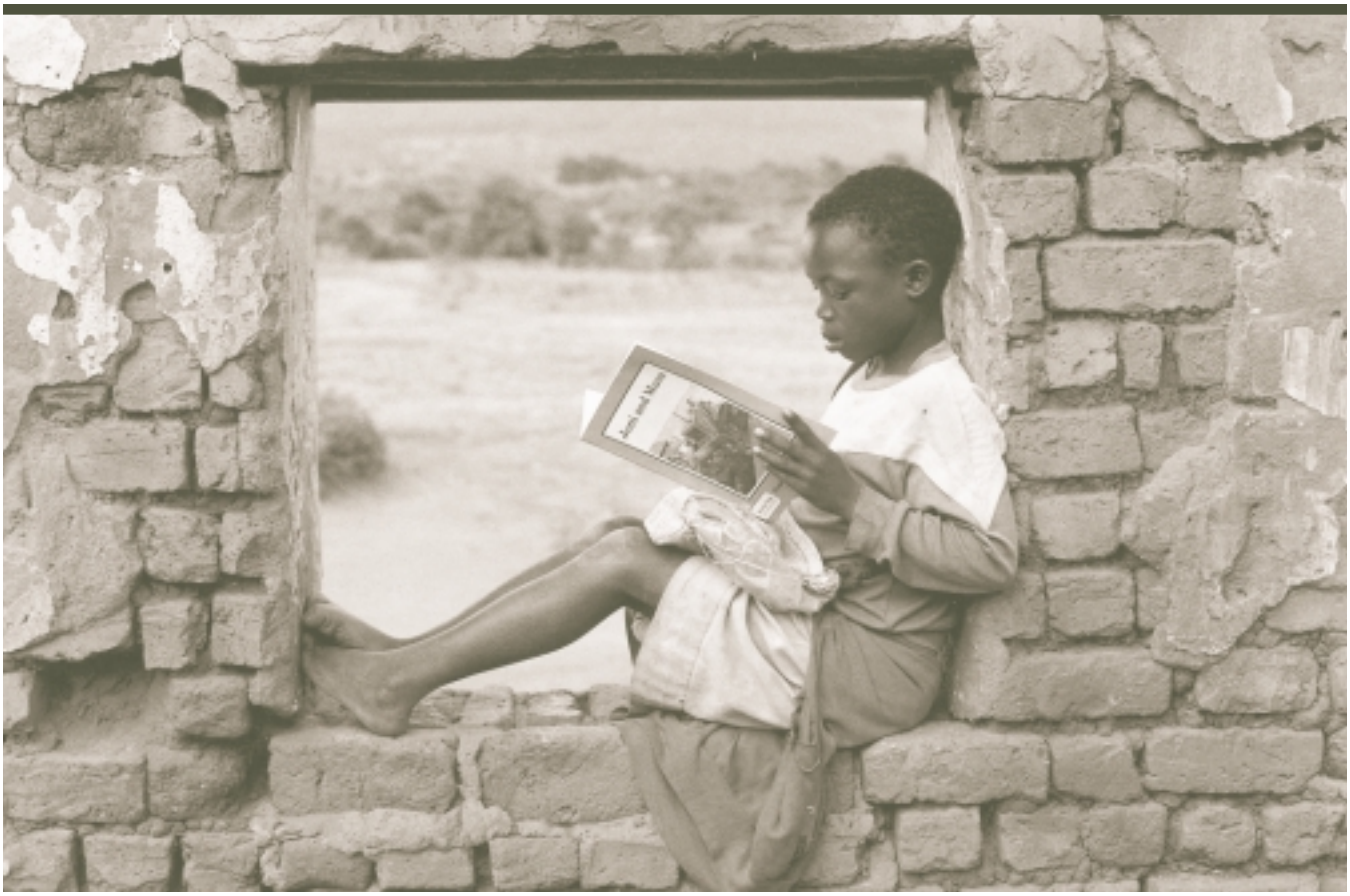
The AIDS stigma.

Savings are depleted and people often go into debt to care for their sick. Food consumption has been found to drop by 41 per cent. The drain on virtually all segments of communities and nations means that very few resources or services remain and fewer can be produced or provided to those on the front line of orphan care.

The vulnerability of orphans. Of the many vulnerable members of society, young people who have lost one or both parents are among the most exposed of all. And this is particularly true in sub-Saharan Africa, where few social support systems exist outside of families and where basic social services are largely inadequate.

Orphans run greater risks of being malnourished and stunted than children who have parents to look after them. They also may be the first to be denied education when extended families cannot afford to educate all the children of the household. A study in Zambia, for example,

Children orphaned by AIDS are often the first to be denied education when their extended families cannot afford to educate them. A boy reads at a community school in Zambia.



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showed that 32 per cent of orphans in urban areas were not enrolled in school, as compared with 25 per cent of non-orphaned children. Children who have been orphaned by AIDS may also not receive the health care they need, and sometimes this is because it is assumed they are infected with HIV and their illnesses are untreatable. Increasingly, children whose parents are dead accumulate ever greater burdens of responsibility as head of household when a grandparent or other guardian or caregiver dies.

Orphans enduring the grave social isolation that often accompanies AIDS when it strikes a family are at far greater risk than most of their peers of eventually becoming infected with HIV. Often emotionally vulnerable and financially desperate, orphaned children are more likely to be sexually abused and forced into exploitative situations, such as prostitution, as a means of survival.

Grieving before death and the tragedy of losing both parents. A child whose mother or father has HIV begins to experience loss, sorrow and suffering long before the parent's death. And since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, the children are far more apt to lose the remaining parent. Children thus find themselves thrust in the role of mother or father or both – doing the household chores, looking after siblings, farming, and caring for the ill or dying parent or parents, bringing on stress that would exhaust even adults.

In addition, because HIV infection progresses from initial infection to mild HIV-related illness to the life-threatening illnesses called "AIDS," children can live with long periods of uncertainty and intermittent crises, as both parents slowly sicken and die. In sub-Saharan Africa, where effective relief for pain or other symptoms is often unavailable, children who live through their parent's pain and illness frequently suffer from depression, stress and anxiety. Many children lose everything that once offered them comfort, security and hope for the future.

The AIDS stigma. The distress and social isolation experienced by children, both before and after the death of their parent or parents, are strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma and the often-irrational fear surrounding AIDS, children may be denied access to schooling and health care. And once a parent dies, children, particularly in the case of girls, may also be denied their inheritance and property. Moreover, as the rights of children are inextricably linked to those of their surviving parent, laws and practices that deny widows their rights and property have devastating consequences for children after their father's death. ■

AIDS orphans defined

UNAIDS, WHO and UNICEF define AIDS orphans as children who lose their mother to AIDS before reaching the age of 15 years. Some of these children have also lost, or will later lose, their father to AIDS. Thus defined, there will be 13 million children orphaned by AIDS by the end of 2001. This cumulative figure includes orphans who have since died, as well as those who are no longer under age 15. In some assessments, paternal orphans – those who have lost only their father to AIDS – are included in estimates of children orphaned by AIDS. A child whose father dies typically experiences serious psychological, emotional, social and economic loss. But because reliable data on the number of paternal orphans are not available in many countries, the orphan statistics used by UNAIDS and UNICEF do not include children who have lost only their fathers.*

** Some organizations have made orphan estimates for up to 30 years in the future. UNAIDS and UNICEF believe the possible margin of error in such long-term estimates to be too great to make them worthwhile or reliable for planning purposes.*

Protecting children from AIDS

Few young people receive the accurate and appropriate information they need about AIDS and its transmission. For instance, a national survey in Kenya in 1998 found that 36 per cent of girls aged 15–19 could not name a single way to protect themselves from HIV infection. And 32 per cent of girls did not know that a healthy-looking person could have HIV or AIDS.

Yet evidence suggests that young people are sexually active, and that few of them use condoms. In sub-Saharan Africa, more than half of young women give birth before age 20. In many places, schools provide no reproductive health education that would encourage girls and boys to postpone intercourse or adopt protection against sexually transmitted diseases.

The results of this are tragic, but predictable. In South Africa in 1997, a small study showed that 9.5 per cent of pregnant girls under 15 years of age were HIV-infected.

Girls, in fact, often become infected at a younger age than boys because they are biologically, socially and economically more vulnerable both to infection and to unprotected or coercive sex. Recent studies in Africa show that girls aged 15–19 are around eight times more likely to be HIV-positive than are boys their own age. Between the ages of 20 and 24 women are still three times more likely to be infected than men their age. Men's infection rates do eventually catch up, but this does not happen until they are in their late 20s or early 30s.

Studies across a range of cultures have shown that education about reproductive health and AIDS does not lead to premature sexual activity; on the contrary, it can lead to delays in the age of first intercourse. Schools are the ideal places for such education. In many countries, though, children drop out of formal schooling before such classes are offered. However, these young people can still be reached and taught about AIDS – through informal methods, by parents and other elders in their community, by their peers and through the media.

Few young people receive the accurate and appropriate information they need about AIDS and how it is transmitted. A Zambian primary school student sings a song about AIDS prevention while her classmates look on.

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Country responses: Botswana, Malawi, Zambia and Zimbabwe

Efforts to protect children orphaned by AIDS are nearly as old as the epidemic, and many are beginning to show real progress. Several of these nascent efforts have taken place in Botswana, Malawi, Zambia and Zimbabwe, 4 of the 10 worst-affected countries in the world in terms of HIV prevalence. These efforts, detailed below, provide encouragement and concrete examples to other countries and communities seriously affected by the pandemic.

It is important at the outset to underline that what distinguishes all successful and sustainable efforts to combat the HIV/AIDS crisis, including providing care for orphans, is political will. One country that has clearly shown leadership in this area is Uganda, where some of the first AIDS cases in Africa were identified in 1982 and where the numbers of orphans had exploded less than a decade later. Uganda's high-level response, and its outspoken acknowledgement of the crisis, remain a model yet to be emulated in most other hard-hit countries.

As early as 1986, the Government acknowledged the AIDS crisis and began mobilizing both domestic and international support to combat it. In the early 1990s, the Uganda AIDS Commission was established within the President's office as were AIDS Control Programmes within several government ministries.

Uganda's non-governmental organizations (NGOs), community-based organizations (CBOs) and religious groups played an important role in developing effective responses.

By the mid-1990s, an emphasis on government decentralization transferred responsibilities for child protection in local areas, over to local governments. At the same time, the Ugandan Government extended education to all children and rebuilt health facilities, leading to improved access and services for children.

The use of radio, which reaches all parts of the country, has played a key role in educating people about how HIV/AIDS is spread and prevented. A public declaration by popular musician Philly Lutaaya that he was HIV positive provided an important opportunity to promote public discussion about AIDS and new prevention and care programmes. Young people have always been the prime focus of many of the country's AIDS programmes.

The experiences to date in providing care and protection for orphans and other affected children need more thorough review and, where satisfactory, considerable acceleration. Nonetheless, the steps described may offer lessons to other countries struggling to meet the needs of their children.

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Uganda has been at the forefront of initiatives to protect children from AIDS through improved basic social services. A major success has been increased enrolment in primary schools. This girl attends a community school northeast of Kampala, the capital.

Botswana:
Mobilizing national resources

UNICEF/94-1217/Andrew

Throughout sub-Saharan Africa, the extended family, often the grandparents, are struggling to care for children orphaned by AIDS. Two brothers, whose parents died of AIDS, play football outside their grandmother's house where they live with seven of their siblings.

The HIV/AIDS epidemic in Botswana is the deadliest emergency and the biggest social and economic crisis facing the country today. After three decades of sustained economic growth, HIV is threatening to wipe out hard-won gains in social development, including improvements in child heath, nutrition and education. By the year 2000, it is projected that AIDS will be responsible for an astounding 64 per cent of deaths of children under five years of age in the country.

With over 20 per cent of its population between 15 and 49 years of age infected with HIV, Botswana grapples with an AIDS epidemic as severe as that of its neighbours. And rates of HIV infection continue to rise sharply, for reasons that are sadly evident. First, denial about the existence of AIDS is widespread. Second, there has been little change in people's sexual behaviour. Finally, there is a high rate of sexual activity among young people. In Botswana's major urban areas, more than 30 per cent of all pregnant adolescent women are infected with HIV.

The impact AIDS has had on the country's children has been nothing short of devastating. The rate at which children have been orphaned in Botswana has quadrupled in just the three years between 1994 and 1997. By the end of 1997, around 4 per cent of Botswana's children under 15 had become orphaned because of AIDS.

Background

With diamonds as its main source of revenue, Botswana is among the wealthier countries in the region, showing strong economic growth. Over the past three decades, against a backdrop of stable democracy, the country has made enormous strides in the area of socio-economic development. During the 1970s and 1980s, infant and child mortality and malnutrition declined sharply, while literacy rates and academic achievement rose steadily.

Furthermore, Botswana has distinguished itself from other countries in the region by its high level of public spending on basic social services, operating relief schemes to assist the worst off and creating safety nets for national emergencies, such as droughts. There are still great disparities, however, between the rich and poor, and a large proportion of the population – some 47 per cent – lives in poverty.

National policy and review of child laws

A National Orphan Programme was established in April 1999 to respond to the immediate needs of orphaned children. The Programme is run by various government departments, NGOs, CBOs and the private sector, and its objectives are to review and develop policies; build and strengthen institutional capacity; provide social welfare services; support

community-based initiatives; and monitor and evaluate activities. The Programme is responsible for coordinating the registration of orphan data through a national database; identifying and addressing the needs of foster children and foster parents; training community volunteers in basic childcare; providing HIV/AIDS counselling; and reviewing and developing government and child protection policies.

A major goal of the Programme is to develop a comprehensive National Orphan Policy, based on the Convention on the Rights of the Child. A number of existing laws that address issues of child support, paternity, custody, financial support and guardianship are being reviewed or amended.

Models as a tool for social planning

To assist policy makers in their planning, Botswana's Ministry of Finance has developed a way to model the impact of the epidemic on population growth and structure, social services and economic activity. Such a model will provide the Government with a clearer picture of the numbers of children requiring care and their needs. In the long term, the goal is for all organizations involved in orphan care to integrate their family and community support projects into larger programmes dealing with health, education, agriculture, water and sanitation.

Services for orphan care in Botswana

The Government encourages communities to provide care for orphans and to rely on institutional care only as a last resort. Orphans in Botswana, therefore, are still usually absorbed by the extended family. Their caretakers are predominantly women. Nationally, 47 per cent of households are headed by women, most of whom are single. And female-headed households make up the majority of all the households living in poverty.

A number of NGOs and CBOs have taken the lead to support these extended and foster families, including Childline Botswana, Botswana Christian Council, Botswana Christian AIDS Intervention Program and Tirisanyo Catholic Mission. These organizations provide services in communities throughout the country, ranging from family counselling and day care for orphans to providing for basic needs such as food, clothing and education.

Contracting out services: The Bobirwa Orphan Trust

In the rural subdistrict of Bobirwa, district authorities have contracted out to the Bobirwa Orphan Trust the delivery of essential government services to orphans in the area. Approximately 58,000 people live in the subdistrict, according to 1991–2021 population projections, and 54 per cent of households are headed by women.

The Government encourages communities to provide care for orphans and to rely on institutional care only as a last resort.

There are still many obstacles and challenges to overcome. First, the country's high-level officials have only recently begun to speak about the problem and make it a national priority.

The Trust is made up of community volunteers and local extension staff – government-paid employees, including social workers, family welfare educators, the Home-Based Care Coordinator and the sub-chief. Under the pilot initiative, members of the Trust identify and register orphans in the subdistrict, through home visits, schools and churches; screen orphans using established criteria to identify the type of assistance they need; initiate community-based foster placement; identify local groups purchasing food, clothing and other necessities and distributing them to orphans; and refer cases needing special attention to the Council of Social Welfare and Community Development (SW&CD) Department. Needy orphans are assisted with food, clothing, blankets, toiletries, counselling, day-care services, toys, bus fares to and from school, school uniforms and other educational needs.

The Trust provides preliminary orphan data to the Council where it is evaluated to determine whether or not assistance is needed. The Council ensures that local orphan identification and registration criteria conform to government criteria as provided in the National Destitute Policy; defines the needs and assistance available; handles referral cases; provides training to local extension staff and community volunteers on government child welfare policies and laws as well as technical support to the project.

A district-based database on orphans, maintained by the Council of SW&CD Department, is also being piloted. By September 1999, 1,084 orphans had been entered into the database. Orphans are also assisted with uniforms and other educational needs by UNICEF, the Bobirwa subdistrict Council and the Trust itself.

Botswana's future obstacles and challenges

There are still many obstacles and challenges to overcome. First, the country's high-level officials have only recently begun to speak about the problem and make it a national priority. Because initial government response to the crisis was slow, AIDS has already done significant damage to previous progress in social development.

Second, responsibility for AIDS within the Government is not well defined. There are two Ministries dealing with orphans – the Ministry of Health (through the National AIDS Control Programme) and the Social Welfare Division of the Ministry of Local Government, Lands and Housing. The split jurisdiction for AIDS orphans between these two Ministries has made it difficult to coordinate a national effort and to document lessons learned along the way.

Third, there is no strong tradition of NGOs and CBOs working in the area of childcare and rights. Communities

Malawi: Striving for early childhood care

have been very much dependent upon government funding to undertake community-based initiatives.

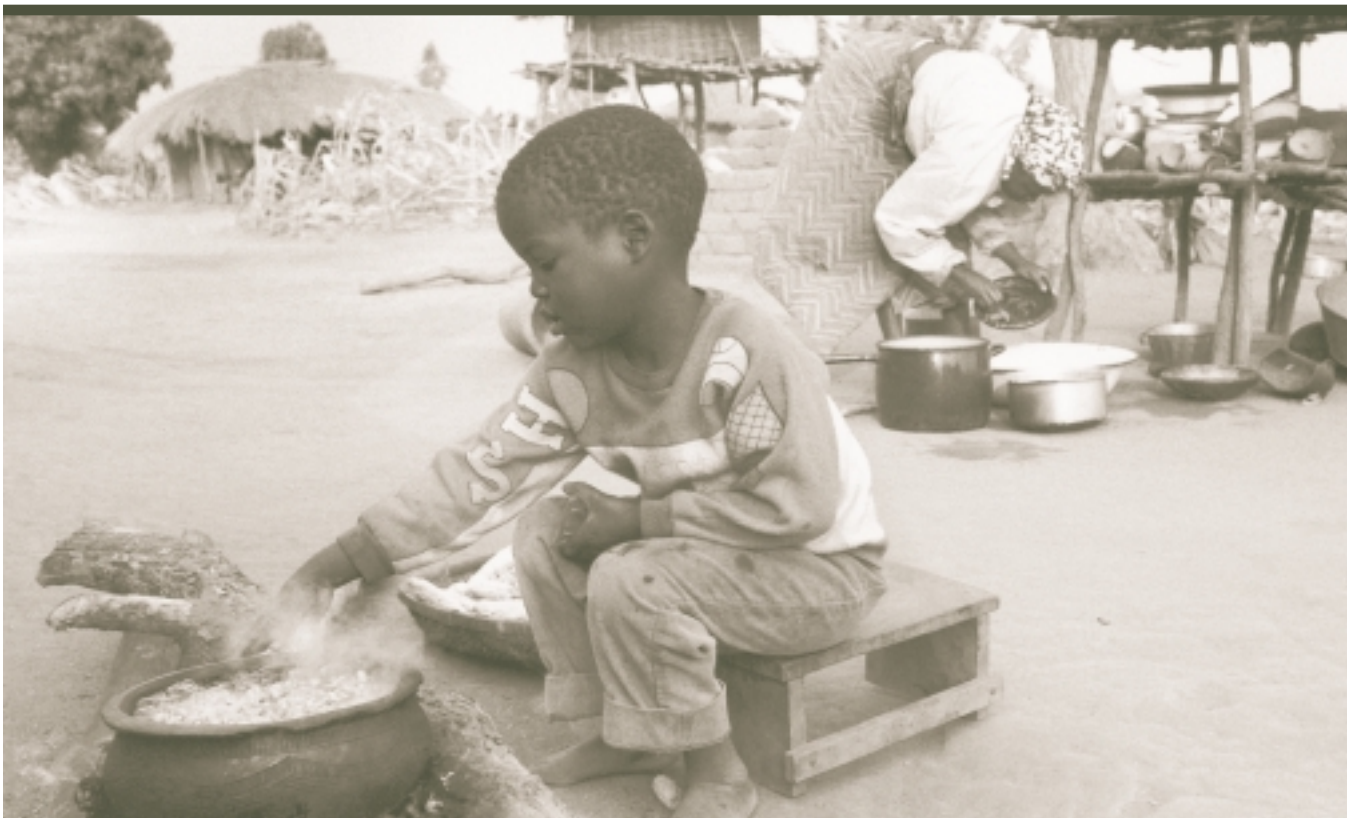
Finally, existing child protection laws and policies are fragmented and outdated.

Despite the challenges, there are hopeful signs that political commitment has begun to accelerate the Government's response to the HIV/AIDS epidemic. This commitment, and the establishment of a National Orphan Programme, are critical first steps towards halting the spread of AIDS and mitigating its impact. ■

It is estimated that around one in seven of the population aged 15–49 years in Malawi is infected with HIV. Over 25 per cent of women attending antenatal clinics in the urban centres of Blantyre and Lilongwe test positive for HIV, and girls aged 15–24 are six times more likely to be sero-positive than boys the same age. The incidence of tuberculosis has more than tripled since the late 1980s, largely due to HIV.

The AIDS crisis has had a crippling impact on the country's children. By the end of 1997, 6 per cent of children under the age of 15 in Malawi were orphans.

By the end of 1997, 6 per cent of children under the age of 15 in Malawi were orphans. A boy orphaned by AIDS tends a pot cooking on an open fire.



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Setting priorities early on

It was recognized early on that because communities are in the best position to assess their own needs, they would play an important role in addressing the AIDS orphan crisis. One of the Government's main strategies, therefore, has been to promote and support community-based programmes.

As early as 1991, the Government of Malawi established a National Orphan Care Task Force. The Task Force – made up of national and district representatives from the Ministry of Gender, Youth and Community Services; the National AIDS Control Programme (Ministry of Health and Population); NGOs; religious organizations and UNICEF – is responsible for planning, monitoring and revising all programmes on orphan care.

One year later, in 1992, National Orphan Care Guidelines were established. The guidelines serve as a broad blueprint to encourage and focus subnational and community efforts. Over the years, the guidelines have been revised and have guided many of the local and district efforts to support orphans. The Government will use the lessons learned from these initiatives to develop a National Orphan Care Policy.

The Task Force has also established a subcommittee that is reviewing existing laws and legal procedures to provide greater protection to vulnerable children. Recommendations for modifying several laws to protect orphans have been submitted to the Ministry of Justice. These laws include the Wills and Inheritance Act, the Adoption Act, the Child and Young Persons Act and the Foster Care Act. A shortage of lawyers in the Ministry of Justice, however, has significantly delayed this process.

Care for the youngest

Researchers have thoroughly documented the importance of the pre- and postnatal months and the first three years of life in a child's development. Concerned agencies such as UNICEF and others are now making what is designated as "early childhood care for In survival, growth and development" a cornerstone of their child programmes.

Malawi has led the way in the region on early childcare and development (ECCD), and its pioneering work has been adopted by neighbouring countries, including Zambia. ECCD, which in Malawi covers children under eight years of age, has played an especially important role in providing care for the country's AIDS orphans.

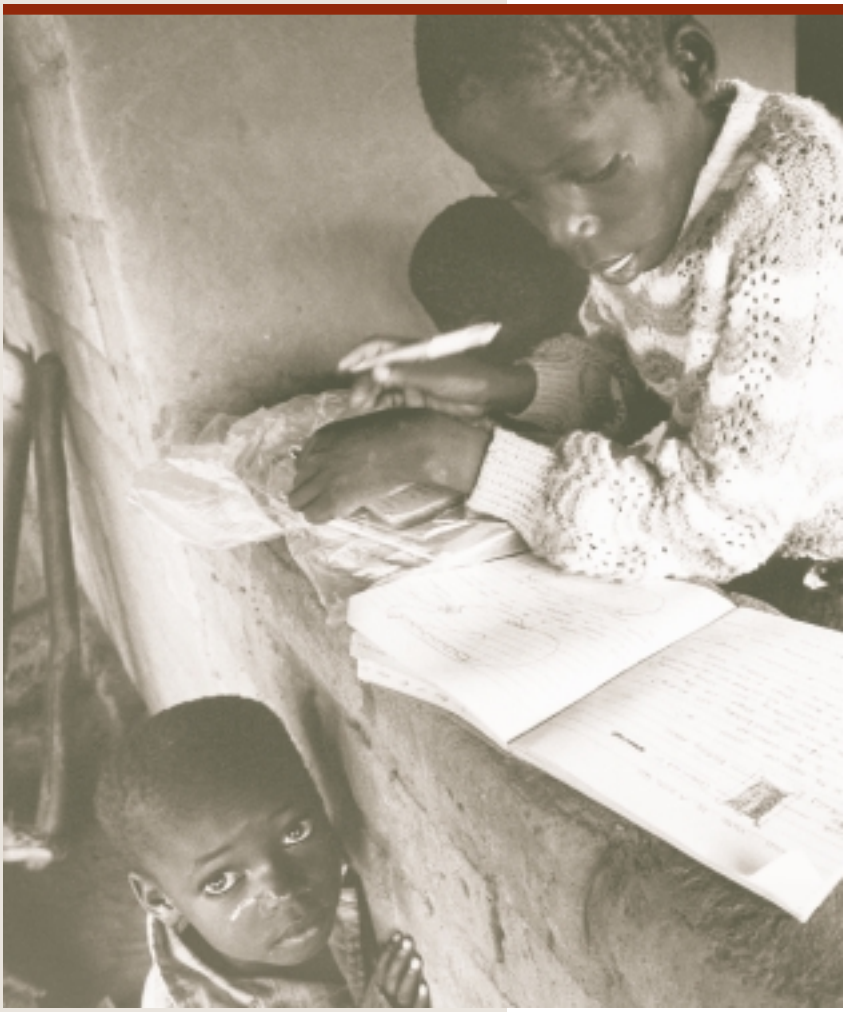
Across the country, community-based organizations, working closely with district social welfare officers, are setting up child-care centres with the aim of improving the care of children as well as increasing their learning opportunities. At the centres, which are for all children in the community, children play, learn, socialize and eat. Caregivers ensure that orphans in their communities attend the centres and benefit from their activities.

Malawi's National Orphan Care Guidelines

In 1992, with advisers from the Uganda Government and NGOs, Malawi's National Orphan Care Task Force developed the subregion's first guidelines for the care of orphans. The main points of these guidelines are:

- The first line of approach in orphan care must be community-based programmes. The Government will coordinate the activities of service providers.
- Formal foster care will be expanded as the second most preferred type of care.
- Institutional care should be the last resort, though temporary care may be required for children awaiting placement.
- Hospitals should record next of kin, so that relatives can be traced if children are abandoned.
- The registration of births and deaths should be improved, to assist the monitoring of orphans.
- The Government will protect the property rights of orphans, and these rights should be widely publicized.
- Self-help groups should be developed to help affected families with counselling and other needs.
- NGOs are encouraged to set up programmes of community-based care, in consultation with the Government.
- The needs of all orphans should be considered on an equal basis, regardless of the cause of death of the parent or parents, or their gender or religion.
- The National Orphan Care Task Force will continuously plan, monitor and revise programmes and policies.
- The Government will encourage donor support for resources to help orphan programmes.
- The lead government body on orphan issues will be the Ministry of Gender, Youth and Community Service.

In 1992, Malawi's National Orphan Care Task Force developed guidelines for the care of orphans. A boy orphaned by AIDS in northern Malawi does his homework on the verandah of his grandmother's home, accompanied by two of his siblings.



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A village in Malawi and its youngest orphans

In a village in rural Malawi, about 30 small children sit in rows, reciting their lesson, singing and clapping their hands. They are assembled in the village's child-care centre, where they are taught and cared for by local volunteers. Some of these children are orphans, cared for by elderly grandparents who are unable to provide them with proper meals. Others are looked after by – or may even themselves be caring for – mothers who are too ill to cope with their children's basic needs.

The centre, which takes children up to primary-school age, is run as a cooperative and staffed by trained villagers. The staff are reimbursed for their time by other villagers who may also look after the staff's fields and provide food for the centre.

The village elders stress that it is important to have a safe place where these children can come during the day to learn and be fed and washed. Health care outreach workers also come to the centre to immunize the children and monitor their growth.

Orphans who need special attention are closely followed up. In some centres, arrangements are made with community health workers to monitor their growth and health status.

Collaboration with district authorities has significantly improved the capacity of the community-based organizations to tend to orphans. The district team trains caregivers on a variety of issues, including childcare, income generation to support the centres and providing psychological support to orphans and their guardians.

Strengthening community responses

In rural and urban areas across Malawi, communities are developing a variety of ways to cope with the growing crisis of AIDS orphans. Village orphan committees have been established in many villages to monitor their local situation and to take collective action to assist those in need. Anti-AIDS clubs have also been created to educate communities about HIV/AIDS transmission and prevention, as well as to address the needs of those infected with the virus. In Namwera village, for example, the local school has formed an anti-AIDS club where pupils carry out AIDS-prevention activities as well as help needy orphans. After children in one family lost their parents to AIDS and their house and living conditions rapidly deteriorated, one group of students built the orphans a kitchen for their home. Older students also look after smaller children and involve them in recreational activities.

Community work in Namwera has been organized through Malawi's Community-based Options for Protection and Empowerment (COPE) project. The project, implemented through Save the Children Federation Inc., helps villages set up local orphan committees to detect, monitor and assist vulnerable families and children. Women, children and youth all participate in decision-making on the village committees. The communities have also set up communal gardens to support at risk families and orphans. At the same time, UNICEF assists families and guardians with loans to boost income-generating activities.

Many NGOs and community-based organizations work closely with government ministries and district authorities to plan and carry out orphan programmes. Most extension workers from the different ministries are members of the Community Orphan Care Committees and provide support through various activities. For instance, agricultural extension workers assist communities in establishing gardens for vegetables and crops, as well as in maintaining small livestock for the child-care centres. Social welfare workers have a school social work programme that also looks at ways to support needy orphans in school.

Zambia: Supporting community commitment

Challenges for the future

Lack of administrative capacity at the national level coupled with inadequate resources has made it difficult for the Government to keep up with the growing pandemic. At the same time, research and data collection need to be improved in order to assess the severity and scope of the problems presented by the large number of orphans and respond effectively.

The dedication and solidarity of community members across the country have been a major factor in the progress that has been achieved so far. At the same time, a strong collaborative effort between the Government, NGOs, community-based organizations and churches, with support from UNICEF, has helped strengthen Malawi's orphan programme in recent years. ■

After Uganda, Zambia has the highest proportion of children orphaned by AIDS in the world. By the end of 1997, some 360,000 children – 9 per cent of children under 15 – were orphaned because of AIDS, and the numbers are increasing rapidly.

But families already worn out by widespread and extreme poverty are stretched beyond their capacity. About 80 per cent of the country's rural population is considered to be living below the poverty line, more than 50 per cent of children are chronically malnourished and large numbers of families are forced to ration food. It has been estimated that 42 per cent of all young Zambian children suffer from stunted growth.

Families are having difficulty coping in urban areas as well, and many children have been forced onto

In Zambia, by the end of 1997, some 360,000 children – 9% of the children under 15 – were orphaned because of AIDS, and the numbers are increasing rapidly. Two brothers in Lusaka, Zambia, wash clothes outside the house where they have lived with a foster family since being orphaned by AIDS.

UNICEF/98-1033/Pirozzi

the streets. In 1991 in Lusaka, the capital, some 35,000 children were living on the streets. Today that number has more than doubled to around 75,000. Many of these children are sexually exploited; half are orphans.

The crisis is eroding the Government's ability to provide services, while at the same time increasing the demand for them. Zambia's primary health care system used to be considered one of the best administered and most decentralized among all African countries, but now, with increasing household poverty, external debt obligations, and demands placed on health services by HIV/AIDS, the system is breaking down. In 1992, HIV/AIDS-related illness accounted for about 30 per cent of hospital beds and 43 per cent of in-patient days, in those hospitals surveyed.

AIDS has made the whole country poorer. All sectors of the Zambian economy have felt the deep ravages of the epidemic. One large company reported in 1995 that its costs from HIV/AIDS illness and death exceeded its total profits for the year.

The AIDS crisis is eroding the Government's ability to provide basic services, while at the same time increasing the demand for them. A woman very sick with AIDS is visited by an NGO health worker in Lusaka, Zambia.

UNICEF/96-1246/Pirozzi

NGOs trying to fill the gap

Zambia has several policies that pertain to children, but no national orphan policy. Although many ministries have included AIDS issues in their planning, the Government has been slow to respond to the AIDS orphan crisis. The Permanent Secretaries from the Ministries of Health, Education, Social Services and Children have formed a task force to look at the problem of orphans and vulnerable children with the goal of establishing a national coordinating body.

As in many countries, NGOs, CBOs and religious institutions have tried to fill the gaps. In the last few years, the number of groups dealing with AIDS issues – previously fairly low – has grown. Most of these organizations recognize that orphaned children should be cared for by the community rather than by institutions and as a result, much of their work focuses on strengthening families and extended families.

Some NGOs, CBOs and religious groups provide direct assistance to orphans and their families in the form of food assistance, clothing and school fees. Many more, however, develop initiatives designed to encourage independence and self-reliance. Frequently, NGOs assist communities to develop community schools as a means to provide education. A majority assists communities to develop some sort of financial sustainability through income-generating activities, including oil pressing, raising chickens and gardening. The money is often designated to pay for school fees and uniforms for orphans. Too often, however, the returns are minimal in proportion to the efforts and resources invested.

Educating orphaned children: Volunteer community schools

Zambia does not provide free primary education to children. With high national poverty rates, parents and guardians are finding it increasingly difficult to pay for the school fees, uniforms and books needed to send their children to a government school. A study in urban areas revealed that 32 per cent of orphans are not receiving formal schooling, compared with 25 per cent of non-orphans; in rural areas, the figures for children not enrolled in school were a staggering 68 per cent of orphans compared with 48 per cent of non-orphans.

Community schools condense the seven-year government curriculum into four years. In the past, children who entered community schools (never having attended a government school) were older than their counterparts and the four-year curriculum allowed them to finish the equivalent grade seven at an age close to that of children in government schools. However, as larger numbers of families are unable to afford government schools, increasingly younger children have begun to attend community schools. In recent years, some of these community schools have begun to provide early childhood education, catering to the needs of very young orphans without caregivers, or to those whose caregivers are either too old or too young to give them adequate care.

Although the Zambia Community Schools Secretariat tries to monitor quality, the growing numbers of community schools make it difficult to monitor them effectively, and quality varies widely. The teachers are often drawn from members of the community: NGOs provide teacher training, frequently using a manual developed by the Ministry of Education, NGOs, UNICEF, teachers and curriculum specialists. The manual provides teaching methodology and outlines a syllabus, including tips on teaching the material. Model lessons are included as well as techniques for monitoring a student's progress.

Zambia does not provide free primary education to children. With high national poverty rates, parents and guardians are finding it increasingly difficult to pay... to send their children to government school.

The Programme was designed to strengthen the communities' capacity to address the growing number of orphans and to create awareness about the problems these children face.

Chikankata Community-based Orphan Support Programme

The Community-based Orphan Support Programme (CBOSP) at Chikankata Salvation Army Mission Hospital is a pilot programme, started in two communities in 1995 and expanded in 1999 to include an additional three communities. Between 2,000 and 5,000 people live in each community, most of them farmers.

Chikankata has been hit hard by HIV/AIDS, although HIV rates are not available because testing is not routinely done at the hospital. In 1999, there were some 1,500 orphans registered in the five project communities. A majority of those orphaned have lost both parents and all their inheritance at the same time because surviving relatives quickly appropriate property. In most cases, however, children are cared for by their grandparents.

The Programme was designed to strengthen the communities' capacity to address the growing number of orphans and to create awareness about the problems these children face. The Programme provides education and health services; facilitates local income-generating projects; conducts HIV/AIDS prevention among vulnerable children; and links up local communities with agencies working with orphans outside the community.

Organizational structure

The Community-based Orphan Support Programme is one of several programmes (Home-based Care, Reproductive Health, Nutrition and Growth Monitoring) run by the Salvation Army Hospital.

The Chikankata Community Health and Development Department Team at the hospital provides technical support and training for Care and Prevention Teams (CPTs), made up of community members, including chiefs, farmers, teachers and businessmen. The teams are the focal points for community responses to all HIV/AIDS-related matters. CPTs identify and care for those who are infected with HIV; help mobilize resources; coordinate activities with local partners; and train community volunteers. The Health and Development Department Team makes regular visits to all communities to follow up on how they are progressing.

In addition to CPTs, local Children in Need (CHIN) committees were also formed. These committees, established in the five communities where the programme is being implemented, consist of 24 members from different sectors of the community, including schoolteachers, community health workers and village headmen. CHIN committee members, known locally as "caregivers," are trained in community education, advocating for children in situations of child abuse, family education and counselling. The CHIN committees register orphans and vulnerable children; conduct regular,

usually weekly, home visits to see how orphans are faring and what needs they have; and organize income-generating activities. A CHIN Coordinator, based at the Chikankata Salvation Army Hospital, supervises the committees.

Data collection

The process of registering orphans is invaluable in helping communities not only to assess the scale of their orphan problem and ensure that benefits reach the correct children, but also in building community awareness and support for initiatives designed to help orphans. Although communities began by looking at the needs of orphans, they soon reformulated their criteria to include other vulnerable children, namely those who are extremely poor. Communities are now formulating their own criteria for vulnerability, which differ from one community to the next. Chikankata communities are continuously counting orphans to assist with planning.

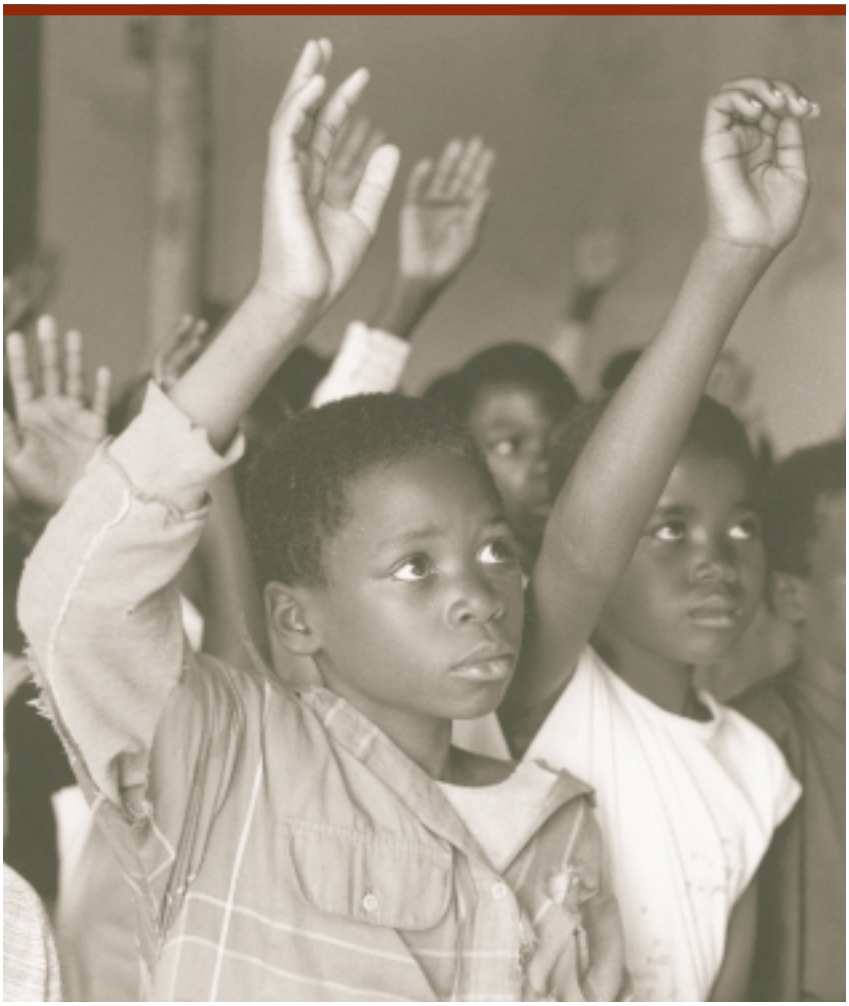
Life skills training

The training of orphans in life skills was introduced this past year. Done mostly through school peer education groups, or the counselling and psycho-social support offered by the local CHIN committee members, the training is designed to teach orphans to make informed decisions about their lives. The hospital is currently looking for a partner to train the orphans in practical skills.

In rural areas of Zambia, 64 per cent of orphans are not enrolled in formal school, compared with 48 per cent of non-orphans. Children attend an outdoor class at a community school in Lusaka, the capital.

UNICEF/98-1021/Pirozzi

Zambian children attend class in a community school in the village of Mazabuka, one of many non-formal education alternatives for extremely poor children, including those orphaned by AIDS.



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Resource-generating activities

Resource-generating projects are managed by local CPTs and CHIN committees. Most communities are running a small shop and a vegetable garden. The produce from the garden benefits the aged, widows and orphans.

A long road ahead

Communities remain in the front line of care for orphans in Zambia. Although NGOs, CBOs, churches and other volunteer organizations are making significant contributions in strengthening local communities, they have a long way to go before making an impact nationally. At present, Zambia's volunteer bodies, churches and NGOs manage to provide assistance to only around 7 per cent of those children requiring it.

A number of factors make it difficult for these institutions to scale up existing interventions. First, their responses are not consistent and there is little coordination between them. Second, government involvement is severely limited at the present time. Third, the funding is totally inadequate to address the issues on a large scale. Finally, institutions are overwhelmed responding to immediate needs of these children and families. With little funding and relying heavily on volunteers, many are stretched almost to breaking point. They have few resources to analyse what is working and what is replicable, much less to scale up efforts.

However, the activities of these organizations mitigate the suffering of orphans. Many of the programmes that exist have a good reputation and community commitment is strong. Supporting these efforts is crucial in the monumental task of assisting families and communities in Zambia to care for the country's orphans. ■

Zimbabwe: Strengthening community responses to orphan care

Zimbabwe has one of the worst AIDS epidemics in the world. Currently, 26 per cent of all adults are infected with HIV, according to figures from the National AIDS Coordination Programme (NACP). The UN Population Division has projected that, in the years 2000–2005, half of all child deaths in the country will be due to AIDS.

As in Zambia, by the end of 1997, there were some 360,000 children orphaned by AIDS – 7 per cent of all children under 15 – and the likelihood is that many more children will share this fate.

Early recognition of the problem

The orphan crisis in Zimbabwe first drew national attention in July 1992, when the Government of Zimbabwe's Department of Social Welfare coordinated a national conference on orphans, with support from UNICEF. At that time, it was recognized that a small number of NGOs and CBOs had already begun to strengthen their own responses to the increasing number of orphans. It also became clear that compared to institutionalization, community-based care was cost-effective and, because it kept children in a familiar social, cultural and ethnic environment, reduced their distress.

In 1995, the Government of Zimbabwe developed a National Policy on the Care and Protection of Orphans, which was finally approved by the Cabinet in May 1999. The Policy reaffirmed the position that orphans should be placed in institutions only as a last resort.

By the mid-1990s, the Department of Social Welfare had begun piloting three models of Community-based Orphan Care: a rural, urban and commercial farm model. Today, 30 communities are at various stages of implementing one of the three models.

The Chief Charumbira Community-based Orphan Care Programme in Masvingo Province

The rural model of Community-based Orphan Care was launched in Masvingo District in Masvingo Province in 1994. This district of 165,879 people is divided into three areas and 94 villages and governed by traditional leaders: Chief Charumbira, sub-chiefs and village leaders. The Orphan Care Programme was structured to utilize the traditional roles and responsibilities of these leaders, who have the authority to mobilize their people and resources in times of crisis and emergency.

Chief Area Committees, composed of the area sub-chief, advisors and village leaders, were established in each of the three areas. These Committees address policy and planning issues and also unify and guide village activities. Local activities are carried out by Village Committees, made up of village leaders and five members of the community. Most of their work is done through community volunteers.

Three phases of Zimbabwe's Community based Orphan Care Projects:

Phase One: Assessing the situation.
During the first phase of the project, data is collected to determine not only the number of AIDS orphans and other children in need of special protection living in the district, but also who is caring for these children and how they are living.

Phase Two: Increasing awareness of the problems affecting AIDS orphans and children in need of special protection.
The data and research collected during the first phase is used to raise awareness of the plight of orphans throughout the community. Communities are encouraged to discuss their problems and share their experiences in order to develop possible solutions.

Phase Three: Strengthening communities.
Communal projects and activities in this phase aim to improve the capacity of caregivers to provide economically for the children under their care.

The Village Committees report to the Chief Area Committees who report to the District Development Committee (DDC) through its Social Services subcommittee. Through the DDC, the community-based structures for orphan care are linked to the formal government. This referral system enables the Government to understand better the needs of the community and gives communities the ability to influence state policy.

Jean, 3, a Rwandan boy who lost both parents to AIDS, nestles against his grandmother, who cares for the boy and his two sisters.

UNICEF/97-1031/Pirozzi

Assessing the problem

The Area and Village Committees are responsible for counting orphans. They are trained by members of the Child Welfare Forum, already established in their districts and provinces, to identify all orphans and other children needing protection and to record them in their registry. The registration process is ongoing and all orphans are registered irrespective of whether or not they need assistance. Information recorded on each child includes name, date of birth, address and nearest school, names of deceased parents, names of caregivers, as well as any particular problems the child is having. Committee members are also trained to refer children to appropriate agencies when their needs cannot be met by the Committees. If a request is beyond the capabilities of the Area Committee, the case is referred to the State through the Social Services subcommittee of the DDC. Both the Village and Area Committees keep records for follow-up and accounting purposes.

It became clear during the first phase of the Programme that extended families were playing a crucial role in caring for orphans. Of 11,514 orphans and children needing protection counted in the Masvingo and Mwenezi Districts, over 11,000 of them were being cared for by relatives living in the community.

The majority of caregivers were women, widowed and over 50 years old. Often, they were the children's

grandparents (frequently their grandmothers). Most of the caregivers had not inherited anything, pointing out there was nothing to inherit. Perennial drought worsened their situation.

Organizing the community

Once the data were collected, meetings with local chiefs and village headmen, church leaders, party leaders, government officials and other interested parties helped to raise awareness of the problems associated with the large number of orphans.

Village Committees organized initiatives using community volunteers as their driving force. Villagers now ensure that orphans are properly fed, clothed and housed. Where possible, they see that school-aged orphans attend and remain in school. Volunteers have even taken on a child's household chores to enable the child to attend school. To help families pay for school fees, in 1995, the Village Committees asked community members to donate Z$1.00 (US$ .03) per household. The Z$2,000 that was raised paid fees for 18 primary school children. The next year, during the drought, households donated Z$2.00, raising Z$3,000. Villagers also pool their labour and monetary resources to develop communal gardens and woodlots to help generate income.

External support

In some cases, Village Committees have sought additional support from local NGOs, international NGOs, UN agencies and other donors to develop their income-generating activities. For example, some communities received funding to sink boreholes in their gardens to ensure a supply of water. In April 1998, an electric dehuller grinding mill was donated by the National AIDS Coordination Programme. Other assistance has come from Africa Groups of Sweden who trained volunteers in home-based care for the terminally ill.

Challenges for the future

The three models for Community-Based Orphan Care – rural, urban and commercial farm – depend upon strong leadership and an unflagging commitment from the community. But as the projects in Masvingo and Mwenezi Districts demonstrate, communities are willing to absorb and care for their orphaned children. The Committee structure ensures that the chiefs and leaders share power and responsibility equally, thus minimizing conflicts. Furthermore, the Committees are effectively linked to official state machinery, ensuring that communities are provided with the technical support they need in a timely manner.

But communities cannot shoulder the burden without support. Many of the volunteers are poor themselves and most income-generating projects are very rudimentary and do not generate sufficient income. There is a

Zimbabwe's orphan policy

Zimbabwe's policy on care and protection of orphans was drafted in 1995, but Cabinet approval was delayed due to the financial implications of the policy on the national budget. The Cabinet finally approved the policy in May 1999. Its main tenets include:

- Care of orphans in institutions should be only a last resort and should be temporary.
- All children, including orphans, should receive education, and there should be laws and guidelines to enforce this right.
- The property rights of orphans should be safeguarded by legislation.
- The care and protection of orphans must comply with the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

Implementation of the national policy at the local level is the responsibility of local government, communities and NGOs working in partnership.

Zimbabwe has one of the worst AIDS epidemics in the world... by the end of 1997, there were some 360,000 children orphaned by AIDS – 7 per cent of all children under 15 .

strong need to build and strengthen business acumen among community members.

Additional resources are needed for community-based care to be replicated on a national scale. To go to scale, the Department of Social Welfare, the coordinating agency, must have a committed and stable presence in the district. At the moment, however, the Department has a small staff and limited resources and doesn't have the capacity to assume this role in all districts. Furthermore, the Government has not yet allocated the resources to replicate this programme nationally. ■

The Farm Orphan Support Trust (FOST) of Zimbabwe

Farm workers in Zimbabwe are multi-ethnic. Many are immigrants or the children of immigrants, and many more are Zimbabweans who have moved from their native villages. Families are therefore often isolated from their extended family networks and no longer have any regular contact with their families back home, leaving children with no one to take care of them if their parents should die.

In 1986, the Farm Orphan Support Trust (FOST) of Zimbabwe was set up as a community response to the situation of orphans in commercial farming areas. On FOST's executive committee there are representatives of the farms – both employees and employers – from Government, academic institutions, churches and NGOs. FOST aims above all to keep sibling orphans together, within a family of the same culture and in a familiar environment. It operates foster schemes on farms, using farm development committees to train caregivers, establish monitoring procedures and raise community awareness. All the farms register orphans individually and send biographic information to a central computerized data bank. This procedure helps in tracing relatives.

FOST promotes five levels of orphan care. Its most preferred is within the extended family. If that is not possible, orphans are to be placed within substitute families. After that, small groups of orphans will live together on a farm, looked after by a carefully chosen caregiver employed by the farm for the purpose. The next most preferred type of care is an adolescent child-headed household with siblings remaining together, preferably in the family home. Here they are cared for by the eldest child with the regular supervision and support of the farm's Child Care Committee, the community and the local field officer. Finally, FOST will arrange for temporary care in an orphanage, until a better solution can be found.

Children at a centre in Nairobi, which provides a temporary home for HIV-positive children and those orphaned by AIDS.

UNICEF/98-1123/Pirozzi

Conclusion

The AIDS epidemic will not diminish until discrimination, including persistent gender bias and inequity, is eliminated. Throughout the world, but particularly in sub-Saharan Africa, the ratio of female to male AIDS cases is rising.

Responses to the crisis of orphans in eastern and southern Africa, such as those initiatives described in the previous section, are still nascent and in no way commensurate with the enormity of the problem. Human, financial and organizational resources are needed on a massive scale if affected countries are to prevent this crisis from completely overwhelming health, education and other basic services and from breaking down millions more families and social support systems. For countries in the region, already characterized by underinvestment in social services, the impact of AIDS on social services has been catastrophic.

The obstacles remain formidable. Poverty, conflict and the very rapid spread of HIV infection itself have all severely limited the range of options for action. In addition, many government leaders and policy makers have been reluctant to face up to the full extent and urgency of the HIV/AIDS pandemic and to communicate these to the public. As a result, denial persists throughout societies, made worse by the general unavailability of voluntary and confidential HIV counselling and testing facilities. UNAIDS estimates conservatively that nine tenths of those infected in eastern and southern Africa do not know they have HIV.

In such a climate, discrimination also thrives. Lack of knowledge breeds unfounded fears that the virus can spread through casual contact and heightens the opprobrium meted out to those suspected of having the disease. As a result, many infected people are too ashamed and frightened to admit their illness. When they courageously break the silence, they may pay dearly, enduring beatings, being thrown out of their homes, deprived of their children and even murdered.

The AIDS epidemic will not diminish until discrimination, including persistent gender bias and inequity, is eliminated. Throughout the world, but particularly in sub-Saharan Africa, the ratio of female to male AIDS cases is rising. Teenage girls are especially vulnerable. The protection of the rights of girls and women is critical in the context of AIDS, especially their right to set the terms of their own sexual activity, including its safety, and to refuse sex altogether. And the responsibilities of boys and men to respect these rights need strong emphasis.

Also incommensurate with the enormity of the AIDS problem are the resources to deal with it. Against a backdrop of poverty aggravated by global trends, debt and miscued budget priorities, AIDS programmes are simply starved of resources. A recent UNAIDS-funded study concluded that the epidemic is expanding three times faster than the resources to combat it. Total spending on AIDS in Africa, which goes largely to prevention, is some $150 million a year – no more

than the annual budget of a small hospital in Western Europe. Barely a tenth of that sum comes from national budgets in the region. And even more resources will be required if small initiatives are to be taken to larger scale.

Under the Convention on the Rights of the Child, States have a duty to act in the best interests of children when allocating the resources available in the society, no matter how small the total amounts. The State must also demonstrate good faith by being able to show that actions have been taken to give children the priority they deserve.

I. What can individual countries do to help affected children?

There are no quick fixes to any of the challenges brought on by AIDS, and problems associated with the large numbers of orphans are no exception. First and foremost, national governments have a responsibility to create an environment where children can realize their rights, including those to survival and development, to the highest attainable standards of health, to education and to protection from abuse and neglect. There are a number of measures that governments can take to protect the rights of children and women in the AIDS crisis:

1. Mobilize political will and reallocate national resources

Strategic action should:

- Invest in poor communities.
- Allocate resources more fairly.
- Increase investment in basic social services, especially education.
- Involve all sectors.
- Coordinate action centrally.

A forthright commitment at the highest political level is a first and vital step in dealing effectively with the AIDS crisis. Uganda set an example of this commitment in the 1980s

Government commitment to AIDS education and prevention efforts for young people is crucial. Here, a Burundian girl in a Bujumbura primary school holds up a t-shirt that reads "We are taught and we teach AIDS prevention."

UNICEF/95-0251/Davies

Only by investing in poor communities can the AIDS challenge be met, as AIDS disproportionately affects the most poor and disadvantaged in developing countries.

and throughout the 1990s, and more recently countries such as South Africa and Botswana have followed suit. Visible and influential leadership is essential to help societies overcome the fear and stigma associated with HIV infection.

This strong leadership must be backed with resources. Only by investing in poor communities can the AIDS challenge be met, as AIDS disproportionately affects the most poor and disadvantaged in developing countries. Governments need to spend more on these communities but they can go a long way towards meeting the fundamental needs of their people by allocating existing resources more fairly. This can be done by channelling a higher percentage of available resources into basic social services such as basic education, primary health care, nutrition and low-cost water and sanitation. Studies have shown that investing in these services benefits the poor more directly than investing in high-end social services such as secondary education or advanced health care.

Since AIDS has wide-ranging effects on a country's education and social welfare systems, religious institutions, agricultural production, private businesses and community groups, coping with its impact requires the cooperation of many sectors. It is essential that policies, technical support, information campaigns and health and social services be coordinated among the actors. Establishing a central and high-level coordinator for national policies – preferably from a powerful office such as the Office of the President or the Ministry of Finance – is an important step to ensure accountability and follow-through on commitments.

2. Bolster the capacity of families and communities to care for and support orphans

Strategic action should:

- Ensure access to basic services.
- Provide assistance through specially targeted programmes
  - child-care services
  - income generation
  - credit/loans
  - food production
  - psychosocial support.

Families provide the best environment for bringing up children and if adequately supported they will be best able to provide the care that children orphaned by AIDS require. This support must encompass improved access to basic services, including health care, safe water and sanitation, and education, as well as assistance with childcare. Policies need to be designed to prevent families with orphans from sinking into deep poverty. These may entail support for income-generating activities, small business cooperatives, vocational training and micro-credit schemes.

Keeping orphans in school is especially crucial in breaking the poverty cycle.

Also key for families is receiving the emotional support and encouragement that will help them deal with current problems and plan for the future. This psychosocial support can be provided by other family members, friends, community members or organizations and is an essential part of home-based care.

Countries that have relied on institutions to care for their orphans have learned that orphanages are not the answer. Expensive to build and maintain, orphanages remove children from their communities and extended families. These and other institutions set up to care for children can have catastrophic consequences on children's emotional lives and development. And when institutions are no longer able to absorb growing numbers of orphans who have no other support systems, some children end up homeless and hungry on the street.

A group of quarry workers in Malawi watch a video on AIDS prevention.

UNICEF/93-1223/Andrew

NGOs, churches and community-based organizations are often the first to respond to the needs of communities affected by AIDS.

3. Stimulate and strengthen community-based responses

Strategic action should:

- Support NGOs and community-based partners with
  - technical assistance
  - policy and planning guidance training
  - resources.
- Identify and strengthen community-based care and support to
  - substitute or foster care families
  - child-headed households
  - orphanages, which play a transitional role.
- Make use of the formal welfare system.
- Promote exchanges of information about experiences.
- Bring small initiatives to larger scale.

NGOs, churches and community-based organizations are often the first to respond to the needs of communities affected by AIDS. They are best placed to identify not only vulnerable children and families but also the best ways to provide them with long-term support.

These organizations have strong motivation and commitment, and their projects, though often small in scale, can have enormous impact. There are two ways in which the good work of these organizations can be supported and magnified. First, some of the less experienced organizations should receive training, policy guidance and management and financial support, essential to help communities assess and analyse problems, formulate appropriate actions and determine what resources are necessary. As was demonstrated in Malawi and Botswana, governments at the local and district as well as national levels can provide such support.

Second, NGOs and CBOs undertaking small or pilot projects can be helped to identify the best practices and implement them on a larger scale. UNICEF and other UN agencies may be particularly well placed to help organizations identify and replicate success stories and to analyse lessons learned. Donors and international NGOs also play an important role in this regard and in supporting community-based initiatives with technical and financial support. When attempts are made to replicate experiences in other settings, affected communities should identify how best to adapt them to their own situation.

Community-based responses to children orphaned by AIDS include:

- *Substitute or foster care families* who can care for children when family members are not available on an informal or formal basis.

- *Family-type groups* comprising orphaned children living together in

a family unit and cared for by a carefully selected, paid caregiver.

- *Support to child-headed households* consisting of children 'parented' by an elder sibling.

- *Orphanages*, which are the least desirable option for reasons stated above.

As shown in Zimbabwe, such community-based interventions can be strengthened when integrated into a country's formal social welfare system. Such integration helps ensure that community groups receive timely technical expertise and support and also have a voice at higher levels that might not otherwise be heard.

4. Ensure that governments protect the most vulnerable children

Strategic action should:

- Obtain political commitment.
- Promote and protect children's human and legal rights.
- Review and reform laws and policies dealing with children.
- Monitor the impact of AIDS on children.

Concerted efforts are essential for children orphaned by AIDS, who are more vulnerable than children orphaned for other reasons, largely because of the stigmatization and discrimination they suffer. It is important

Children orphaned by AIDS are more vulnerable than children orphaned for other reasons, largely because of the stigmatization and discrimination they suffer.

UNICEF/96-1424/Pirozzi

to ensure that the rights of such children are respected, that their living situations are secure and that health and education services are available to them.

Governments have an obligation to review and reform laws and policies dealing with children and women, especially the most vulnerable. This is crucial in the case of AIDS, where deaths in the family commonly leave orphans and widows at risk of losing their inheritance and property rights – often their major sources of income and food. Laws may exist to protect children and women, but these sometimes marginalized members of society may be unaware of the laws or have no channel to take advantage of them, making strong advocacy in this area essential.

Governments also need to monitor the impact of HIV/AIDS on children and families, to plan interventions and determine their effectiveness. Accurate information on the numbers of children orphaned, where they are, the circumstances of their lives and the nature of their needs is vital. As an advocacy tool, such information can also help raise awareness about the social impact of AIDS and promote realization of children's rights.

Governments should take strategic action to develop alternative education programmes. Children drink water from a handpump in a non-formal community school in Zambia.

UNICEF/96-1223/Pirozzi

5. Build the capacity of children to realize their rights and fulfil their needs

Strategic action should:

- Support psychosocial and family counselling.
- Enable children to obtain education and training through
  - sponsorship programmes developing non-formal and alternative education programmes
  - empowering children through life skills programmes.

It is essential to address the emotional needs of children devastated by their parents' deaths from AIDS. Commonly, children orphaned by AIDS not only

watch their parents die but often nurse them through a long period of wasting disease, which may include incontinence, depression and dementia. A child's grief and depression are often hidden and remain unrecognized. Where possible, emotional support through individual and family counselling should be given to children as well as to their families before the parents' death. Parents with HIV or AIDS must also be helped to come to terms with their approaching death and to plan for their children's welfare.

Assistance to families prior to parents' death should also encompass practical help for the household in such areas as nursing care, food production and preparation, and upkeep of the home.

This psychosocial support needs to be accompanied by assistance for education and training in income-generating skills, both of which foster self-reliance. Such assistance may go directly to families and children or to non-formal or alternative education programmes benefiting part-time students.

II. What can the global community do?

Improved access to quality education and information about sexual and reproductive health should be a priority. Life skills, such as those taught in Zambia's Chikankata programme, are a particularly important part of this effort. Children, especially those orphaned by AIDS, need skills that will help them avoid being exploited sexually or legally. Such skills, which should be culturally sensitive and appropriate to the children's age and maturity, include:

- How to make sound decisions about relationships and sexual intercourse.
- How to resist pressure for unwanted sex or drugs.
- How to recognize and avoid or leave a situation that might turn risky or violent.
- How and where to ask for support and obtain access to youth-friendly health services.
- How to negotiate for safer sex, including protected sex.
- How to obtain information, advice and assistance regarding human rights, including legal rights such as inheritance.
- How to care for people with AIDS in the family and community.

A global response to AIDS needs to reinforce the entire spectrum of children's rights and help change the underlying conditions of underdevelopment, poverty and rural/urban inequities that so severely limit the ability of people and nations to cope with problems and develop their potential.

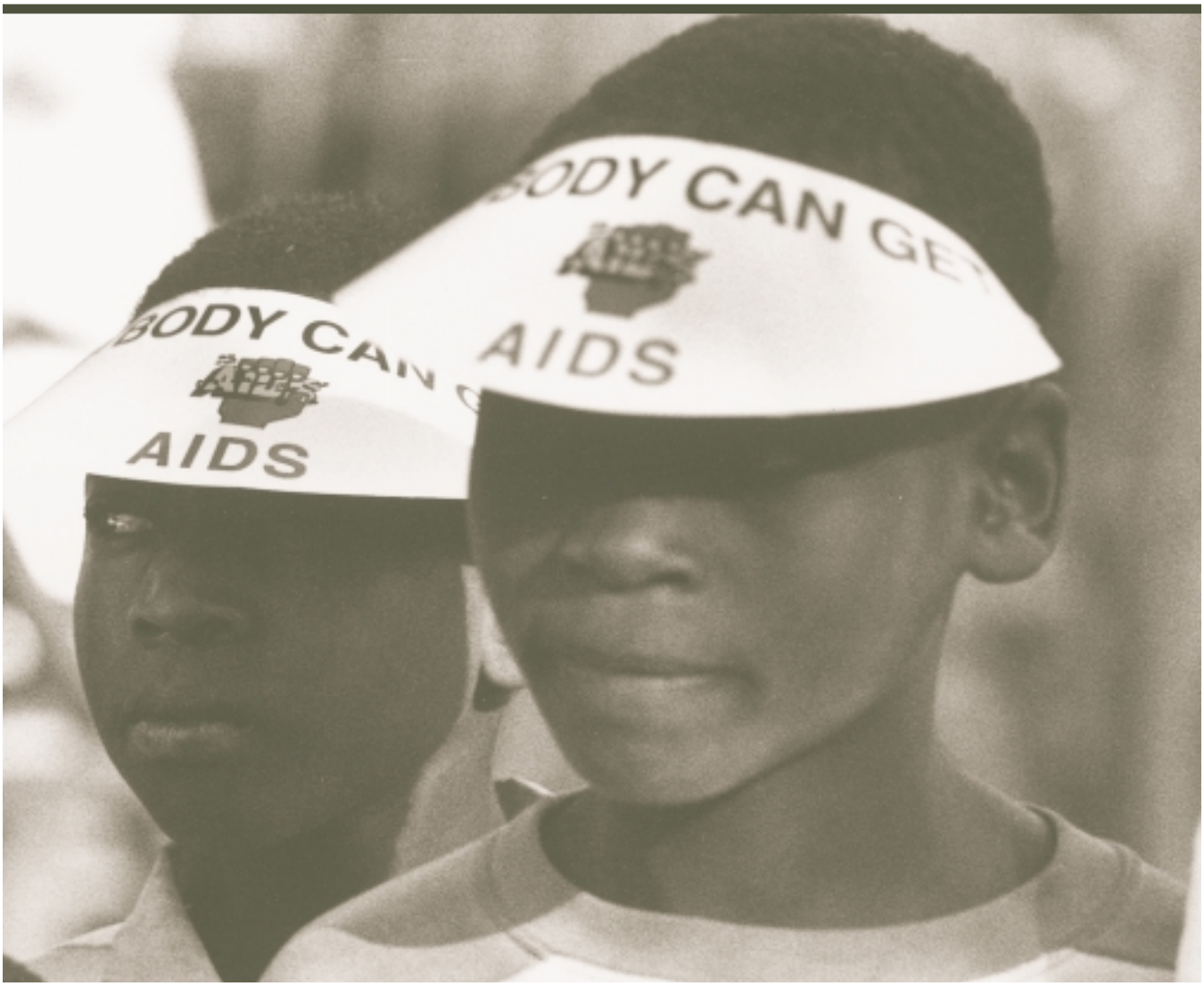
Strategic global action should:

- Increase needed resources to the most-affected regions.
- Support sustainable development.
- Support and promote the Convention on the Rights of the Child, including children's right to be protected from discrimination.
- Financially support local projects and interventions helping children orphaned by AIDS.
- Highlight the AIDS crisis, including orphans, in sector-wide programmes.

One tangible and important measure would be for the donor community to halt and reverse the plunge in official development assistance (ODA). In 1997, levels plumbed new depths, falling to the lowest average ever, of .22 per cent of donor GNP, at a time when global wealth was growing rapidly.

If the world renewed commitment to increasing this assistance – in 1970 countries had agreed to an aid target of .7 per cent of donor GNP – sustainable development could be accelerated and poverty reduced. These enhanced levels of ODA could go towards strengthening basic social

AIDS is a global emergency. As the visors worn by these Kenyan children proclaim, "Anybody can get AIDS".



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services, especially education, as well as HIV prevention and support for orphans, through such measures as the 20/20 Initiative.

Among the steps the global community can take are:

1. Declare a global emergency
The AIDS pandemic has turned sub-Saharan Africa into a killing field, creating an orphan crisis of epic proportions requiring nothing less than an emergency response. Political leaders, international agencies and national and international NGOs need to increase awareness of the scale and urgency of the AIDS orphan situation.

2. Exchange information
Exchanging information about successful experiences and projects can spark and guide action among neighbouring countries. International and governmental development agencies, as well as NGOs, can play an important role in facilitating such cooperation and exchange.

3. Keep Africa high on the development assistance agenda
Official development assistance to Africa, in decline for a number of years, needs to be increased along with support from private foundations and other sources. Resources are needed of a magnitude that can help bring successful actions to national scale. And they must be allocated with a regularity that governments and other actors can count on. These resources can go a long way, as there is a vast well of experience to guide actions in sub-Saharan Africa, from the community level on up. These actions should aim to improve access to services and promote other measures to strengthen families and communities in the struggle against HIV/AIDS.

4. Make AIDS a priority in poverty reduction through debt relief
While increased ODA to Africa is crucial, it is clear that addressing the crisis of HIV/AIDS and orphans will require greater resources than bolstered ODA could offer.

Debt relief provides one avenue for such large-scale resource mobilization, particularly since sub-Saharan African countries are disproportionately burdened by debt. With AIDS-exacerbated poverty, debt is a major stumbling block to improving basic services. A 1998 UNICEF-UNDP study of 12 countries in sub-Saharan Africa showed that 7 of them spent more than 30 per cent of their national budgets on debt-servicing but only between 4 and 20 per cent of their budgets on basic social services.

Through the HIPC Initiative, initiated by the World Bank and International Monetary Fund in 1996, a few countries in Africa have obtained debt relief, but the relief is too little and too late. To improve the Initiative, the major industrialized

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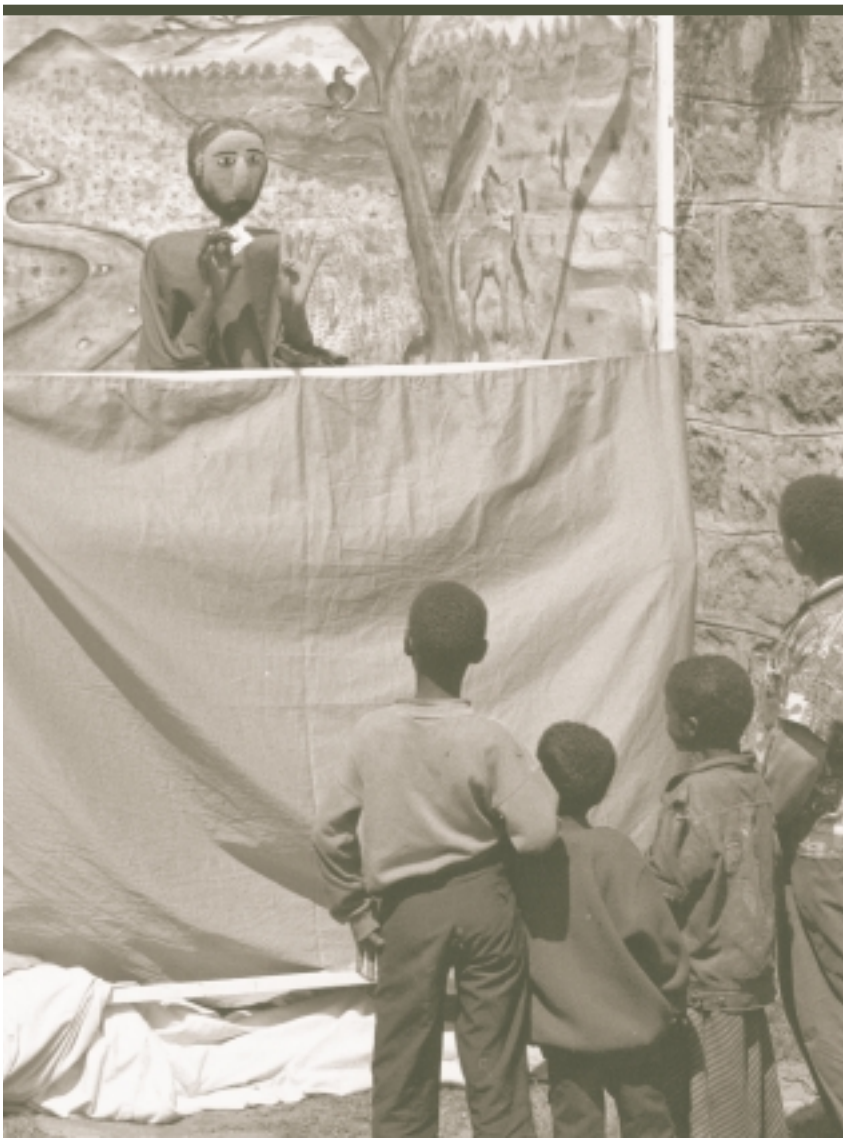
African governments and their development partners are increasingly allocating resources to social sectors. Here Ethiopian children enjoy a puppet show on health education and AIDS prevention.



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countries advocated for accelerated debt relief, particularly for Africa, at their June 1999 summit in Cologne, and there is clear agreement amongst all creditors and most debtor governments that debt relief should be strongly linked to poverty reduction.

The UN system, including UNICEF, UNAIDS and key partners, must work with governments to ensure that the poverty-reduction plans linked to debt relief include significant contributions to the struggle against HIV/AIDS, including service provision for orphans and other children affected by the pandemic.

5. Make HIV/AIDS a priority in sector-wide approaches to development

African governments and their development partners are increasingly allocating resources to social sectors, especially education, health and water and sanitation, through the mechanism of sector-wide approaches (SWAPs) or sectoral investment plans (SIPs). In these schemes, governments, in consultation with partners, define objectives and strategies for sectoral support, and all parties apply their resources to this common plan or strategy rather than carrying out independent projects. World Bank sectoral lending is an important part of this sector-wide approach in many African countries. It is essential that social service needs associated with HIV/AIDS, including those of greatest relevance to orphans, be accorded high priority in sector-wide approaches. This prioritization of HIV/AIDS should be the focus of advocacy and policy development efforts of UNICEF and other UNAIDS co-sponsoring agencies partaking in sector-wide discussions and planning.