LIST OF TABLES AND FIGURES

ACKNOWLEDGEMENTS

The publication of this monograph was funded by the Ford Foundation. Their generous assistance is gratefully acknowledged.

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GLOSSARY

CBO	Community-based organisation
CDG	Care Dependency Grant
CSG	Child Support Grant
CSIS	Centre for Strategic and International Studies
FCG	Foster Child Grant
HACI	Hope for African Children Initiative
HSRC	Human Sciences Research Council
ILO	International Labour Organisation
IOM	International Organisation for Migration
MTCT	Mother-to-child-transmission
NGO	Non-governmental organisation
REPSSI	Regional Psychosocial Support Initiative
SADC	Southern African Development Community
SALSS	Statistics on Living Standards and Development Survey
SAYP	Survey of Activities of Young People
UCOBAC	Uganda Community-Based Association for Child Welfare
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
VSI	*Vijana Simama Imara* – Youth Standing Firm

EXECUTIVE SUMMARY

HIV/AIDS is acknowledged as an increasingly significant humanitarian and developmental concern. It is also increasingly seen as a security issue, with implications for the well-being of individuals, households, communities and states. Faced with the prospect of growing numbers of AIDS orphans, some analysts have speculated that large numbers of orphans could themselves represent a security challenge.

It has been argued that by reducing the resources available to children and destabilising the institutions on which they depend—such as the family, school and community—HIV/AIDS may severely affect children's development. This may not only result in increased child mortality, morbidity and school drop out, but also increased victimisation and exploitation of children. By reducing the financial and emotional resources available to children, causing trauma and alienation and effectively limiting the realistic aspirations of the youngsters affected, it is also feared that the epidemic may create generations of disenfranchised and potentially dysfunctional young people who lack the socialisation necessary for constructive social engagement. Growing numbers of marginalised children may in turn impact on stability and security in at least two ways: they may become both the victims and perpetrators of crime; and may provide a ready recruitment pool for individuals and organisations wishing to challenge the existing status quo.

Most of these arguments are, however, based on a particular vision of what orphanhood generally entails. The picture painted conjures up images of hordes of traumatised, unwanted children being cast to the very fringes of society; suffering wanton neglect and abuse and, ultimately, being left to fend for themselves in a world where life is often 'short, harsh and cheap'. This vision itself is based on a number of assumptions, including that:

- the HIV/AIDS epidemic will result in large numbers of children being left in vulnerable circumstances;

- the experience of children affected and orphaned by HIV/AIDS will generally be qualitatively different from that of other children; and

- large-scale orphaning will result in large numbers of scarred and marginalised children who will be unable to become healthy, productive adults capable of contributing to and running healthy societies in the future.

The aim of this monograph is to examine such assumptions by exploring both the context in which HIV/AIDS orphaning is occurring and the likely developmental implications of both HIV/AIDS and AIDS-related orphanhood. In so doing it seeks to better understand both what it means to be a child in Southern Africa and the factors affecting the interplay between HIV/AIDS, poverty and vulnerability. Key issues raised in the monograph include:

- *Many children are not raised in ideal, stable family environments:* Irrespective of HIV/AIDS, large numbers of children grow up in single-parent households, usually headed by women, and fathers are often absent. Levels of fosterage are high and the reality of children being sent away from their natal home in order to access care or resources is not new.

- *Orphanhood is a complex phenomenon:* While orphaning is on the increase, and will have risen exponentially in most countries in the region by 2010, relatively few children would presently seem to be living in situations of extreme vulnerability. Indeed, although increasing numbers of orphans are beginning to place stress on traditional coping mechanisms such as the extended family, they are still remarkably intact and surprisingly small numbers of children have so far found themselves without the support they provide. Children are most likely to be orphaned during adolescence and often have a surviving parent, usually their mother.

- *It is often difficult to determine where the effects of HIV/AIDS begin and end:* Many children in the region are going to be negatively affected by HIV/AIDS. Children may experience a range of impacts including economic need, reduced levels of care, poor health and nutrition, new responsibilities and work and school drop out, as well as psychosocial impacts such as abuse, trauma, stress and a loss of social connectivity. They may also be placed at greater risk of infection. The effects of the epidemic on children are, however, not only likely to vary considerably by age, but high levels of

ambient poverty often makes it difficult to determine the causality of these effects. The conditions in many poor communities mean that few, if any, of these effects are specific to children affected by HIV/AIDS and it is impossible to isolate the effects of conditions that pre-date the death of a caregiver. It is also clear that HIV/AIDS increasingly affects almost everyone in severely affected communities, even households without HIV-positive members.

- *'Affected' children are not habitually treated differently to 'unaffected' children:* Although some orphaned and fostered children are abused, mistreated, exploited or abandoned, most studies suggest that children are generally not treated differently by caregivers on the basis of their orphaned or fostered status. Measured largely in terms of educational enrollment, most evidence suggests that relatives often go to considerable lengths to meet the needs of the children in their care, including borrowing money through informal networks and selling their own assets.

- *Not all children are equally vulnerable:* While some children are left in precarious circumstances as a result of parental illness and death, many children remain linked into support networks of various kinds. Children, such as those in child-headed households and street children, who at face value live in extremely vulnerable circumstances, often continue to benefit from some type of adult support. In some cases, child-headed households and street work may represent coping mechanisms developed in response to the HIV/AIDS epidemic.

- *Negative experiences do not necessarily result in negative psychosocial outcomes:* While HIV/AIDS stands to exacerbate the multitude of risks faced by children in poor communities, children are often remarkably successful in overcoming such difficulties. The impact of risk factors is mediated by a range of factors, including personality and temperament, learned coping style, age of exposure, the availability of caring adults and social supports in their environment and, critically, opportunities for recovery afforded by achievements, new relationships, changing circumstances and the like. The implications of negative experiences are thus as much a result of the circumstances surrounding the experience, and the way it is interpreted, as the nature of the experiences *per se*; and it is estimated that only about one-third of children exposed to severe adversity will suffer negative

psychosocial outcomes. Even where children do suffer negative effects as a result of their exposure to difficulties, studies suggest that they tend to show internalising rather than externalising symptoms in response to such impacts—depression, anxiety and withdrawal—as opposed to aggression and other forms of antisocial behaviour that may affect the security of communities and states.

- *Effective responses are being put in place:* Despite difficulties posed by the epidemic, communities throughout Africa have begun to add additional layers to their community safety nets by providing material, educational, emotional and psychosocial support to children affected by HIV/AIDS. A number of local, national and regional level initiatives have also been developed which have successfully helped to mitigate the psychosocial impacts of the epidemic on children and families. Such initiatives are still relatively few in number and have been limited in their reach and impact, but both illustrate that valuable, cost-effective responses can be, and have been, put in place and provide valuable lessons for scaling up effective responses to the epidemic.

These points suggest that while HIV/AIDS does indeed pose a notable humanitarian and developmental challenge, it is open to question as to whether the impacts of the epidemic will play out in such a way that children themselves pose a significant threat to stability and security in the Southern African region. Potential linkages between HIV/AIDS, insecurity and instability do exist and it is thus likely that a certain number of children affected by HIV/AIDS will suffer negative psychosocial outcomes. Some will be exploited, abused and victimised and will themselves perpetrate crime and violence. This is obviously undesirable and every effort should be made to address the underlying vulnerabilities that expose children to such conditions. Yet, not all children are equally vulnerable and there exist a number of factors that will determine whether children at risk suffer such outcomes. Moreover, in a context where levels of ambient poverty are already high, few if any of these outcomes will be confined to children affected by HIV/AIDS (even if such a category can be defined).

Mechanisms nevertheless need to be put in place to support both those children that do 'fall through the cracks' and the extended family that has up to this point proved so resilient. Community institutions, governments and

international agencies can and have put in place effective programmes. The lessons presented by such initiatives need to be heeded and decisive action taken by stakeholders at all levels to mobilise the human and financial resources necessary to implement such responses successfully.

CHAPTER 1

INTRODUCTION

Robyn Pharoah

With an estimated 38 million people living with HIV/AIDS worldwide,[1] the virus is acknowledged as a significant humanitarian and developmental challenge. It is also increasingly seen as a security issue, with implications for the well-being of individuals, households, communities and states. As argued by the Centre for Strategic and International Studies (CSIS):

> HIV/AIDS can be so pervasive that it assaults, as surely as prolonged armed conflict, the essence of the nation-state: secure families and communities; economic and political institutions; military and police forces. Children are orphaned, communities are decimated, fields go untended, and the risk of famine grows. The long-term effects of HIV/AIDS on macro-economic growth, productivity, food supply, and nutrition—and the precise interlinkages among these factors—are not yet well understood. What is clear is that the pandemic is reversing developmental gains achieved through major investments over the last 50 years.[2]

The problem of children left orphaned and vulnerable by HIV/AIDS has received particular attention. Increasing numbers of organisations are involved in researching, advocating for and supporting such children. Yet even as the global community has acknowledged the human tragedy that orphaning on the scale heralded by the HIV/AIDS epidemic represents, it has been speculated that large numbers of orphans may themselves represent a security challenge.

The impact of HIV/AIDS

In contrast to most other infectious diseases, HIV/AIDS does not impact most on the weak, the very young and the elderly. Individuals are most likely to contract HIV in their late teens and 20s, and due to the lag between contracting HIV and developing the symptoms of AIDS, are likely to become ill and die in their 30s and early 40s. In South Africa, for example, it is estimated that the

average age of those dying as a result of AIDS is 37 years.[3] This has several implications, not least of which is that individuals fall ill and die at a stage of their life when they should be contributing most to the household and national economy. They also fall ill during the years they are most likely to be having children, leaving them at risk not only of infecting their progeny but also being unable to care for and raise them.

The implications of this are diverse and are as yet being understood, but it is speculated that by debilitating and killing large numbers of parents, workers, civil servants and politicians, AIDS will increasingly undermine the foundations of human and economic development. In the absence of accessible, comprehensive responses to the epidemic, it is argued that Southern Africa and other hard hit regions of the world will experience growing socio-economic problems: the wealth and assets of many affected households will be reduced, economic productivity will decline, the quality, reach and responsiveness of government institutions and service delivery will be reduced, families will be broken up and the demographic structure of populations skewed. Such impacts, in turn, will affect households, communities and societies in a range of ways. Key consequences could include increased poverty, vulnerability, inequality, and declining life chances and choices for the generations to come.

Most relevant to the discussion at hand, it has been argued that by reducing the resources available to children and destabilising the institutions on which they depend—such as the family, school and community—HIV/AIDS may severely affect children's development. This may not only result in increased child mortality, morbidity and school drop out but also increased victimisation and exploitation of children.

Moreover, by reducing the financial and emotional resources available to children, causing trauma and alienation and effectively limiting the realistic aspirations of the youngsters affected, it is feared that the epidemic may create generations of disenfranchised and potentially dysfunctional young people who lack the socialisation necessary for constructive social engagement. In the words of Barnett and Whiteside:

> We are talking about unsocialised, uneducated, and in many instances unloved children struggling to adulthood. The costs to them remain unmeasured. The costs to the wider society are potentially enormous ... .[4]

Orphans, crime and instability

According to the literature, growing numbers of marginalised children may impact on stability and security in two ways. First, such children may become not only victims but also perpetrators of crime. Schonteich, for example, maintains that increasing numbers of children with fewer life chances and less support may lead to higher levels of crime. He argues that growing levels of poverty and vulnerability, the emotional trauma associated with AIDS-related parental death, reduced levels of parental guidance and control and the loss of positive role models may encourage not only victimisation of children but also delinquency and criminal behaviour. Schonteich also argues that an over-representation of young people, especially young men, between the ages of 15 and 24 in high-prevalence countries may create an environment conducive to higher levels of violent crime and group-based aggression.[5] Citing an American National Institute for Justice paper on violent crime, Schonteich notes that:

> Age is so fundamental to crime rates that its relationship to offending is usually designated as the 'age–crime curve'. This curve, which for individuals typically peaks in the late teen years, highlights the tendency for crime to be committed during the offender's younger years and to decline as age advances.[6]

The point that poorly supervised, traumatised and marginalised children may be more likely to become involved in both crime and 'anti-social' behaviour is also made by Steinberg and his colleagues, who argue that:

> Many orphans will grow up as street children or will form child-headed households to avoid being separated from siblings. Others will be brought up by grandparents with limited capacity to take on parenting responsibilities. All will have been traumatised by the illness and death of parents, and often by separation from siblings. Trauma will be exacerbated by stigma and secrecy ... that hampers the bereavement process and exposes children to discrimination in their community or even extended family. Orphans will probably be more susceptible to becoming HIV-infected through abuse, sex work or emotional instability leading to high-risk relationships. As children grow up in these pressurised circumstances, without adequate parenting, support and opportunities, they are at high risk of developing antisocial behaviour

> and of becoming less productive members of society. The consequences for affected children and society as a whole will be profound.[7]

The links between growing vulnerability and criminal behaviour are also highlighted by Oni and colleagues in their examination of the likely economic implications of the epidemic for rural households in South Africa's Limpopo province. They write that:

> Many of these children [orphans through HIV] may become destitute, hungry, exploited, and in some cases left completely vulnerable to all sorts of crime, including child prostitution and drug abuse.[8]

Second, they may provide a ready recruitment pool for individuals and organisations wishing to challenge the existing status quo. Considerably less has been written on this aspect of the orphan issue and the authors that do tackle this subject generally draw on the experiences of countries in Central and West Africa. Cheek, for instance, argues that orphans who are disconnected from social, economic and political support structures may constitute "'an extra national' population group, *who* could easily become tools for ethnic warfare, economic exploitation, and economic opportunism". He gives the example of Sierra Leone, where children marginalised by war were recruited into the Revolutionary United Front (RUF) with promises of food, alcohol, drugs and a sense of community—boys as 'child soldiers', girls as sex slaves to male fighters. Cheek writes that uneducated, malnourished and purposeless children represent "a potential army in search of a leader", which if exploited, could effectively destabilise most countries in Southern Africa.[9]

Zack-Williams, referring to his study of child soldiers in Sierra Leone, draws similar conclusions. He notes that where societies are under stress and governments have little to offer, orphaned children may easily take up arms, be recruited by millenarian cults or fall prey to unscrupulous politicians.[10]

As with many other analysts, Cheek also emphasises the threat posed by increased numbers of street children. Indeed, although his paper highlights the dangers presented by growing numbers of unsupported, disenfranchised children, there would seem an implicit assumption that the majority of these children will end up on the streets. Describing the implications of the epidemic for society Cheek argues:

> The implications for children are staggering. Those living with grandparents rarely attend school regularly. Many are malnourished. Those living on the streets lead nearly wild lives. Starvation, violence, crime, and sexual exploitation are 'normal' activities. Having already experienced death and the reality of survival on the streets, life for these children is short, harsh, and cheap. They exist in a world where money is begged or stolen, food is unreliable, education is irrelevant, and survival of the fittest is the norm. Their ties to civilisation and society are being eroded by the need to survive on terms they can not control.[11]

Later, describing the potential for children to be recruited into militant groups, Cheek writes of South Africa that:

> While no potential leader currently exists in South Africa, latent bitterness over economic disparity and ethnic/racial tensions provide adequate tinder in search of a spark. Even without a formal leader, [the prospect of] hundreds of thousands of street children terrorising Soweto/ Johannesburg, the Cape Flats/Cape Town, and Durban is frightening enough to draw international attention.[12]

Questioning the assumptions

Inherent in virtually all of these arguments is the idea that orphanhood, and AIDS-related orphanhood in particular, will often leave children in precarious circumstances; children will be damaged by the trials and tribulations they experience and will ultimately be less equipped to contribute meaningfully to or run healthy societies in the future. As argued by Bray in her critique of prevailing predictions of the consequences of orphanhood in Southern Africa:

> The logic is presented as a direct causal relationship that runs something like this: parentless children will grow up without role-models, and hence will lack social skills, a moral framework and discipline. Large numbers of children and young adults who do not have these qualities will precipitate a breakdown in the moral order and social fabric.[13]

Bray notes that underlying such supposedly causal relationships are a number of assumptions, including that: AIDS mortality rates will produce high numbers of orphans; these orphans will not live in social environments that will

adequately equip them for adult citizenship; the experience of such children will be qualitatively different from that of other children; poor socialisation will result in them not living within societies' moral codes (becoming street children or delinquents) and that large numbers of 'asocial' children will precipitate some kind of societal breakdown.[14] To this list I would add the assumption that children raised in difficult circumstances will almost inevitably suffer negative psychological, social and behavioural outcomes.

Yet, can we make such assumptions? Many of the arguments highlighted above are openly speculative in nature, are based on limited empirical data and would seem part of a growing body of advocacy-oriented literature aimed at raising awareness of HIV/AIDS as a potentially significant security (as opposed to health) issue. This they do admirably, but in the process do they perhaps paint an overly pessimistic and insufficiently nuanced picture of what HIV/AIDS may mean for children and society in the future? Will orphaning as a result of the HIV/AIDS epidemic necessarily result in large numbers of children being left in uncertain circumstances?

In a region where millions of children already live in varying degrees of poverty and vulnerability, and care arrangements seldom resemble the 'ideal' nuclear or extended family, will the experience of children affected and orphaned by HIV/AIDS be qualitatively different from that of other children? Will the epidemic necessarily result in large numbers of scarred and marginalised children, and what may make some children better able to weather the hardships created than others?

The objective of this monograph is to begin answering some of these questions. It is by no means a definitive analysis of the issues, but aims to contextualise the above arguments by exploring both the context in which AIDS orphaning is occurring and the likely developmental implications of both parental illness and death. In so doing it seeks to better understand both what it means to be a child in Southern Africa and the factors affecting the interplay between HIV/AIDS, poverty and vulnerability.

To this end, Chapter Two examines the psychosocial implications of HIV/AIDS for children, particularly the impact of parental loss and stressing of care and support systems. Chapter Three explores the characteristics that make some children better able to withstand adversity than others. It looks at the factors

that are associated with risk and resilience and, given the experience on which the risk and reliance literature is based, discusses the likely consequences of the epidemic for children and the societies in which they live. Chapter Four considers the support environment available to children in Southern Africa. It focuses on the interplay between informal mechanisms provided by the family and the community and formal support mechanisms provided by the state and the non-governmental organisation (NGO) sector, the implications of various models of care and how statutory agencies can strengthen family and community safety nets to cope with orphans and other children made vulnerable by HIV/AIDS. Chapter Five examines key issues that policy makers should be aware of in designing interventions to support children made vulnerable by HIV/AIDS. It then goes on to highlight programmatic responses used successfully to date in the region, before finally bringing together the lessons learned from such programmes. Chapter Six draws together the key lessons illustrated in the four papers, their contribution to the debate and main policy issues for the future.

Notes

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3 Families tipping into destitution, *Mail & Guardian*, 27 September 2002.
4 T Barnett & A Whiteside, *AIDS in the twenty-first century: Disease and globalization*, Palgrave Macmillan, Hampshire and New York, 2002, p 210.
5 See M Schonteich, AIDS and age: SA's crime time bomb, *AIDS Analysis Africa* 10(2), 1999, pp 1–4; M Schonteich, *A generation at risk: AIDS orphans, vulnerable children and human security in Africa*. Paper presented at a conference on Orphans and Vulnerable Children in Africa, Nordic Africa Institute, September 2001; R Pharoah & M Schonteich, *AIDS, security and governance in Southern Africa: exploring the impact*, Insititute for Security Studies Paper, 65, ISS, January 2003; M Schonteich, *HIV/AIDS, policing and crime in South Africa: exploring the impact*. Draft working paper for the CSIS Task Force on HIV/AIDS, CSIS, February 2003.
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7 M Steinberg, A Kinghorn, N Soderlund, G Schierhout & S Conway, HIV/AIDS: Facts, figures and the future, *South African Health Review*, Health Systems Trust, 2000, Chapter 15.
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9 R Cheek, *A generation at risk: Security implications of the HIV/AIDS crisis in southern Africa*, National Defence University, Institute for National Strategic Studies, Washington DC, 2000.

10 A Zack-Williams, cited in R Bray, op cit.
11 R Cheek, op cit, p 3.
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13 R Bray, op cit, pp 6-7.
14 Ibid.

CHAPTER 2

THE IMPACT OF HIV/AIDS ON THE DEVELOPMENT OF CHILDREN

Linda Richter

Introduction

This paper considers the psychosocial impact of HIV/AIDS—particularly the loss of caregiver support and the resultant stress on caregiving systems—on children's development and adjustment.

First, the paper reviews in general terms the expected effects on children in the domains of economic and food security, psychosocial care, education, health, family composition and stability of care. The close association between poverty and HIV/AIDS is then discussed and attention is drawn to the likely co-occurrence of HIV/AIDS, poverty, loss of caregivers and deprivation associated with deepening poverty. Finally, the argument is made that the impact on large numbers of children of the combined effects of poverty and HIV/AIDS—namely school drop out, child labour abuses and the sexual exploitation and trafficking of children—are likely to cause significant social disruption.

The potential impact of HIV/AIDS on children

There is growing research and programme literature on the impact of the HIV/AIDS epidemic on children. These impacts occur in a number of overlapping and interdependent domains, including children's psychosocial development. Some of these effects have been reviewed elsewhere[1] and the main points from these reviews are reiterated here as an introduction to considering the impact of HIV/AIDS on children's development.

- *Economic impact:* In several countries, income in orphan households has been found to be 20–30% lower than in non-orphaned households.[2] Studies in urban households in Côte d'Ivoire, for example, show that where a family member has AIDS, average income falls by as much as 60%, expenditure on health care quadruples, savings are depleted and families often go into debt

to care for sick individuals. Other studies have suggested that food consumption may drop by as much as 41% in orphan households.[3] Asset selling to pay for health care, loss of income by breadwinners and funeral costs may deplete all household reserves, as well as savings.

- *Migration* has been identified as an important family and community coping mechanism in the face of the HIV/AIDS epidemic. This is especially so in Southern Africa and, to a lesser extent, in Southeast Asia. Migration occurs for several reasons and people move both within and between rural and urban areas. Some identified forms of migration include 'going-home-to-die', rural widows moving to town to seek work or the help of relatives, and potential caregivers and dependants moving between kin households to achieve the most optimum care arrangements for all concerned. Children are frequently relocated. Adolescents are particularly affected by migration, as girls are sent to help out in other households, or as children are encouraged to try and fend for themselves by working—including street work.[4]

- *Changes in caregiver and family composition:* As a result of death and migration, family members, including dependent children, often move in and out of households. Caregivers change and siblings may be split up. Separation from siblings has not only been found to be a predictor of emotional distress in children and adolescents,[5] but children become more vulnerable when they are cared for by very aged relatives due to the conditions of mutual dependency that often exist between adult and child. Death and migration may also result in the creation of child-headed households. These are most likely to form when there is a teenage girl who can provide care for younger children, when there are relatives nearby to provide supervision, and siblings either wish to stay together or are requested to do so by a dying parent.[6]

- *New responsibilities and work for children:* Several studies have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents or caregivers become ill or die. In such circumstances, instances of work and responsibility being given to children as young as five have been observed.[7] Responsibilities and work in the household include domestic chores, subsistence agriculture and provision of caregiving to very young, old and sick members of the household. Work outside of the home may involve a variety of formal and informal labour,

including farm work and begging for food and supplies in both the community and beyond.[8]

- *Education:* In households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities, medication and health services. Even where children are not withdrawn from school, education often begins to compete with the many other duties that affected children have to assume. In addition, stigmatisation may prompt affected children to stay away from school, rather than endure exclusion or ridicule by teachers and peers. A study in Zambia, for example, showed that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children.[9] At a national level, a World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children by as much as 22% and secondary school children by 14% as a result of increased child mortality, and decreased attendance and dropping out.[10]

- *Loss of home and assets:* As effects on households deepen and parents die, children may suffer the loss of their home and livelihood through the sale of livestock and land for survival, as well as through asset stripping by relatives.[11] Loss of skills also occurs because fewer healthy adults are present in the household and/or are involved in livelihood activities.

- *Health and nutrition:* Children affected by HIV/AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet demonstrated increased morbidity and mortality among broadly affected children compared to unaffected control groups. In this regard, it has been suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic;[12] or alternatively, that orphans may not be worse off than peers living in extreme poverty. Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV/AIDS.

- *Psychosocial impact:* Affected and orphaned children are often traumatised and suffer a variety of psychological reactions to parental illness and death.

In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatisation as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of children's reactions suggest that they tend to show internalising rather than externalising symptoms in response to such impacts—depression, anxiety and withdrawal—as opposed to aggression and other forms of antisocial behaviour.[13]

- *Vulnerability to infection:* Apart from other impacts, children affected by HIV/AIDS are themselves often highly vulnerable to HIV infection. Their risk for infection arises from the early onset of sexual activity, commercial sex and sexual abuse, all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape. Some studies of street children, for example, show that vulnerable children do little to protect themselves from HIV infection because the pressures for basic survival—such as finding food—far outweigh the future orientation required to avoid infection.[14]

- *Long-term psychological effects of emotional deprivation:* Children who grow up without the love and care of adults devoted to their wellbeing are at higher risk of developing psychological problems.[15] A lack of positive emotional care is associated with a subsequent lack of empathy with others and such children may develop antisocial behaviours. Not all children are, however, affected or affected to the same degree. Protective factors—in the form of compensating care from other people, including teachers, as well as personality predisposition—may lessen the impact on children of reduced care in the home environment.

The listed effects of the HIV/AIDS epidemic on children are likely to vary considerably by age. One might expect preschool-aged children, for example, to show primary effects on growth and health, and school-aged children to show education, work, psychosocial and vulnerability effects. In addition, none of the effects cited have been shown to be specific to children affected by HIV/AIDS, even if such a category of children can be more precisely defined. It is also impossible to isolate and exclude the effects of conditions that pre-date the death of a caregiver. Such pre-existing or development influences include

poverty and social disorganisation, parental preoccupation, depression and social isolation.

Of greatest concern, however, is the generality of these effects and their strong association with poverty. The impact of the HIV/AIDS epidemic on children and families is incremental;[16] poor communities with inadequate infrastructure and limited access to basic services are worst hit. Poverty amplifies the impacts of HIV/AIDS on children and renders their effects on children unrelenting. At the same time, changes associated with the illness and death of caregivers and breadwinners can push children into conditions of desperate hardship. As John Williamson says:

> The common impacts [of HIV/AIDS] include deepening poverty, such as pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets. Psychosocial distress is another impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care.[17]

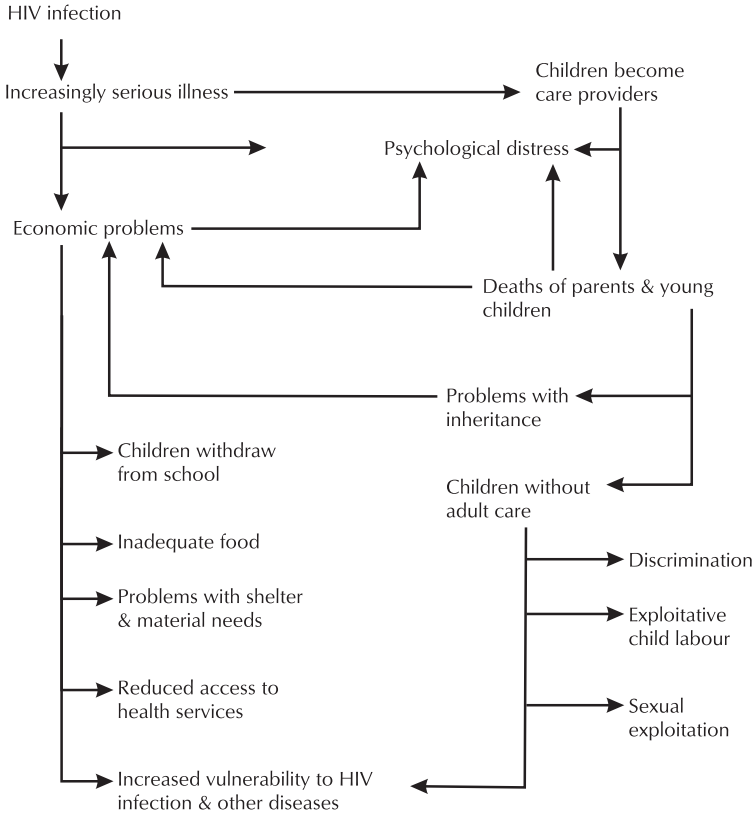
A model of the effects of HIV/AIDS on children has been developed, as reflected in Figure 1 (*over page*).

What data is available on affected children and what does it tell us?

There are three main sources of national level South African information on affected children. There is considerably less information from other countries, except from demographic and health surveys, on which estimates of orphans are based.[18] By affected children are meant orphans, fostered children and child-headed households. The term 'affected children' is also used to denote children living in households that have taken in orphans, who are sometimes referred to as co-residents. These children are affected in the sense that household resources are stretched by the increased dependency ratio created by additional children. This group of children is not, however, included here because there is limited information available about them.

The first source of data is the modelled increases in orphaning produced by the Actuarial Society of South Africa.[19] The second consists of the analyses of the

Figure 1: Problems among children and families affected by HIV/AIDS



Lippincott Williams & Wilkins, cited in Foster & Williamson, 2000.

1995–1999 October Household surveys, the 1998 Demographic and Health Survey and the 1996 Census done by Barbara Anderson and colleagues during her research residency with the Human Sciences Research Council (HSRC) in 2001–2002.[20] The third comprises data from the Nelson Mandela/HSRC Study of HIV/AIDS.[21]

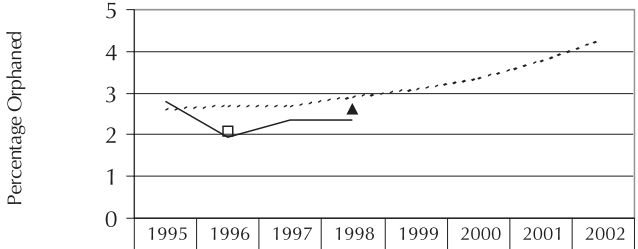
Orphans

Contrary to popular usage, where an 'orphan' is generally considered to have lost both parents, several definitions of orphan status are widely used in the

current research and advocacy literature. Maternal orphans include children whose mother has died, while paternal orphans refer to children whose father has died. The term 'double orphan' refers to children who have lost both parents. Some definitions also consider children whose mother is seriously or terminally ill as maternal orphans, as the inability of the mother to provide care in these situations results in children becoming *de facto* orphans despite their parents being alive. For the purposes of this paper, following the Joint United Nations Programme on HIV/AIDS (UNAIDS) convention, maternal, paternal and double orphans are defined as children under 15 years of age whose mother, father or both parents have died.[22]

Figure 2 shows the data presented by Barbara Anderson and her co-workers, including a comparison with predictions from the Johnson and Dorrington model. Table 1 (*over page*) shows the percentage of maternal, paternal and double orphans reported in both the Nelson Mandela/HSRC study and the 1998 South African Health and Demographic Survey. Both Figure 2 and Table 1 illustrate a relatively slow pick-up in orphaning, which begins around 1998, and shadows HIV infections by eight to ten years. Table 1 also indicates that orphaned children most often have a surviving parent, usually their mother. This finding is supported by other studies. Ainsworth and Filmer, for example, argue that because mortality among men is still higher than among women of comparable ages, close to 70% of paternal orphans in the region live with a surviving parent, their mother.[23]

Figure 2: Estimated and modelled percentage of orphans 1995–1999



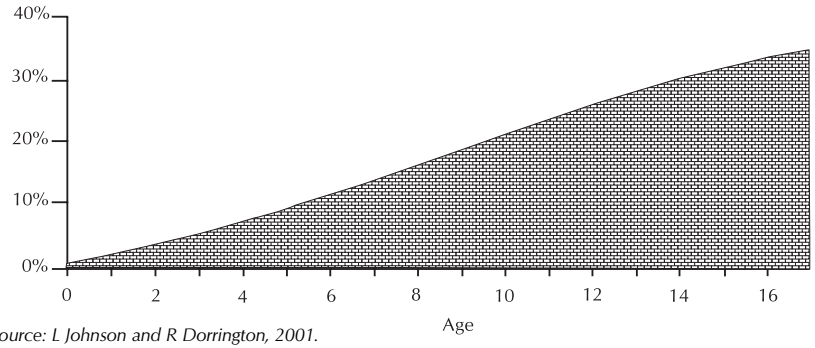
	1995	1996	1997	1998	1999	2000	2001	2002
October Household Survey	2.8	1.9	2.3	2.3				
1996 Census		2.1						
1998 SADHS				2.6				
Johnson & Dorrington Model	2.6	2.7	2.7	2.9	3.1	3.4	3.8	4.3

Table 1: Percentage orphans by age

	2002 NM/HSRC study			1998 DHS study
	2–9 years (n=1,722)	*10–14 years (n=1,157)*	*15–18 years (n=1,110)*	*<15 years*
Mother dead	3.6	2.2	4.0	2.1
Father dead	6.5	10.8	16.1	8.7
Both parents dead	0.5	3.5	3.9	0.7

Modelling by Rob Dorrington and his group at the University of Cape Town suggests that AIDS orphaning, defined as the death of a mother before the child's 15th birthday, is on a steep increase in South Africa. The number of orphans is predicted to peak in 2015 at about 1.85 million children, assuming no interventions to prolong the lives of parents and no changes in preventive behaviour. Figure 3 shows the percentage of maternal orphans under the age of 18, as predicted to occur in 2015.[24] The graph shows that the older a child is, the greater the chance that he/she will be an orphan.[25] Due to the association between child age and parental death, relatively fewer pre-school children will be orphaned as compared to older children, although loss of a mother at this young age may have the longest lasting effects on children. Between 20% and 30% of ten to 14 year olds, however, are expected to lose their mother, while more than 30% of young people over the age of 14 years are likely to be maternal orphans by 2015.

Figure 3: Percentages of maternal orphans by age in 2015



Source: L Johnson and R Dorrington, 2001.

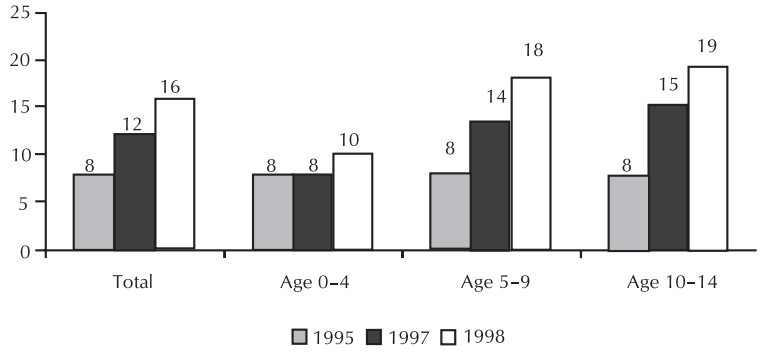
In *Children on the brink*, Hunter and Williamson provide regional information on orphaning calculated from data maintained by the United States (US) Census Bureau. This data suggests that the epidemic began earlier in Zambia, Malawi and Zimbabwe than in South Africa and, as a result, orphaning is peaking earlier in these countries. For example, they estimate that in 1990 approximately 2.6% of all children in South Africa were maternal or double orphans (all causes) as compared to 6% in Malawi and Zimbabwe and 8% in Zambia. By 2010 it is estimated that, with approximately 17% of children orphaned, South African will 'catch up' with Zimbabwe (19%) and exceed Malawi and Zambia (12%).[26]

Fostered children

Fostering refers to the presence of children who are not offspring of any of the adults in the household and whose biological parent(s) live elsewhere. However, although short- and long-term fostering is common throughout Africa, there is little quantitative information on the prevalence and effects of fostering on either fostered or co-resident children.

Figure 4 shows the rapid increase in fostering rates among three age groups of black children between 1995 and 1998, as found in the South African October Household surveys by Barbara Anderson and her group. Unfortunately, this data is difficult to interpret because available information suggests high levels

Figure 4: Children fostered between 1995–1998 by age



Source: B Anderson et al, 2002.

of baseline fosterage prior to 1995. Using the project for Statistics on Living Standards and Development Survey (SALSS) conducted in South Africa in late 1993, Kaufman, Maharaj and Richter[27] found that child fosterage in South Africa was high. Approximately 17% of black children aged 6–19 years were living apart from their biological parents, 12% of Coloured and just fewer than 5% of Indian and white children were also seemingly fostered. Most fostered children were grandchildren of the household head (60% and 53%, for black and Coloured children respectively). In addition, close to 30% of all black children and just over 20% of Coloured children, were living in a household with a fostered child or children. No definitive conclusions could be drawn about the impact of fostering on schooling, either among fostered children or co-resident children, assessed in terms of years of schooling and rate of progression through school.

Child-headed households

The only national data on child-headed households comes from the Nelson Mandela/HSRC study. This study found that between 1% and 2% of young people aged between 12 and 18 report that they are the head of the household in which they live. The study showed that young women were twice as likely to head a household as young men.

These figures should, however, be treated with some caution. There is ongoing debate about the meaning of both women-headed households and the criteria by which individuals are designated the head of the household. It is uncertain whether such designations are made on the grounds of moral authority, earnings, decision making or presence in the home and responsibility for day-to-day household functions. It is also not clear what level of responsibility is accorded, or expected of, people designated as household heads.[28] Given this debate, notions of what constitutes a child-headed household are even less clear. Teenagers have for many years looked after households in rural areas while mothers migrate on a weekly, monthly or longer-term basis to work as domestic workers in nearby cities and towns. Such figures also fail to reveal how many households consist only of children, or of the level and frequency of support available to them.

What are the implications of the information collected? On the basis of such data, a number of trends can be discerned. These include the following:

- Levels of orphaning vary across the region. Orphaning in South Africa is still at an early stage in the epidemic, although it is beginning to move up a very steep growth curve and will soon be comparable to neighbouring countries with more mature epidemics. While government and NGOs already feel the pressure from increased demands for services for orphans, the current level of orphaning in South Africa is less than a quarter of what it will become at its peak, without decisive intervention in the form of prevention and treatment. It is thus critical that plans are made and mechanisms of support devised at this early stage, to avert the potentially catastrophic effects associated with the precipitous rise in orphaning that is expected in the next decade.

- Children over the age of ten years are most vulnerable to becoming orphaned, but are a group neither specifically targeted by many current programmes nor by the increase in institutions to house affected children. For this older age group of children, family, community and school-based intervention is essential.

- As highlighted later in this monograph, fosterage and community-based family care are robust care mechanisms that have long existed in the region—both as a result of cultural practice and as a way of maximising family resources and access to education for children. Available national data does not indicate negative effects associated with fosterage, although Case and her colleagues argue that orphaned children who are fostered are at a distinct disadvantage in that they are less likely to attend school than co-resident children in the household.[29] Fosterage is a critical response mechanism and it is essential that comprehensive, targeted mechanisms are put in place on a very large scale to provide economic, social, legal and other support for foster families.

- Orphaned children most often have a surviving parent, usually their mother. The widespread absence of fathers and lack of support by men for families and children in South Africa is a major gap in potential resources for affected children. Statistics South Africa, for example, has estimated that close to half of all children under seven years of age live only with their mother, and fewer than half of all maternal orphans in South Africa live with their surviving father. In Zambia, where marriage rates are higher and fathers are more often present in the household, more than 65% of maternal orphans live

with their surviving father.[30] For this reason, the Child, Youth and Family Development research programme at the HSRC, in collaboration with the United Nations Children's Fund (UNICEF) South Africa, the South African Men's Forum and others, has launched a media and advocacy intervention to promote fatherhood.[31]

The need for a change in perspective

The intersection between HIV/AIDS and poverty necessitates a shift in perspective in approaches to meeting the needs of affected children. The familiar Introductory Psychology illustration of a figure–ground illusion shows that if you focus on the figure you see a chalice or vase; if you focus on the background, you see face-to-face profiles. The lesson from this illustration is that we respond to what we see, but it is possible to see things differently.

In the current situation, we can either focus on the HIV/AIDS epidemic and its impact on children (what I consider to be the existing foreground), or we can focus on the background—the pervasive and increasing poverty of certain vulnerable groups of children. The change in perspective necessitates a switch in the perceived scope and scale of the required response. An emphasis on the HIV/AIDS epidemic highlights a specific group of children, orphans and children affected by HIV/AIDS, and necessitates a focus on individuals. In contrast, an emphasis on poverty takes in a much larger group of vulnerable children and necessitates a focus on social determinants and interventions directed at social institutions.

According to a variety of measures—and without taking into account the effect of the HIV/AIDS epidemic on socio-economic conditions—it is estimated that an average of six out of ten children in South Africa live in poverty.[32] Using the Fifth Labour Force Survey, Ingrid Woolard[33] from the HSRC has calculated that an estimated 4.8 million children aged 14 years and younger, or 33% of all children in this age range, live in households where no one is employed. If a child is defined as a person of 18 years and younger, then 6.1 million South African children—again 33% of all children in this age range—live in workerless households.

A rough estimate, calculated with disregard for all kinds of potential confounders, is that one in five or six children is living with an infected mother.

There is likely to be a very large overlap between those children who live in poverty and those living with an HIV-positive mother. Poverty is the undeniable background to the HIV/AIDS epidemic and HIV/AIDS itself deepens the poverty of already vulnerable children. Owing to this, one needs to look beyond AIDS orphans to all vulnerable children. Our efforts need to be focused on poor children with tenuous social, institutional and material supports, as the situation of these children in likely to be considerably worsened by HIV/AIDS.

If we shift our perspective from individual children identifiably affected by HIV/AIDS to the large group of children made especially vulnerable by poverty and HIV/AIDS, a number of questions can be posed about the combined or synergistic effects of the epidemic on children in the region.

Individual suffering and social disorder

There is no doubt that the HIV/AIDS epidemic has, and will, precipitate enormous suffering for countless children, families and communities. Unknown numbers of children will go hungry, starve and suffer stunted physical and mental growth. Similarly, many children will endure enormous anguish as they potentially find themselves alone and unsupported, the butt of cruel commentary and behaviour, excluded, exploited, beaten, raped and forced into labour. Many children will have to make their own way in the world, sleeping rough, doing opportunistic work, begging and soliciting patronage and protection from street groups. None of this will leave anyone in South Africa or the region untouched.

However, individual suffering, even on a massive scale, does not necessarily imply that children will lack critical socialising experiences, or that they will become alienated, disturbed or pose a potential threat to social stability.

Mel Freeman,[34] former director of Mental Health and Substance Use in the South African Department of Health, expressed a view shared by a number of people in South Africa and beyond. He suggested that despite a large number of children affected by HIV/AIDS being taken into the stable and caring homes of family and neighbours, many are likely to develop mental health problems because they will not be exposed to several formative influences. Freeman speculates that these include the:

- early bonding experiences critical for good, caring human relationships;
- modelling, boundary setting and development of value systems necessary for moral development; and
- support, caring and discipline needed for emotional stability.

As part of the intrinsic processes which drive child development, however, children actively seek out these experiences—even in conditions of great difficulty. This is at the heart of what we know about the resilience of children growing up in extreme adversity.[35] As a result, these formative influences may be absent only in children lacking any adult supervision or support, in children subjected to cruel and dehumanising treatment, or reared in institutions over a long period of time.

A very small proportion of children affected by HIV/AIDS will find themselves subject to these depriving conditions. Knowledge gained from working with street children, displaced children and children in conflict and disaster situations demonstrates that even on the street, in conflict or under abusive and dehumanising conditions, children attempt to seek out bonding experiences with adults and engage their support.[36] Even low levels of support in childhood appear to enable quite dramatic compensatory responses in children.[37]

Determinants of psychological and social disorders in children tend to be non-specific: that is, no particular interpersonal or environmental determining condition is associated with a specific psychosocial manifestation. For example, although parental divorce is associated with psychosocial trauma in children, children whose parents get divorced do not all become depressed, wet their beds or suffer discernible signs of maladjustment. In fact, only a minority of children show ill effects when exposed to adverse conditions. Rather, children's response to high levels of stress is determined to a large degree by personality and temperament, learned coping style, age of exposure, the availability of caring adults and social supports in their environment and, critically, opportunities for recovery afforded by achievements, new relationships, changing circumstances and the like. About a third of children exposed to extremely disadvantaging conditions thrive, achieve high intellectual standards and are well adjusted. Less than a third of such children are affected in negative ways. The basis of so-called resilience is to be found largely in children's

ongoing relationships with caring others, and their continued membership of social networks and social institutions.[38] This is one reason why strong cultural effects are found in children's response to disasters; for example, children in cultural groups that have strong social connections through extended kin are less affected by events in the nuclear family than are children who have fewer and less intense kin networks beyond the household.[39]

The likelihood of maladjustment is increased when adverse conditions endure over time, when stresses are cumulative and when children are given few opportunities for support and hope. Thus, long-term maladjustment is dependent on the availability of conditions for recovery as much as, or more than, the form or severity of precipitating stresses.[40]

It is thus necessary to prevent the social conditions and poverty of families made especially vulnerable by HIV/AIDS from deteriorating to the degree that large numbers of children find themselves in these extremely difficult situations. It also means that the widespread institutionalisation of children in residential settings, which is almost invariably associated with abuse and delay, must be averted.[41]

On a very broad level, there are three main categories of 'determinants' of poor adjustment that are likely to occur in the context of the HIV/AIDS epidemic, given prevailing conditions:

- *Poverty:* As discussed, the HIV/AIDS epidemic is inextricably bound up with poverty. In general—and without considering associated confounding effects such as substance abuse in the home or residential instability and displacement—poverty is associated with deprivation syndromes in children. Deprivation syndromes include poor growth and health, decreased motivation, increased passivity, impoverished experience and frames of reference and lower cognitive performance.[42]

- *Loss, separation and bereavement:* Many children in the region are going to be separated from and lose their parents, caregivers and the breadwinners on whom they depend. Again, without considering associated confounding effects such as residential and school change and worsening socio-economic conditions, the loss of parents and loved ones is associated with internalising psychological conditions including anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem.[43]

- *Cruel and impersonal child care:* Children affected by HIV/AIDS may be subjected to impersonal and abusive child care through: exploitative family and community care; poorly chosen and supervised foster care; and long-term institution-based rearing. In general, and without considering associated effects such as pre-existing home conditions, separation and bereavement, impersonal and abusive care is associated with a range of psychological disorders, including a reduced capacity for affection and compassion, acting out and more aggressive coping styles.[44]

At this stage its unclear how many children are exposed to unmitigated poverty, multiple loss and bereavement, and/or cruel and impersonal care. Of those children who are exposed to these conditions, it is not known what proportion will succumb to the effects of the associated stresses and begin to show disturbed behaviour or diminished capacity.

Among children who do show disturbances or delays, it is not certain how many children will show enduring maladjustment because they have few, if any, opportunities for recovery. What we do know is that children exposed to multiple severe stresses, without compensating support, are more likely than other children to show disordered behaviour. At the level of the individual child, the programme implications are clear. Every effort must be made to ensure that affected children have stable, preferably family-based, care and adequate social support. As already described, children appeal to available adults and peers for social support in their efforts to cope with stressful situations.[45] Social support at the level of the family, school and the wider community reduces the impact of stresses on children living in adverse conditions.[46] Lack of social support—through poor coping by available adults, the depletion of social networks and isolation from regular social institutions—increases children's vulnerability to stress by reducing their resources for dealing with stress. The implications of this framework are, principally, the following:

- Individual or group predisposition to socially disordered behaviour does not necessarily accompany or follow from aggregated human suffering. Disordered behaviour of the kind that threatens security, such as widespread aggression and disregard for social norms, has a closer association with the weakening of social institutions than with individual-level experiences.

- For this reason, the strength and quality of social institutions, such as the

family, school, church and community associations are critical for children's capacity to cope with the effects of the epidemic, and to avert personal distress, maladjustment and social disorder. It is also true that these institutions are likely to be weakened as a result of the epidemic, as key individuals become ill and die, and as those people who remain become demoralised and overwhelmed by loss and the demands placed on them by difficult conditions. Therefore, every effort has to be made to support and strengthen these social institutions in the face of the epidemic, as they provide the cornerstone for the protection of children. In particular, schools need to be adapted to provide a range of supports for children: schooling must be available to all children and every effort must be made to ensure that all children remain in school; educators and older children can be sensitised and trained to provide support for children; food and clothing, especially uniforms, can be provided through schools; and shorter- or longer-term accommodation can be developed for children in especially difficult circumstances. Maintaining children's schooling is an important intervention in several ways. It retains children's connectedness to peers, familiar adults and to an institutional identity. Schooling provides children and society with future knowledge and skills. Keeping older children in school could also help to prevent vulnerability to HIV infection, by protecting children and reducing the child's need to seek shelter, food and clothing through risky encounters with unscrupulous adults.

- Every effort also needs to be made to avert conditions that result in impersonal and cruel child care. Orphanages and unstable foster care have been identified as high-risk environments for neglect and abuse.[47]

- Finally, it is critical to address the background poverty effects experienced by children affected by HIV/AIDS. Mechanisms exist to identify and target assistance to needy children and families. Children out of school, working children, children not living with either biological parent and adult sickness and death are all indicators of potential vulnerability. Such indicators need to form the foundation of an early warning system in which economic and other assistance is provided to families and children.

Social trends likely to impact on children

In addition to any personal psychological maladjustment that may be

precipitated in a small number of children who suffer extreme stress, a number of broader social trends are over the longer term likely to exert insidious and pervasively injurious effects both on children and on the society in which they live. Three such trends can be identified: school drop out; child labour; and sexual exploitation and child trafficking.

School drop out

According to the 1999 South African October Household Survey, as many as 35% of rural African children between the ages of six and 17 years do not attend school. In the sub-Saharan region, an estimated 44 million children, more girls than boys, are not attending school.[48] School drop out is likely to increase as families become unable to afford the costs of schooling and as children's contribution to care and work is required at home. Experience suggests that the most vulnerable orphans are those in their school years, aged ten years and older. Thus, despite all their shortcomings, schools have significant potential to play a critical role in obviating the worst effects of the HIV/AIDS epidemic on children. Apart from the accrued personal and social benefits of education for work and national development, schooling provides stability, institutional affiliation and the normalisation of experience for children. It also places children in an environment where adults and older children are potentially available to provide social support.

Child labour

Many children in South and Southern Africa already work hard. The Survey of Activities of Young People (SAYP) commissioned in 1999 by the South African Department of Labour found that more than half a million children between five and 14 years of age work for long hours, mainly collecting wood or water. Close to 400,000 children do night work; 183,000 do three or more hours a week of paid domestic work and 137,000 work with or close to dangerous machinery or tools. About 19,000 children (0.1%) beg for money or food in public for three or more hours a week. More than 70% of children work to help their families, either willingly or unwillingly. About 30% of children's work is in contravention of the law.[49] The International Labour Organisation (ILO) estimates that worldwide approximately 120 million children in the five to 14 year age group work on a full-time basis, and this figure rises to around 200 million when those for whom work is a secondary activity are included. Other surveys conducted

by the ILO have found that, over a 12-month period, the proportion of economically active children in the five to 14 year age group could rise to as high as 40% in developing countries. Such studies conclude that children's labour contributions are an important component of household income, in some cases amounting to as much as one-third of household income.[50]

While not all child labour is necessarily injurious—a moderate amount of responsibility can have a positive influence—illegal child labour can be damaging to children's physical and mental health, may prevent children from attending school and may be cruel and dehumanising. Child labour is likely to increase as economic conditions of children in families affected by HIV/AIDS deteriorate. Instruments dealing with child labour infringements—such as the Convention on the Rights of the Child and, in South Africa, the constitution and multiple laws—do not in their current form lead to financial assistance for the child or the family to ameliorate the economic conditions leading to child work.[51]

Sexual exploitation and child trafficking

There is very little hard data available on the extent and nature of human trafficking in either the region or beyond and much of what is available is based on relatively small-scale research.[52] According to the International Organisation for Migration (IOM), however, the trafficking of women and children is the third most lucrative type of organised crime in the Southern African region, following the sale of arms and drugs. A recent report released by the IOM suggests that considerable numbers of women and children are trafficked annually in the Southern African region. Trafficking in children occurs for the purposes of child prostitution, illegal and false marriage, illegal adoption and child labour. An unknown number of children are trafficked for body parts. In the Southern African Development Community (SADC) region, children are trafficked primarily as bonded labour and for the purpose of sexual exploitation. The IOM report highlights, as examples of trafficking in the region, a European-led child sex tourism industry in Malawi and the trafficking of Mozambican children into prostitution in Johannesburg.[53]

It is likely that as the ratio of dependent children increases as a result of the HIV/AIDS epidemic, so will the chances of children being lured into trafficking and sexual exploitation. Once imprisoned, or left without the means of escape, children are at their most vulnerable.

School drop out, child labour, sexual exploitation and child trafficking present real dangers to children as well as to society: they reduce individual and national developmental potential; marginalise and dehumanise children and separate them from available sources of help and support; engender widespread disregard for children; and have close associations with crime. Without schooling, both individual potential and social capital is lost, leaving affected individuals vulnerable to unemployment, menial working conditions and poverty. Similarly, child labour is often physically damaging, psychologically stunting and demeaning to the dignity of children whose labour is exploited. Together with sexual exploitation and the trafficking of children, school drop out and child labour indicate the disintegration of the social institutions that serve to protect and develop children and, by their existence, they further undermine fragile families and communities. In addition, child labour and sexual exploitation fuel crime as children become traded for profit.

Conclusion

The HIV/AIDS epidemic is going to be more terrible to live through than any of us can imagine. We are only beginning to experience the effects of AIDS deaths. The most important interventions for children are nationally oriented responses that identify, target and effectively implement mechanisms to provide economic and other assistance to poor families and to maintain and improve their access to services. In this way, the values and organising coherence of families, neighbourhoods and schools will assist children to cope with the increasing adversity accompanying the epidemic.

Notes

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CHAPTER 3

RISK AND RESILIENCE

Beverley Killian

Introduction

Resilience is one of the *great puzzles of human nature*[1] and at the same time it appears to be *an ordinary magic* that enables some children to progress well despite difficulties. The study of resilience is a fascinating subject that identifies those characteristics that empower some children to do well in life, even though they have experienced what seem like insurmountable difficulties. In our daily lives, we all know such individuals—the person whose father was an alcoholic and whose mother was frequently hospitalised with a psychiatric disorder, yet who is now a happy and dedicated family man; the person who rose from the most severe deprivation and poverty to become a competent, caring medical doctor; the child who was orphaned at a young age, grew up in children's homes, became a juvenile delinquent and then settled into stable employment and is now a respected member of his community; the person who experienced major discrimination in his youth, was unfairly imprisoned for many years and then went on to become an icon of compassion, forgiveness and dignity. Of course, we also know people whose lives have seemed to follow a very different pattern: individuals who seem to have had every advantage that life could offer—a loving family, supportive friends, a good education, enough money and so forth—yet seem unable to become well-adjusted and productive adults.

The study of risk and resilience has enabled social scientists to understand which factors place children's adaptive development in jeopardy and which processes increase the chances of them becoming happy, well-adjusted adults. This field of investigation is useful in providing both an insight into what the impact of the HIV/AIDS epidemic on children could be and in guiding policy makers and practitioners on how best to assist children affected by the pandemic. Thus, while some social scientists have predicted that HIV/AIDS will result in increasing insecurity, with future generations being brought up with limited social attachment to significant others and major impairments to their cognitive,

social, behavioural and moral functioning, studies of resilience suggest that only some children will be adversely affected. Work in this area further suggests that every layer of society (policy makers, health practitioners, educators and members of civil society) has a role to play in increasing the chances of vulnerable children developing into competent, caring and confident citizens.

One needs to enter this complex subject of study by understanding that in all aspects of any child's life there is a constant, simultaneous juggling of advantages and disadvantages, of strengths and difficulties. It is useful to begin by identifying these processes and systems, before throwing all the balls into the air and beginning the juggling process that constitutes an understanding of child development in a community affected by HIV/AIDS. This chapter will therefore first consider the social ecology of child development, then go on to identify those factors that are associated with risk and resilience, before applying these various components to the HIV/AIDS epidemic within communities in Africa.

The social ecology of childhood

A social ecological model of child development is similar to environmental models of ecology. The ecological models we studied in school serve as a good basic starting point for understanding such models. For example, each organism in a river system supports and maintains other organisms. As long as the system is in balance, it is mutually beneficial to all to live in it; tampering with one aspect, however, could damage or kill off the entire system.

The social ecology of childhood involves many and varied factors, some of which are temporary and will pass, while others are more enduring. Child development can be influenced in many ways and from many sources. It is possible to group together the major factors potentially influencing child development into four interacting dimensions:[2]

- *Person factors* include the individual biological, temperamental, intellectual and personality characteristics of the child and significant others in the child's life—such as parents, siblings, educators, etc.

- *Process factors* include the forms of interaction that take place between individuals (supportive, destructive, informative, inclusive, power-based, etc.).

- *Contextual factors* include families, communities, cultures, ideologies, etc.

- *Time variables* take into account the changes that occur over time. Context, person and process variables change over time as a child matures and as the environment changes. The rate of change in the environment varies, but the HIV/AIDS epidemic, together with urbanisation and Westernisation, is causing rapid change.

The way in which an individual child's development is influenced by these dimensions depends on how the various person, process and contextual dimensions interact with each other and with external influences. It also seems that the way in which children and key role players understand and think about events and circumstances is critically important in determining their impact. A child who is being raised in the midst of a major disease epidemic is going to experience a different childhood to one who is raised in middle class suburbia where, in general, only old people die. A child raised in extreme poverty has a different childhood experience to one raised in a highly materialistic family in which much value is placed on possessions.

Contextual factors are critically important in determining the type of childhood experienced. A child usually lives in a family. A family lives in a neighbourhood, within a community. Communities in turn form subcultural groups within particular socio-political systems. Political and cultural systems adopt particular ideologies about how to raise and value children and make decisions about how resources are to be used and disbursed. Each of these systems (family, community, political party or culture) consists of an "organised collection of activities and resources that exist within definable social and physical boundaries".[3] Each has a purpose and regulates social exchanges. Each also has rules, roles and power relations, which determine activities and the use of resources.[4] These five systems, and the relationships between them, are referred to as: microsystems, mesosystems, exosystems, macrosystems and chronosystems. These change over the course of a child's development.[5]

A *microsystem* consists of the pattern of activities, roles and interactions experienced by children in their immediate environment; for example, the interactions that develop between a child and a parent, sibling or educator. Bronfenbrenner[6] demonstrated that it is these face-to-face interactions between children and other people that are the most influential in shaping stable aspects

of development, since they are likely to develop into repetitive and predictable patterns. When children are young, it is likely that their major microsystems will be found within their family. As they grow up, peers and school are likely to become significant.

Such relationships may either promote or restrict development and adaptation. Bronfenbrenner[7] emphasised that it is the way in which the child perceives these relationships that is crucial. Supportive microsystems can facilitate optimal development. Such microsystems are characterised by a network of enduring and reciprocal caring relationships.[8] Conversely, high-risk microsystems are characterised by a lack of mutually rewarding relationships and/or the presence of destructive interactions. For example, where a family's focus is primarily on caring for someone who is sick, the chances are high that children in that family will feel neglected, or at least of secondary importance. The family may also not have the time or energy to interact with their community.

A *mesosystem* consists of the linkages that exist between two or more microsystems in which a child plays an active role. The mesosystem contains sets of associated microsystems and the interrelationships between them. Examples of mesosystems include the interactions that occur between families and schools, or between children and community members. It is important for children to have several positive connections between their family and others.

A beneficial mesosystem has a number of strong, positive connections that can offset the negative influence of other aspects of children's lives. For example, a child living in a household where there is domestic violence may have a supportive educator with whom she enjoys a warm and caring relationship that protects her from some of the damaging effects of emotional neglect by her family. Similarly, a child's mother may be very ill and dying, but the child's close relationship to his aunt, together with a shared faith in God and commitment to their local church-going community, may provide an emotional haven. A high-risk mesosystem would be characterised by weak or destructive associations between microsystemic contexts. For example, where families suffer stigma and discrimination, there may exist a negative relationship between the family and the school or community. Families who are socially isolated and have few personal or community-based ties tend to suffer increased rates of conflict and child abuse.[9]

The *exosystem* includes those settings that influence children's development but in which they do not play an active role. The parent's workplace is a prime example of an exosystem. Although the child is unlikely to interact directly with the parent's work environment, employment policies and relationships are likely to impact on the child's life, and could either curtail or enhance the time and energy that parents have to interact with their children. An example of a risk-inducing exosystem could include a work environment in which a domestic worker is only permitted to go home to her own children one weekend a month. Another could be a weak health care system which, unable to provide adequate medicines, increases the sense of hopelessness experienced by terminally ill patients and their families.

Exosystems are likely to become particularly important in the context of the HIV/AIDS epidemic. Children living in developing and impoverished communities are more likely to participate actively in the affairs of their neighbourhoods and communities. Indeed, children's active participation in community matters has been demonstrated in the most adverse circumstances associated with political protest and war.[10] In the face of the challenges arising from the HIV/AIDS epidemic, it is likely that children will become increasingly active in their communities. And it will be grassroots community responses—guided by national policy—that will determine whether children's participation will prove beneficial or detrimental to them.

The *macrosystem* is the cultural 'blueprint' for any given society;[11] the combination of ideological and institutional systems that characterise a particular culture or subculture.[12] In its broadest sense, the macrosystem dictates children's place in society. Each community has a specific cultural history that includes various traditional practices, rituals and beliefs pertaining to children. Within the context of HIV/AIDS, these include religious and traditional customs about how children take on responsibilities within the home, care for sick people and are to behave at funerals and during mourning periods. Beliefs about what happens once someone has died can be considered part of the macrosystem. A country's policy and legislative framework also forms part of the macrosystem. South Africa, for example, is a signatory to the Convention on the Rights of the Child,[13] as well as the African Charter on the Rights and Welfare of the Child.[14] These documents prescribe the way in which children are legally defined, prioritised and treated within the South African context. The Constitution of the Republic of South Africa[15] also

places a particular legal perspective on childhood, with section 9 of the constitution specifying that age, gender and disability (among other criteria) may not be used to discriminate between people. The constitution also contains the Bill of Rights, which "enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."[16]

The fifth and final system, the *chronosystem*, considers the cultural and historical changes that transform all of the person, process and contextual variables. The historical features of the period may contain both relatively stable elements, such as family structures and conceptions of childhood, as well as disruptions created by economic depression, political changes and the information technology revolution, among other things. Southern African communities are experiencing very rapid rates of change due to political, cultural and technological transformation. The impact of this changing world on children has been greatly exacerbated by the HIV/AIDS epidemic.

Childhood risks and adversity associated with HIV/AIDS

One method of conceptualising the difficulties and risks faced by children affected by HIV/AIDS is to consider the sequence or path of adversity encountered by children from both a medical and psychosocial perspective.

The implications of HIV from a medical perspective

HIV/AIDS has a number of medical implications for children, not least of which is that they may be infected with the virus. HIV can be transmitted to children during pregnancy, labour and delivery or breastfeeding. Such mother-to-child-transmission (MTCT) is thought to account for about 90% of all HIV infection in children under the age of 15 years.[17] Children living in affected households are also at risk of becoming infected through blood-to-blood contact when they share cutting instruments (e.g. razors), or are exposed to blood when cleaning bleeding or weeping wounds. Some may also become infected as a result of sexual abuse. In communities in which there are high rates of gender-based violence, adolescent girls are being infected at five or six times the rate of boys in the same communities.[18]

Children infected with the virus obviously suffer from the opportunistic

infections associated with AIDS and most will die before their sixth birthday. Children living with HIV-positive family members may suffer particularly poor health, as opportunistic viral and bacterial infections are able to spread rapidly through groups of co-habiting, immunologically compromised people.

The health of uninfected children may also suffer. Children living in affected households are more often exposed to opportunistic infections such as tuberculosis and pneumonia and, with caregivers often sick or absent, are less likely to receive the medical attention they need.[19] The lack of basic hygiene and sanitation created by the scarcity of running water and functional toilets in many homes and schools exacerbates the spread of these opportunistic infections.[20]

The implications of HIV from a psychosocial perspective: The journey of disadvantage

Many psychosocial issues associated with HIV/AIDS transcend economic, political and other macrosystemic boundaries, as children made vulnerable by the epidemic become embroiled in a downward spiral of distress and difficulties that affect multiple aspects of their lives. Being orphaned is only one of the ways in which children are adversely affected by HIV/AIDS. Most children living in highly affected communities are likely to experience some degree of psychosocial impact. Where HIV/AIDS strikes closer to home, the psychosocial impact begins when the parent or primary caregiver becomes infected with HIV and continues long after their death. Children living with HIV-positive family members are likely to experience a range of stressors and because the clinical course of HIV infection involves intermittent crises followed by periods of relatively good health,[21] often live in situations of extreme uncertainty. Far from having the stability and security that children need through childhood, such children's lives are continuously in a state of flux.

One method of understanding the psychosocial impact on children and their families is to follow their life path. This entails exploring each of a number of stages likely to be experienced by children 'walking the HIV/AIDS road'.[22] The most common of these stages include the following:

- *Children become aware of HIV/AIDS:* The emotional impact of HIV infection begins when children realise that many people in their community are sick

and dying. Killian[23] found that 76% of South African children living in high-prevalence communities are extremely anxious and at times obsessively ruminate about illness and the potential death of loved ones and themselves.

- *AIDS-related illness becomes personal:* Awareness of AIDS-related illness and death becomes personalised when children become aware that a loved one is beginning to show signs of illness (such as weight loss, lethargy, etc.), may be HIV-positive and may be suffering a stigmatising terminal illness.

- *Children become involved in caring for someone who is terminally ill:* Children witness and/or participate in the home-based care of the sick and dying and become aware of the profound and distressing problems that accompany the severe physical debilitation that accompanies AIDS-related illness and death.[24]

- *Children experience loss:* As the virus progresses, children experience the death of beloved parents, family members, neighbours, friends and educators.

- *Children adjust to the changes consequent to the death of a parent:* This usually involves decision making about the future care and custody of children, sibling dispersal, inheritance issues and the impact of multiple losses.

- *Children adjust to a new home and/or care arrangements:* They may be placed in *de facto* foster care, institutional care, live in child-headed households, or may fall through all of the community safety nets and drift on to the streets due to abandonment or exploitation. These new arrangements may be very different from the children's familiar routine and may require them to adapt to a new environment, neighbourhood or school.

- *Children may themselves suffer the effects of the virus:* Many children will also experience the major physical, social, emotional and behavioural consequences of their own terminal illness.

In addition, the sexual transmission of HIV, together with the prevalent myths and misconceptions that exist in many communities, mean that children may:

- *Experience repeated deaths:* If one parent is HIV-positive, the probability of the other parent also being HIV-positive is high, and children affected by HIV/AIDS may lose both parents within a relatively short period of time.[25] They may also lose siblings who acquired HIV peri-natally through MTCT.

- *Experience conflict and isolation:* The disclosure of an HIV-positive diagnosis can lead to major intrafamilial conflict in the form of domestic violence, marital breakdown and family dysfunction. They and other surviving family members may also suffer stigma and discrimination long after the AIDS-related death of a loved one.[26]

- *Be at greater risk of sexual abuse:* The myth that sexual intercourse with a virgin can cure HIV/AIDS has enjoyed much media and grassroots attention in the region and may have increased the risk of children being sexually abused. The emotional and behavioural consequences of child sexual abuse have a profound impact on many aspects of children's functioning.[27] In addition, sexual abuse exposes children to severe discrimination and hardship. For example, Kriel[28] found that many educators inaccurately believe that once girl children have experienced abuse they entice boy children into sexual activity.

As vulnerable children progress through life they will have to deal with a new onslaught of psychosocial risks at each stage of the 'HIV/AIDS road'. The literature recognises the following psychosocial risks as having particularly adverse effects on children: poverty; growing up in war-torn communities or in families with mentally ill, alcoholic, abusive or criminal parents; child abuse and neglect; a lack of secure attachments to a primary caregiver; parental death; and a lack of stability and routine. Most of the children in high-prevalence communities are concurrently exposed to many of these risk factors; some are likely to be more resilient in the face of such risks than others. Despite the odds, many children affected by HIV/AIDS will become well-rounded, successful individuals. The challenge is to find ways of boosting children's resilience, especially given that psychosocial risks are harsh and numerous.

Understanding resilience

Resilient children seem to do well in life, appearing to have the ability to bounce back and cope well in the face of profound problems.[29] Despite having

experienced hardship and adversity, they work well, play well, love well and expect well.[30] In fact, studies have shown that 50% to 66% of children growing up in circumstances of multiple risk appear to overcome the statistical odds to live lives that manifest coping and resilience.[31] These children provide researchers with clues about how to assist others, as they seem to either have a natural ability to cope in the face of difficulties, or receive help that facilitates a positive outcome. Studies also suggest, however, that children have varying degrees of resilience at different points in their lives. Children who seem resilient in one set of circumstances may suffer when other difficulties arise, or vice versa. This suggests that it is the interaction and accumulation of individual and environmental risk factors that contributes to both risk and resilience.[32]

Issues of definition and function

Resilience may be defined as the process of, or capacity for, successful adaptation despite challenging or even extremely threatening circumstances.[33] These three aspects of the definition have created some confusion about whether resilience is:

- an *outcome* for children who experience difficulties and still have a positive outcome;
- a *skill* or *capacity* to cope under conditions of enormous stress and change[34] that may be assisted by the ability to access social support;
- a process of *adaptive coping*; or
- a *set of person and environment variables* that may be specific to particular developmental stages and environmental or contextual circumstances.

These four aspects of the definition also raise questions of chronology, in terms of whether resilience processes:

- *pre-exist adversity*, so that children have certain characteristics before, during and after exposure to distressing circumstances that enhance their ability to function optimally despite adversity;

- *come into being at the time of adversity* and, as such, can be considered coping strategies that emerge as a result of difficulty;[35] or

- *begin to function once risk is established*, when they serve to decrease the

likelihood of developing problems.[36] Kirby and Fraser[37] have metaphorically compared such processes to immunisation: receiving an inoculation does not enhance health, but provides protection when exposed to the pathogens associated with that specific immunisation.

There is still much confusion about how to define resilience. Various principles have, however, been consistently identified as fundamental to understanding how resilience-enhancing or protective processes function:

- The child plays an active role in negotiating risk situations and overcoming adversities,[38] with the child's (and for younger children, their primary caregiver's) appraisal of a situation being a more significant predictor of outcome than the nature of the event itself.[39] For example, how a child understands a parent's death will determine his/her emotional reaction to it, which in turn will influence its eventual impact on the child.

- Protective processes, like risk factors, have an accumulative impact—success in one area of a child's life can serve as a springboard for success in other areas.[40]

- There are certain protective mechanisms that are especially important as they create the foundation upon which resilience is built. In children, these include secure attachments, availability of good role models and access to social support.[41] In adults, the three critical components of resilience seem to be a staunch acceptance of reality, a deep belief—often buttressed by strong spirituality—that life is meaningful and an uncanny ability to improvise.[42]

- Certain protective processes are linked to cognitive, emotional or social maturity, as they only come into operation as the child matures.[43]

Resilience models

Various conceptual models have been advocated as tools for better understanding the concept of resilience. The first model conceived resilience as simply being *the opposite of risk*.[44] The early resiliency studies assumed that risk and resilience represented opposite ends of a single spectrum. At times, these assumptions held true. For example, having a poor parent–child relationship is

a risk factor, and having a good parent–child relationship contributes to resilience.[45] There are, however, sufficient exceptions to this simple model to require further conceptual refinement.

The *universal strengths model* was developed during the work of the International Resilience Project.[46] This model maintains that resilience is a universal human capacity that enables a person, group or community to deal with adversity by preventing, facing, minimising, overcoming and even being strengthened or transformed by adversity. This model maintains that we are naturally endowed (probably through evolution) with the ability to cope with adversity, but that this capacity needs nurturing and support within a facilitative environment to enable resilience to win over vulnerability and risk. In many respects, the universal strengths model is consistent with theories on the social ecology of childhood (as described above), since it encourages a focus on those contextual variables and systems that can either support or detract from optimal functioning.

This model had the clear advantage of having shifted the focus away from individual deficits to individual strengths, competencies and capacities and, as such, was a critical step in understanding resilience within the context of the individual, family and larger social environment.[47] Previous work had focused on deficits and problems that required diagnoses and treatment. The paradigm shift to a *strengths model* focused on building individual, family and community strengths. Grotberg[48] also challenged the notion that people could be "vulnerable but invincible", arguing that people do not remain unscathed by adversity. She contends that resilient people are not protected against, but are better prepared for, difficulties and hardship. Resilient people address adversity more successfully than non-resilient people: a person grieves the death of a loved one; a rape survivor chooses the long, slow road to recovery; someone who is terminally ill addresses their fears and worries.[49] This model has decided appeal and has made important contributions towards theory building. It does not, however, always hold up in practice. It seems that only 50% to 66% of children have the capacity to bounce back despite adversity.[50] There are also individual variations in the degree of resilience exhibited by different children, at different points in time, and in different contexts.[51]

A third model of resilience states that certain children, families and communities have *protective capacities or processes* that enable them to cope

better with the trials and tribulations of life. Protective processes encompass a breadth of experiences and mechanisms that enable positive adaptation despite adversity.[52] Protective processes, like risk factors, include personality and genetic characteristics, as well as external dynamics within the family, school or community environment.[53] These are often interrelated and interdependent and include:

Internal personal strengths

Some children begin life with certain advantages. They are either born with, or develop through the interaction of genetic and environmental factors, internal strengths or qualities that enable them to cope better with life. Children who are observant, good at solving problems and believe in their own ability to cope with difficulties often do better in the face of adversity. These children are also more likely to understand and attribute a deeper meaning to adverse events.[54] Resilient children are socially competent, have positive self-esteem and a sense of their own efficacy and ability. Intellectually, there may be a window of ability that is associated with greater resilience—children with above average intelligence do better than those who are below average or are intellectually gifted. Resilient children are more creative, innovative and naturally curious. Parenting and schooling systems that encourage questions and curiosity enhance resilience more than schooling and parenting styles that uphold obedience and respect as the ultimate qualities of a well brought-up child.

Children who are able to understand and express a wide range of emotions in a socially appropriate manner are also more resilient. Indeed, a goal of most intervention programmes is to enable children to identify a wider range of emotions and to express these emotions in socially acceptable ways. This is because by externalising distressing experiences people are able to psychologically process such events and so gain a sense of mastery and control over them. Children express their feelings in words, actions, play or drawing. Being able to talk about or play out difficult experiences, while not dwelling on painful memories, is a basic principle underlying all psychotherapy.[55]

Gender is also considered important in moderating risk and resilience. In first world countries, pre-adolescent boys report less stress, and exhibit more distress, than girls. Boys are thus more likely to develop childhood problems.[56] This pattern is reversed during adolescence,[57] when girls experience more

distress. In many developing countries, high rates of child sexual abuse and gender-based discrimination place girls at particular psychosocial risk. In these countries girls are more likely to have to sacrifice their education, take on household responsibilities and chores and be accorded lower status than boys[58]—all of which seem to make them less resilient than their male counterparts.

Interpersonal resources or skills

Another source of strength stems from children's interactions with others. The ability to access social support is significant in predicting resilience.[59] Resilient children trust and enjoy secure attachments to others—confident that people will be there for them. They thus seek and find emotional support and are confident of their right to such support. They relate to others in a positive manner and have the ability to see humour in difficult situations. They also discuss difficulties with people whom they trust and respect. Such traits help children to develop relationships and a network of supportive others which they can draw on when difficulties arise. Such relationships serve as a buffer during adversity and create opportunities for positive interaction, messages and experiences. The ability to find and make use of social support outside of the family also improves communication skills and problem-solving ability. Interestingly, such social support systems are especially protective for children from low socio-economic groups.[60]

Resilient children also tend to have a sense of purpose and future orientation, combined with a sense of usefulness. Werner[61] identified 'required helpfulness'—wherein children have set responsibilities and tasks in the home, community and/or school, such as taking care of siblings or relatives, or being responsible for animals or pets—as a resilience factor. Boys do better when given tasks and clear routines, whereas girls benefit from being given appropriate responsibilities, especially in caring for others.[62] Careful consideration of what constitutes appropriate tasks and responsibilities for children is, however, needed. Children need time to be children: to go to school, play with peers and have fun.

Faith in a higher power, or a religious philosophy of life, has also been identified as a resource. A resilient person, adult or child, is likely to have a strong spiritual or ideological belief that there is a God, or one or more Higher Beings, which

transcend life on earth. Such belief systems are usually instrumental in creating a vision of moral order and a sense of justice, in which there is a clear distinction between right and wrong and acceptable and unacceptable behaviour.[63] The form that this belief system takes is unimportant—a child may believe in one God, in many gods or in the power of ancestors.

External supports

The extent and nature of the supports, resources and structures available to children may either build resilience or increase vulnerability. A positive emotional climate and the availability of supports and resources within the family and broader community context can serve a protective function. A supportive environment can also help to develop personal qualities that enable children to cope with adversity. These resources often take the form of social relationships, as opposed to facilities that need to be made available. They make children feel important and give them a sense that others are concerned about them.

As already mentioned, feeling secure, loved and accepted by more than one person is an important resilience factor. Beyond infancy, security of attachment is demonstrated by the time spent with children—listening, showing an interest, being actively involved in what they do, think and feel[64]—and recognition of their achievements.[65] When a parent is terminally ill it is imperative that the child begins to develop a secure attachment with those who will be responsible for their care once the parent has died. In many African families care of the child will be vested in several family and community members.[66] The presence of multiple caregivers who offer consistency, care and secure attachments augurs well for children's emotional development. The disadvantage may be that children lack consistency in care, which may contribute to a lack of security in interpersonal relationships.

The availability of adequate and competent adults who serve as consistent role models is also important in moulding a positive attitude and adaptive coping.[67] Resilient children seem to be especially adept at actively recruiting surrogate parents[68] and it is imperative that there exist adults who make themselves emotionally and socially available to such children. Positive role models are instrumental in helping children develop strong moral values[69] and principles to guide them through life and provide structure and form to their dreams and

aspirations. Realistic goal setting, combined with the motivation and support necessary to achieve such goals, is associated with resilience.

A sense of belonging and feeling integral to a family, community and culture is another key feature of resilient children.[70] Being able to trust their primary caregivers provides children with the security that enables them to venture out, explore and engage with the world.[71]

Bronfenbrenner supports this view but also highlights the importance of cultural connections and a sense of history.[72] Since resilient children feel that they belong within their family, home, school and community, they are more likely to participate actively in decision-making processes—an often-neglected clause of the Convention on the Rights of the Child.[73] A further consequence of having a sense of belonging is that the network of people from whom social support can be sought is significantly broadened, making it easier for children in distress to access support. Feeling part of a community and believing that you belong generates both security and pride, which in turn precipitates helpfulness, altruistic and social behaviours.

External supports and resources operate within the three primary systems of the child's world—at microsystemic, mesosystemic and exosystemic levels.[74] It is clear that certain families, schools, communities and cultures have protective processes that promote resilience. Resilient families who live in poor and disrupted communities, yet cope successfully through disadvantage, serve as important positive role models for their children.[75] Resilient families tend to have certain characteristics in common. Such families:

- have a strong, durable belief in their ability to control life;
- establish and maintain a sense of order through the implementation of routines for activities such as meals, bedtimes, household tasks, etc.;
- have systems for celebrating and acknowledging key events in the life of the family and its members;[76]
- establish clearly delineated parent–child roles and relationships with firm boundaries—the child is not expected to be the parent's friend, confidante, or to provide emotional support;

- have parents who provide firm and consistent guidance without repressing or rejecting the child;

- have parents who display an active interest in school, encourage the constructive use of leisure time and support the child's achievements;

- exhibit a manageable maternal workload, both in terms of the number of children cared for and daily tasks;[77]

- enjoy financial stability so that families are able to get on with the business of living and bringing up children without constant worry about where the next meal will come from.[78] Closely aligned with this variable is having sufficient food, clothing, shelter and medical services available to meet the basic survival needs of children and families. The problem of food security is a major contributor to the social disarray that exists in many high-prevalence communities.

Cultural variations in child-rearing patterns are also important. Beneficial practices, such as praising children for finding their own solutions and demonstrating independence or providing them with the support to help overcome adversity, can build resilience.[79]

There are also various cultural practices that increase risk. These include:

- severe punishment;

- excluding children from various activities in an endeavour to protect them from the harsh realities of life and death;

- a focus on obedience to the exclusion of the development of inner strengths and independence;

- not discussing sexuality with children; and

- leaving children to solve their own problems, without providing them with opportunities to ask for assistance.

Resilience-promoting schools can ameliorate the impact of stress associated

with disadvantaged homes. Most children spend at least five hours a day at school during term times. Schools therefore have the potential to be a major resource for at-risk children. The characteristics associated with effective schools are almost identical to the qualities of those that build resilience in their learners.[80] Effective schools provide children with positive experiences that are associated with success and pleasure in a variety of arenas—academic, sport, cultural, good peer and educator relationships and shared responsibilities.[81]

The educational literature has identified five major strategies to enhance resilience within schools.[82] These involve:

- offering opportunities for learners to develop significant relationships with caring adults;

- building on social competencies and academic skills to provide children with experiences of mastery and success;

- offering opportunities for learners to be meaningfully involved and take on responsibility;

- working to identify, collaborate with and co-ordinate support services for children; and

- striving to 'do no harm' by ensuring that the structures, expectations, policies and procedures do not add to the risks already experienced by children.

The bantu education system that was established during the apartheid years in South Africa led to school being a place of misery for many children.[83] De-motivated, authoritarian teachers—often themselves products of an inferior education system—ruled through the use of corporal punishment, frequently never got to know the children in their class by name and viewed the curricula as irrelevant but dominant.[84] Failure rates were inordinately high and many school leavers had no future prospects of employment due to excessively high unemployment rates. The recent shift towards an outcomes-based education system is one step forward in terms of transforming schools into more learner-sensitive environments, although the rapid rate of change has put many educators under significant stress. The Schools Act of 1997 takes into account some of the features of effective schools and encourages the establishment of

school governing bodies so that parents, and therefore the community, become active partners in the education of their children.

The external protective processes at community level are remarkably similar to the resilience-enhancing processes that pertain to traditional African societies. Implicit and critically important in many traditional lifestyles is the belief that "our children are gifts from Our Creator and it is the family, community, school and tribe's responsibility to nurture, protect and guide them".[85] A culture's worldview is grounded in fundamental beliefs that guide and shape daily life, and the valid and positive role that culture plays in supporting youth, connecting them with a common heritage and tapping their resilience has long been recognised by traditional peoples. Through their work amongst Native American youth, for example, HeavyRunner and Morris[86] identified ten innate and natural aspects of resilience-promoting traditional cultural beliefs, namely:

- spirituality;
- child-rearing/extended family;
- respect for nature;
- veneration of age/wisdom/tradition;
- generosity and sharing;
- co-operation/group harmony;
- autonomy/respect for others;
- composure/patience;
- relativity of time; and
- non-verbal communication.

This research found that the interconnectedness embodied in cultural spirituality was especially important in promoting resilience. Although these findings cannot necessarily be extrapolated to all children and youth, they suggest that traditional rituals—such as those associated with a child's birth and naming or puberty rites—which explicitly acknowledge the interconnectedness of all life are associated with resilience.

Most of these protective processes appear to transcend ethnic, social class, geographical and historical boundaries.[87] For example, having good relationships within one's family enhances resilience no matter what one's life circumstances are or where one lives. In fact, there is a growing world literature which reflects much consistency in those features that make children resilient, especially if their

lives are threatened by adversity.[88] Table 2 lists the most frequently reported protective processes,[89] many of which were discussed above.

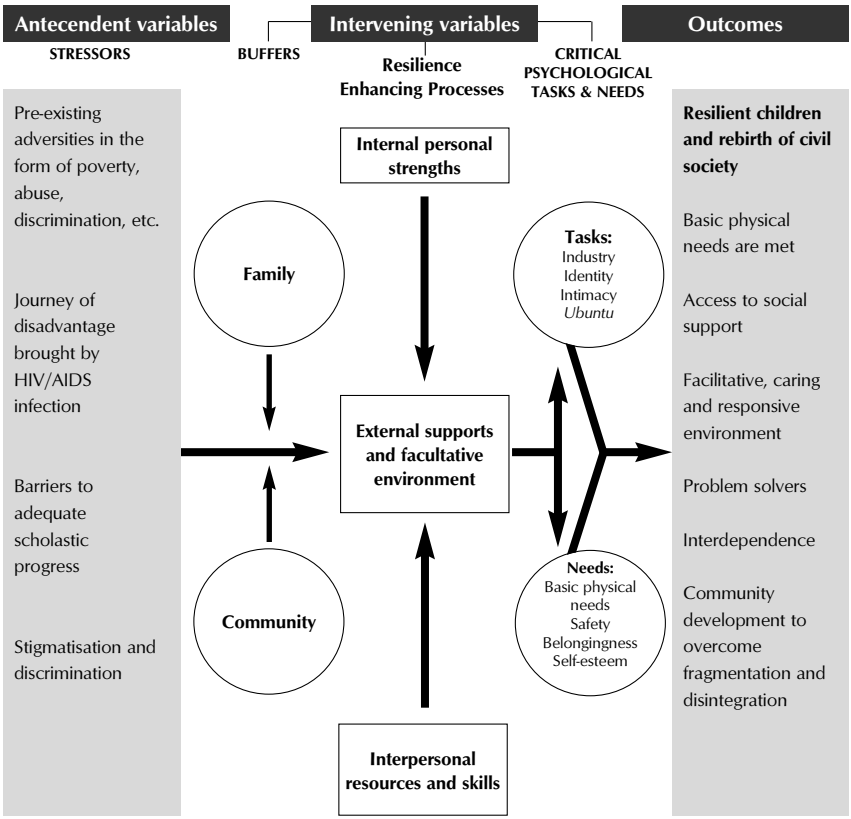
Table 2: The most frequently reported protective processes

Internal personal strengths	*Interpersonal resources*	*External supports and skills*
• Good intellectual skills • Sense of self efficacy and self esteem • Autonomy and sense of control over one's own life • Achievement oriented • Problem-solving skills • Creative, innovative, resourceful personality • Appealing or easy temperament • Talents valued by self and society • Ability to focus and maintain attention • Ability to experience and express a wide range of emotions	• Trusting relationships • Secure attachments • Sense of humour • Sense of being loveable • Socially competent • Ability to regulate themselves socially • Ability to empathise and consider situations from another's perspective • Receive recognition of achievement • A sense of meaning in life, usually in the form of faith and religious affiliations	• Caring supportive parents • Connections to caring and competent adults • Parental encouragement, praise and active involvement • Positive role models • Emotional support outside of the family • A sense of belonging, cultural and family heritage • Socio-economic advantages • Stable school • Community resources • Access to health facilities • Routine and rituals • Child-aware and sensitive community and country

An *integrative model* of resilience consistent with the categorisation of protective processes presented in Table 2 could be conceptualised and diagrammatically represented as in Figure 5. Application of the principles of social ecology, as well as those associated with the concepts of risk and resilience, takes into account the dynamic, interactive relationship and multi-directional influence between each of the components. This model of resilience incorporates the different kinds of processes (resilience is not a discreet quality) that have been internationally recognised as integral to understanding and utilising the concept of resilience. The child is at the centre of this model and each of the layers of influence stem from and between the child. The child is regarded as an active participant in his or her own growth and adaptation.

Protective processes can moderate, mediate or generate adaptive responses to risk situations.[90] Given that protective processes have these effects, it becomes logical to incorporate them into intervention programmes. The objective of

Figure 5: An integrative model of resilience



nearly all intervention programmes for vulnerable children should include opportunities for children to build and develop greater resilience.

Mechanisms through which resilience can be developed

Resilience is a dynamic and unfolding process in which individuals and their environment interact to produce beneficial outcomes. Resilience is "not something some children simply have a lot of". It is an acquired capacity influenced by on-going changes in context.[91] Children evolve the capacity to stay organised, to cope and to maintain positive expectations in the face of challenges and across successive periods of adaptation. Acknowledging that

resilience is a learned phenomenon enables the development of intervention programmes that have clear aims and objectives. One can explicitly focus on building resilience and protective processes, thereby enhancing individual, family or community abilities to face adversity.

Both resilience and protective processes can be nurtured through:

- *Reduction of exposure to risk:* Protection is afforded to some children simply by reducing their exposure to risk. Family and community variables are significant in building this form of resilience. For example, some children experience minimal exposure to risk by virtue of their family or community circumstances. They live in close, secure families in which hostility is handled effectively and their basic physical, emotional and social needs are met. Activities aimed at the exo- and macrosystemic levels are particularly important in reducing exposure to risk. If the principles of the Convention on the Rights of the Child are embraced, children are protected from many risks, and advocacy to this end will always form an integral aspect of an effective intervention.

- *Minimising negative chain reactions:* A stressful event or experience often sets in motion a sequence of negative chain reactions, which results in accumulation of risk from both external and internal sources. For example, having a parent with HIV sets off a sequence of diagnosis, illness, recovery, further illness and, finally, death. This often adversely affects children's school performance, which in turn leads to loss of self-esteem. Programmes that provide psychosocial support to children who have suffered, or soon will suffer, the death of their primary caregiver[92] aim to reduce such negative chain reactions. Poverty alleviation programmes aim to reduce negative chain reactions associated with poverty[93] by providing food security, adequate sanitation, health resources and mental stimulation.

- *Promotion of self-esteem and self-efficacy:* Positive self-esteem is recognised as being critically important in boosting resilience. One method of promoting self-esteem is through enhancing opportunities for accomplishment and a sense of achievement by developing competency and success in the various spheres of life.[94] Experiential programmes that offer new opportunities can create cognitive and emotional shifts in self-concept and can enhance self-esteem through the provision of challenges

within a supportive and facilitative environment. The Masiye Camp Model discussed later is an example of such an intervention programme.[95]

- *Provision of opportunities for positive relationships and experiences:* Where people develop their social networks through participation in positive and supportive processes, they develop greater resilience. Positive relationships and experiences thus offer children access to much needed resources and new directions in life. The goals of most community development programmes are consistent with this form of resilience building. Their major goal is to empower individuals through participation in programmes that enable supportive, caring and focused interpersonal interactions, as well as opportunities to experience new ways of being.

All of these resilience-building mechanisms are relevant to the current epidemic. Children and communities in the region face numerous profound risks and hardships. Individuals, families and communities pass in and out of difficult and challenging circumstances on a more or less continuous basis. Thus, although little is actually known about either resilience or coping in such dire circumstances,[96] experience suggests that facilitative intervention programmes and policies need to encourage as many protective processes as possible. This can in large part be achieved by adopting an empowerment-oriented approach. Somewhat simplistically, one can think of empowerment as being based on two generally accepted principles:

- Given a nurturing environment that taps into universal strengths, all people have an innate capacity for change and transformation.

- Human potential is always there, waiting to be discovered and invited forth, even in situations of dire adversity.

Empowerment is usually achieved through community organisation, democratic decision-making processes and active participation of community members in a sustained and responsible manner. These are the age-old principles of *ubuntu*.[97] Such an approach values respect, participation and care as critical aspects of all interactions with community members, be they children or adults.

These values provide important mechanisms through which change, development and transformation become possible. Caring relationships

provide love, consistent support, compassion and trust. High expectations convey respect, provide guidance and build on the strengths of each person, family and community. Opportunities for participation and contribution provide meaningful responsibilities, real decision-making power, a sense of ownership and belonging, and ultimately a sense of spiritual connectedness and meaning.[98] Programmes, however, also need to ensure that basic needs are fulfilled. If people are starving and are worried about their basic survival, they may rightly be too preoccupied with where their next meal is coming from to embrace activities that aim to empower.

A significant conclusion from the International Resilience Research Project was that resilient individuals are helped to become resilient. Although Grotberg[99] defined resilience as a universal capacity that allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity, it is important that partnerships be formed to facilitate this process. People can be helped to draw on their inner resources and strengths within a structure of guidance, direction and support.[100] Intervention programmes need to target several aspects of microsystemic and macrosystemic interactions in order to build resilience and minimise the impact of the risks brought about by the epidemic.

It seems that there are a few critical factors that would enhance resilience in the general population of vulnerable children. First, adherence to the Convention on the Rights of the Child[101] would certainly assist in making policies that are child friendly. Of paramount concern in this regard is that all those children who are entitled to receive government assistance be helped to access such support. This would constitute one important step in alleviating the dire poverty experienced by most children in the region.

Beyond this, educators, leaders of faith-based organisations and all community members can facilitate the development of resilience by:

- genuinely attempting to build trust between adults and children in their community;
- focusing on the individual and not on the problem;
- remaining positive;

- establishing high expectations and providing the support that children and youth need to fulfil these expectations;

- providing opportunities for community involvement in supporting vulnerable children;

- involving parents and other family members in activities that include the entire family; and

- creating a sense of community that encourages people to strive towards the ideal of *ubuntu*.

There has been a tendency in the past to focus on children's obvious physical and educational needs at the expense of their psychological, social and spiritual needs. The study of risk and resilience has thrown into sharp focus the need to address these psychosocial needs. Resilience could thus also be developed in large numbers of children by strengthening the capacity of individuals, families and communities to offer psychosocial support. Introducing psychosocial support can effectively enhance the impact of community-based initiatives. As discussed later in this monograph, the Regional Psychosocial Support Initiative (REPSSI) has created a set of training materials that can be applied in this regard.[102]

Juggling all the balls to predict the outcome for children

HIV/AIDS stands to increase poverty and social fragmentation, which decreases resilience and increases risk. As described in the previous chapter, poverty is the most severe form of psychosocial risk to which a child can be exposed. Poverty, and the existence of poor populations alongside better-off ones, in turn encourages the spread of the virus[103]—potentially creating a vicious cycle of risk and infection.

In this context there are multiple risk factors that may render children increasingly vulnerable to adverse outcomes in the form of social, emotional and behavioural problems. The dire predictions associated with the risk literature indicate that several generations of children will lose out on the basic socialisation processes that are integral to the functioning of a civil society. Off-setting this, the resilience literature suggests that there are a number factors that

increase the likelihood that children will be resilient, rise above adversity and function adaptively. This literature also offers several meaningful ways in which effective interventions can meet the needs of children, families and communities rendered vulnerable by the HIV/AIDS epidemic.

In view of the scale of the epidemic there is urgent need for both micro and macrosystemic intervention so that policy and services reach as many children as possible. Indeed, working on a one-to-one basis with individual children is arguably neither effective nor sensible unless such activities are supported by policy changes that impact on many children. For example, working with groups of orphans and vulnerable children can be highly effective in reducing depression and other psychiatric symptoms and in increasing children's perceived access to social support.[104] However, unless such interventions work together with poverty alleviation programmes that target the health and nutritional status of children, their long-term impact may be less than desired. Indeed, unless every government department, NGO, community-based and family-based organisation works together in the best interests of children affected by HIV/AIDS, the best intentions are likely to amount to very little.

In order to ameliorate the risks to which future generations are exposed, all stakeholders need to work together in an informed and collaborative manner to enhance and build resilience at each of the systemic layers. At the microsystemic level, children need supportive, caring adults with whom they can interact on a regular basis. At the mesosystemic level, the child's various microsystems (family, school, parents, siblings, community members, church-goers) need to network, working together to create a facilitative environment in which the child can grow and feel secure. Exosystemic policies and environments need to promote active decision-making by all participants, including children, for the purpose of enhancing the stability of our next generation. At the macrosystemic level, it must be decided if children really need to be given special consideration and assistance, and if they do, we need to put money towards enhancing and maintaining resilience-promoting environments for children.

By actively considering as many ways as possible in which one can teach, train, develop and enhance resilience, and at as many layers of society as possible, we are ensuring that the world will be a better place for our children.

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CHAPTER 4

SAFETY NETS FOR CHILDREN AFFECTED BY HIV/AIDS IN SOUTHERN AFRICA

Geoff Foster

Introduction

The devastating consequences of HIV/AIDS on African societies, and its particular impact on children, is requiring every organisation involved in fighting the epidemic to find new strategies to address adequately both the scale of the problem and its duration. The crisis of children left behind by AIDS is a humanitarian, development and human rights challenge of unprecedented proportions.

Although there have been substantial gains in improving overall child survival, these gains are being eroded in African countries hardest hit by the epidemic. The scale of the epidemic on this continent makes its repercussions qualitatively different from those in other parts of the world. The economic and social effects of HIV infection and AIDS on children include malnutrition, migration, homelessness and reduced access to education and health care. Psychological effects include depression, guilt and fear, possibly leading to long-term mental health problems. The combination of these effects on children increases their vulnerability to a range of consequences, including HIV infection, illiteracy, poverty, child labour, exploitation and the prospect of unemployment.

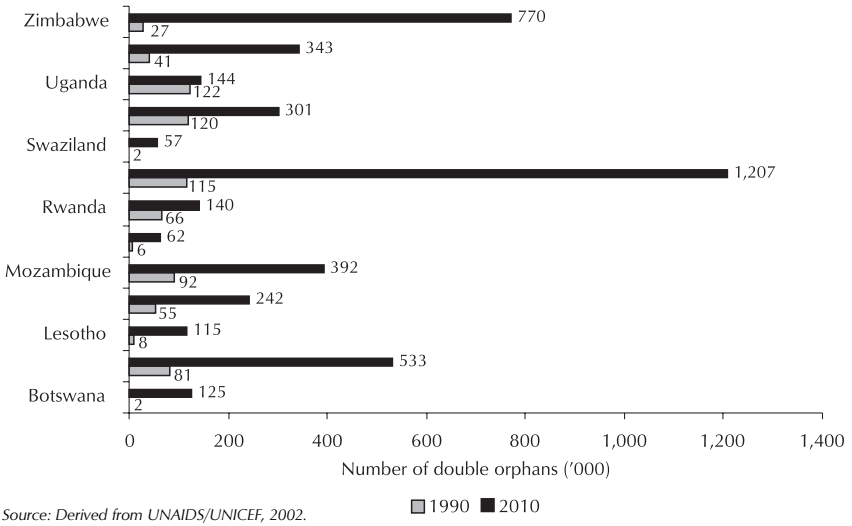
The first line of support for vulnerable children is their family, including the extended family and distant relatives, while households that struggle to meet the needs of vulnerable children may be assisted by members of their community. These informal safety net mechanisms are responsible for the care and support of the majority of vulnerable children in Southern Africa. Formal mechanisms, such as those provided by government and civil society, also provide services, especially for children living in situations of extreme vulnerability. This paper considers the interplay between informal mechanisms provided by the family and the community, and formal support mechanisms

provided by the state and NGO sectors. It concludes with a set of recommendations for ways in which statutory agencies can strengthen family and community safety nets to cope with orphans and other children made vulnerable by HIV/AIDS.

Children and AIDS: The scale of the problem

It is estimated that in 41 African countries, the number of children who are orphaned, for any reason, will nearly double between 1990 and 2010,[1] when almost three-quarters of double orphans in the world will be from Africa. In seven countries in Southern Africa, the most severely affected region, the number of orphaned children to have lost both parents is projected to increase by a staggering 1,100%, from 250,000 to 2.9 million (see Figure 6).

Figure 6: Estimated numbers of double orphans



Source: Derived from UNAIDS/UNICEF, 2002.

On their current trajectory, HIV and AIDS are set to leave millions of children orphaned and millions more in situations of vulnerability. Many children are first affected during the terminal illnesses of their parents, when they shoulder new responsibilities such as additional domestic chores, taking care of sick parents, income-generating activities and childcare duties for younger siblings. Indeed, it is now recognised that educational, social, economic and psychological

problems may be more severe before, as opposed to after, children become orphans.[2] In addition, AIDS increasingly affects almost everyone in severely affected communities, even households without HIV-infected members. Children may thus be affected when families provide money to support sick relatives and mothers leave home to provide care for AIDS-affected relatives, or when their children's standard of living deteriorates when cousins move in after the deaths of aunts and uncles.

Traditional extended family caring

The extended family safety net is still by far the most effective response to economic and social crises throughout sub-Saharan Africa. Members of extended families assist each other socially, economically, psychologically and emotionally. Financially, such assistance most often takes the form of regular urban–rural, inter-household income transfers. When crops fail, family members in town purchase food and bring cash to needy relatives in rural areas. When a relative in town loses a job, they are sent food from the rural areas or are received back into their rural homestead. Households experiencing income stress due to AIDS may send their children to live with relatives who become responsible for feeding the children in their care.

Coping mechanisms regarding orphans are, however, complex and vary according to social setting. In most African communities, the concept of 'adoption' does not exist in the Western sense. Even in the absence of parental death, children are often fostered; a practice whereby natal parents allow their children to be reared by adults other than themselves (see Table 3, *over page*). Child fostering is a reciprocal arrangement that contributes to mutually recognised benefits for both natal and fostering families and fostering by non-relatives remains uncommon. It has also been said that, traditionally, there is no such thing as an orphan in Africa,[3] as relatives such as aunts and uncles have almost always taken on the parenting of orphaned children. The concept of a 'social orphan' is thus a new phenomenon in most African societies.

In the past, the sense of duty and responsibility of extended families towards other members was almost without limits. Even though a family did not have sufficient resources to care for existing members, orphans were taken in. Today, many families still cope with deaths by ensuring that relatives provide care for orphaned children. This may involve a member of the extended family moving

Table 3: Percentage of children (5-14) fostered in the developing world (Demographic Health Survey (DHS), 1990-96)

Africa	%	Near East	%
Namibia	35.5	Morocco	5.9
Uganda	24.3	Turkey	1.5
Zimbabwe	22.0		
Côte d'Ivoire	21.6	**Asia**	
Cent. African. Rep.	21.5	Phillipines	7.5
Zambia	21.2	Indonesia	6.6
Ghana	20.1	Kazakhstan	3.2
Malawi	19.5	Pakistan	2.2
Tanzania	19.4		
Cameroon	18.6	**Latin America**	
Senegal	17.8	Haiti	23.7
Niger	17.1	Dominican Rep.	19.1
Nigeria	15.5	Paraguay	10.6
Burkina Faso	14.8	Colombia	10.3
Kenya	13.9	Brazil	8.8
		Guatemala	7.3

Source: M Ayad et al, cited in S Hunter, 2000.

into the orphan household to care for children, or orphans moving into the household of one or more relatives.

Weakening of the extended family

Cases of abuse, mistreatment or exploitation of fostered children have been reported. Girls in particular may be taken in by relatives because of their economic value in carrying out domestic chores or obtaining bride price. Judging by reports from child rape centres, cases of sexual abuse of orphans also appear to be increasing. However, though several studies have demonstrated that orphans are disadvantaged compared to non-orphans in other families, few studies have demonstrated significant differences in the ways relatives treat their own biological children compared to fostered children. Though such cases undoubtedly occur, for the most part, relatives go to considerable lengths to keep orphans in school, including borrowing money through informal networks and selling their own assets.[4]

Yet the extended family, which has proved so effective in the past, is becoming stressed as a result of both a dramatic increase in the number of maternal and double orphans and a reduction in the number of prime-age caregivers, such as aunts and uncles. If present rates of death among prime-age adults continue, it is projected that this will result in distortion of the population structure of affected countries. Although not entirely undisputed, it is argued that a new type of demographic structure, termed the 'population chimney', will replace the more familiar pyramid that characterises developing countries. Distortion of the pyramid will occur ten to 15 years after the age at which people become sexually active, when those infected with HIV early in their sexual lives begin to die. The population of women beyond their early 20s and men beyond their early 30s will shrink in heavily affected countries, leading to fewer middle-aged people—the so called 'chimney' effect. Due to the fact that more women become infected with HIV, do so at younger ages and die earlier, the epidemic is also expected to take a greater toll on women. The net product of both these trends will be a greater disparity between the number of children in need of care and the number of adults able to provide such care in the future.

Even prior to the HIV/AIDS epidemic, the role of extended families and communities in coping with orphans was in a state of flux. Table 4 outlines some of the changes that have taken place which have weakened kinship

Table 4: Changes leading to weakening of kinship systems in recent years

Change	*How this has weakened extended families*
Labour migration, urbanisation and the cash economy	• Reduction in the frequency of contact with relatives. • Social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family.
Increased life expectancy and family size	• Impossible for an extended family of three or four generations to reside together. • Diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture.
Formal education	• Education about social values occurs through schools and interactions of children with their peers, rather than through traditional mechanisms, lessening the ability of older people to exert social control over children.

systems. The extent of such changes varies from place to place: where traditional values are maintained, such as in rural communities, the extended family safety net is better preserved. Where countries are more urbanised, extended family safety nets are weaker.

As the traditional practice of orphan inheritance by uncles and aunts has lessened, it has been replaced by alternative safety nets, with care provided by grandparents or other relatives. Grandparents are, however, often a last resort and agree to take in orphans because other relatives refuse. It goes without saying that although this provides short-term respite, the ability of many elderly grandparents to protect and provide for children in the long term is limited.

Children who live in situations of extreme vulnerability

The extended family is thus not a social sponge with infinite capacity to soak up orphans. Some children do slip through the extended family safety net and end up in a variety of extremely vulnerable situations. These include living and working on the streets, working for other people in low-paid domestic or agricultural settings, or living by themselves with their brothers and sisters in child-headed households.

It is difficult to obtain accurate estimates of the numbers of children living in extremely vulnerable situations. Estimates for children in these categories vary because of the lack of community-based surveys, standardised definitions (since not all children in these situations are equally vulnerable) and because some agencies inflate numbers for promotional purposes.[5]

Given these caveats, however, the total proportion of unsupported or exploited children living in extremely vulnerable situations probably represents less than 2% to 3% of all orphans, even in the most severely affected countries (see Table 5).[6]

Child-headed households

As a result of the impact of AIDS on communities, changes are taking place in care-giving arrangements for affected children. An increasing proportion of orphans are now in the care of either the elderly or teenage boys or girls. The increase in the number of double orphans has led to the establishment of

Table 5: Estimates of vulnerable children in selected countries

Country	*No. of children 0–17, years, 2004*[7]	*No. of orphans 0–17, 2004*[8]	*Child-headed households*	*Street children*	*Economically active children 10–14*
Burundi	4 million	660 000	20 500[9]		49%[10]
Eritrea	2 million	230 000		3 002[11]	
Rwanda	5 million	810 000	45 000[12]		
South Africa	17 million	2 200 000			
Swaziland	0.6 million	100 000	10%[13]		
Tanzania	14 million	2 500 000	0.03%[14]		
Uganda	18 million	2 000 000	2–3%[15]		45%[16]
Zambia	6 million	1 100 000		75 000[17]	
Zimbabwe	7 million	1 300 000	0.4%[18]	1 000[19]	50 000[20]

households headed by children, mostly in their teens, but with some headed by children as young as ten to 12 years old. This was previously unknown in sub-Saharan Africa.[21]

The number of child-headed households throughout Africa is, however, unknown. What we do know is that there are more child-headed households in urbanised countries such as Zimbabwe and Zambia than in predominantly rural societies like Tanzania, where safety nets are better preserved.[22] In countries with severe HIV/AIDS epidemics, it may be anticipated that the number of child-headed households will increase significantly in the future.

Methods of establishment

In some cases grandparents, usually grandmothers, take in orphaned children. As these grandparents' age or experience deteriorating health, the situation in which the elderly provide childcare is reversed and grandchildren end up caring for increasingly frail grandparents.

When grandmothers die or move in with other relatives because of illness, children are sometimes left to live by themselves. Relatives may take in younger children, leaving older brothers and sisters living together. In other cases, child-headed households are formed when brothers and sisters insist on staying together and refuse to move away from their deceased parents' homestead.

Child-headed households are usually temporary arrangements. In many instances, it simply takes time for families to organise coping strategies in response to unaccompanied children, and it is accepted that such children will eventually become part of adult-headed households. In other cases, child-headed households disintegrate as a result of various catastrophes, following which children are taken into relatives' households. Often, it is only after crises that relatives who were previously equivocal about not providing care become amenable to taking in vulnerable children.

Problems faced by child-headed households

The situation of children living in child-headed households is often perilous. 'Child adults' often drop out of school for lack of school fees, money to buy books and uniforms and, sometimes, stigma. Many must work hard to feed and educate their younger siblings, while younger children may be forced to labour in domestic or agricultural chores once carried out by adults. Girls may feel their family's situation might improve if they were married, which may result in teenage motherhood and being forced to choose between their family and their husband if he rejects their younger siblings. Children living in child-headed households thus face problems that are common to other vulnerable children living in destitute households, such as:

- food insecurity;
- problems of access to education and skills training;
- the struggle to meet material needs;
- the absence of psychosocial support;
- poor life skills and knowledge;
- abuse and exploitation;
- absence of an extended family network;
- poor housing conditions and insecurity of tenure; and
- poor access to health care.

What is unique is that these problems are extreme and unrelenting and must be faced without adult assistance.

Child-headed households as a coping strategy

The appearance of child-headed households does not necessarily mean that

extended families have abandoned their responsibility to care for relatives' orphaned children. Not all child-headed households are equally vulnerable, and some child-headed households live in close proximity to nearby relatives who visit regularly and provide them with material support.[23] Indeed, some cases can be viewed as a new mechanism to cope with the impact of AIDS. The high prevalence of child-headed households in Swaziland, for example, is a consequence of traditional extended family living arrangements in that country, which enable child-headed households to live in supported situations. Many child-headed households are, however, left to fend for themselves and receive little support from their relatives who are already struggling to feed, clothe and educate their own children. Unsupported child-headed households are particularly vulnerable to exploitation as a result of destitution and a lack of adult supervision.

Street children

In Africa, it is thought that around one million children live and work on urban streets, with the highest rates in post-conflict countries where poverty and family disintegration as a result of war are common.[24] Most street children are engaged in trying to earn money, whether by begging, car guarding, buying and selling or crime. An important distinction to make, however, is between children *on* the street and children *of* the street.

Where children live *on* the street, the family support base has generally become weakened and so children share the responsibility for family survival by working on city streets. For these children, the home ceases to be the centre of play, culture and daily life. Nevertheless, while the street becomes their daytime location, the majority return home most nights. Despite potentially deteriorating family relationships, familial ties are still in place and the children continue to view life from the perspective of their families.

Children *of* the street constitute a smaller number of children who live, work and sleep on the street and struggle daily for survival, alone and without support. Though many people believe that street children have been abandoned by their relatives, in many cases it is more accurate to view such children as having abandoned their families—often as a result of insecurity, rejection and violence. Their ties with home have been broken and they are without families.

Many street children are orphans. In Zambia, for example, 65% of 'child prostitutes' and 56% of children living on the street were orphans.[25] Similarly, in a survey of 81 male and 15 female street children in Mutare, Zimbabwe, 67% were orphans, compared to an estimate of approximately 20% for the child population as a whole.[26] Two-thirds of these children were *on* the street, mostly staying with a relative; one-third were *of* the street and had no other dwelling place. It is impossible to say how many such children have been orphaned by AIDS, but given the growing contribution of AIDS to levels of orphaning in the region, it is likely that the epidemic is leading to increasing numbers of street children in Africa.

Problems identified by street children

Table 6 lists the main problems identified by the 96 street children in Zimbabwe.[27] Significantly, glue-sniffing—which is associated with social, medical and psychological consequences—was not mentioned, probably because it is viewed by street children as a solution to their predicament rather than a problem.

Table 6: Problems facing street children in Zimbabwe

Problem	*Number*
Bullying by older boys	52
No food/clothing	17
Fighting	9
Sexual harassment	7
No blankets	7
No shelter	7
No money	6
Harassment/humiliation by society	5
Lack of treatment for diseases	4
Harassment by police	4
Exploitation	2
Nowhere to bathe	1
No problems	13

Source: FACT, 2000.

Since the majority of street children live with or maintain ties with their families, strategies to respond to their situation should focus on strengthening the capacity of families to care for and protect their children.

Working children

In all societies, children are involved in work, whether for their own families or for money outside the home. Not all labour is necessarily damaging to children, and it is often difficult to draw a line between children's work that is a normal part of childhood development, such as assisting with family activities, and child labour that is exploitative and harmful. In families, parents or guardians assign work and responsibility compatible with a child's age, gender and developmental level. Families do not normally and intentionally exploit children.

Africa has a higher proportion of child labour than any other region, with 41% of children below the age of 14 in the labour force. This equates to over 80 million children, almost twice the Asian rate. This more often reflects the adverse economic situation facing families in Africa than regional approaches to child rearing. The most extensive market for child labour in sub-Saharan Africa is for domestic services, such as cleaning, washing, cooking and child minding for girls and gardening, farming, animal husbandry or herding for boys. Other common child labour practices include contract labour on commercial farms and estates, vending, hawking and selling, mining, touting customers for transport, brothels and shabeens and commercial sex work. In some West African countries, the demand for domestic services by children is so high that it may lead to child trafficking.[28]

Children's work and the impact of HIV/AIDS

The economic consequences of the HIV/AIDS epidemic are impacting on children, both within and outside the family home.[29] Children affected by HIV/AIDS are increasingly taking on adult roles at a young age, including providing care for a sick parent and taking on extra household responsibilities. Some children, especially girls, also have to give up school in order to generate an income.

Orphanhood, in particular, is associated with increased child labour.[30] Most child heads of households engage in income generation to support their young

families. Adolescents may also leave orphan households to seek work, while some girls become involved in commercial sex or enter into marriage as girl brides to provide for the needs of the young or the elderly in their household. In Tanzania, for example, more than half of those children working full time in the country's mines were orphans.[31] In Addis Ababa, Ethiopia, more than 75% of child domestic workers were orphans.[32]

Orphans seem more likely to be child labourers as a result of their poorer living conditions, as opposed to discrimination against them by their caregivers. These inappropriate responsibilities can create long-term emotional problems, contribute to lost opportunities in education and development and lead to sexual exploitation. Child labour is illegal in many countries, but law-enforcement will have little effect unless families are supported in order to find adequate alternatives to child labour. The state and the community thus have a responsibility to ensure that children affected by HIV/AIDS are not denied their childhood.

Community safety nets

Seeking relief from family, friends and neighbours is a common response to economic crises. Even the poorest and most vulnerable people have set up resilient and ingenious coping mechanisms. Most communities throughout Africa have a tradition of voluntary associations or solidarity groups that provide essential support to households affected by misfortune. This type of community 'safety net'—the provision of short-term relief and assistance by individuals and organisations within the community—is a common response to an array of disasters, both natural and man-made.[33] In Tanzania, for example, there is a long tradition of social support groups. Members assist one another in routine ways by helping to cultivate one another's fields and by contributing labour, money or food to one another at times of special need such as sickness and funerals, or on occasions such as marriage ceremonies.[34] Voluntary associations provide a wide range of support that includes loans, food, funeral assistance, labour and cash through mechanisms such as:

- burial associations;
- grain loan schemes;
- self-help groups;
- labour-sharing schemes;

- savings clubs; and
- revolving credit-and-loan schemes.

Voluntary associations are poor people's insurance policies. Relatives, friends and neighbours provide both moral and material support to the sick and vulnerable on the assumption of future reciprocation, and supportive actions are part of a clearly understood system of solidarity, which ensures that all contributing individuals receive support in times of adversity. Culture reinforces such arrangements through oral tradition, as illustrated by the Shona proverb: "What has befallen me today will befall you tomorrow."

Weakened community safety nets

The amount of assistance that voluntary associations can provide is, however, generally limited and short-term in nature. In the case of death, for example, the duration of support is usually limited to the period of mourning. In addition, community safety nets are being weakened as a result of the steadily growing impact of the HIV/AIDS epidemic.

Better-off families, in particular, are increasingly finding their economic reserves depleted due to the continual demands placed on them by relatives affected by AIDS. Families in these circumstances become less able to contribute in cash, kind or by the provision of work to families in need. As AIDS causes the number of families falling from poverty into destitution to increase, the amount of relief that can be provided per destitute family is likely to decline.

Community initiatives in response to orphans

Without outside influence, community groups in Africa do not generally provide substitute parental care and few have established community foster homes or institutions in response to increasing numbers of orphans. However, starting in the 1990s, communities throughout Africa have begun to add additional layers to their community safety nets by providing material, educational, emotional and psychosocial support to children affected by HIV/AIDS. These community-based support initiatives have been established largely in the absence of significant external facilitation or financial support and are growing in scope and number. Recent research in East and Southern Africa has documented the high prevalence of community responses initiated by

churches, mosques, other religious groups, women's groups and community-based organisations (CBOs).[35] In this study, interviews conducted with 690 faith-based organisations found that over 9,000 volunteers were supporting in excess of 156,000 orphans and vulnerable children. Table 7 summarises different support activities carried out by community groups.

Table 7: Community-based support activities provided by 505 faith-based organisations (FBOs)

Type of response	*FBOs*	*Description of response*
Religious education and spiritual support	90+%	Spiritual support to families and children through scripture reading, religious instruction, prayers, singing and encouragement to attend worship.
School assistance	73%	School fees, levies, uniforms, equipment, books, boarding fees, etc.
Material support	62%	Essential material support such as food and clothing to individual children from destitute households.
HIV prevention Visiting/home care	51% 39%	Increase awareness of HIV and moral guidance for children. Volunteers identify needy households in their neighbourhood, regularly visit and provide parenting, advice, household supervision, meal preparation, dwelling maintenance and assistance in household agriculture or income generation.
Psychosocial support	32%	Specifically provide counselling to children while others incorporate psychosocial support group activities.
Medical care	30%	Enable children to access essential medical support through the provision of medical fees or medicines.
Income generation/ vocational training	19%	Initiatives seek to raise money or provide experience in managing projects such as nutrition gardens, husbandry projects, manufacturing co-operatives and buying-and-selling initiatives or skills in carpentry, dressmaking, etc.
Day care centres	11%	Care during the day and food for pre-school children, often while caregivers are working.
Community schools Fostering promotion.	5% 3%	Non-formal education facilities for out-of-school children. Encourage fostering and adoption by non-relatives of orphans.

Source: G Foster, 2003.

Such community initiatives support vulnerable children by enabling families to continue to provide care for orphans. Though most community responses to date are small scale and localised, the cumulative impact of large numbers of local initiatives is proving increasingly significant, and such community initiatives will be an essential element in caring for growing numbers of orphans and vulnerable children in coming years. Yet in order for them to continue to function and expand to address the multiple dimensions of care and protection required by vulnerable children, they require financial and technical support. The nature of the orphan crisis is such that small amounts of long-term funding will be needed to supplement community support mechanisms over the course of several decades. Unfortunately, most donors make large, short-term grants to a small number of contractors and few provide long-term, low-level support directly to community groups. Many grants also involve complicated and expensive application procedures and stringent reporting requirements that make them inaccessible to most CBOs.

This approach is generally incompatible with the situation in affected countries, where thousands of community groups are struggling to sustain social structures in the face of an epidemic with long-term and cumulative repercussions. There is thus an urgent need for the creation of innovative mechanisms to channel resources to community groups. This could be done through intermediary institutions, such as locally administered trust funds, local and regional networks, multi-layered committees and capacity-building NGOs.[36]

State social security interventions

Where family and community networks fail, become overburdened or require supplementing, the state is often the final port of call. In this regard, there are many mechanisms by which governments can improve the situation of children made vulnerable by HIV/AIDS. These include employment creation, supporting families through the provision of access to basic services such as free basic education, good health care and community development programmes, as well as direct support initiatives such as feeding schemes and the provision of grants. With the exception of countries such as South Africa, Botswana and Namibia, however, state mechanisms in the region are relatively weak.

South Africa has one of the most well-developed statutory social support

schemes in Africa. Family and child benefits in South Africa currently include the following:

- Child Support Grant (CSG), which currently targets children under the age of 11, and will by the end of 2005 target children under the age of 14. The grant is means tested[37] and caregivers are eligible for a grant of R170 (approximately US$28)[38] a month.

- Foster Child Grant (FCG) for children placed in foster care. This grant is for the sum of R530 (approximately US$88) a month and only children placed in foster care by a court of law are eligible to receive it.

- The Care Dependency Grant (CDG) for children with severe mental or physical disabilities who require permanent home care. The grant is means tested and amounts to a sum of R740 a month (approximately US$123). There is no specific provision for children with chronic illnesses such as HIV/AIDS and relatively few children in the terminal stages of the virus have managed to access this grant.[39]

In addition to these grants, the South African government has put in place Social Relief of Distress measures, which take the form of temporary assistance—in cash or food—for people in need of immediate help to survive. The monetary amount or equivalent of such relief is less than the monthly value of the grants received by the household and will only be given to households for up to three months.

However, while such mechanisms are an important source of support for a range of children living in vulnerable circumstances, problems exist that cast doubt on the ability of the system to meet the needs of children affected by HIV/AIDS.

It is evident that, irrespective of the epidemic, only a minority of the poorest families receive child support grants from the state. It was estimated in 2003 that just over three-and-a-half million (3,622,479) children were registered to receive the CSG.[40] Take-up rates have increased in recent years but it clear that many of the poorest children still do not have access to the grants, with a recent report suggesting that between 28% and 39% of poor children under the age of nine do not access the CSG (see Table 8).[41]

Table 8: Percentage of poor children aged seven and eight receiving the Child Support Grant per province (2003)

Province	Total 7–8 year olds	Provincial poverty shares	Approximate no. of children 7–8 in poverty	Children 7–8 receiving grants	Percentage of poor 7–8 year olds receiving grants by province
Eastern Cape	325 193	75.1%	244 220	74 214	30.4%
Free State	108 642	61.2%	66 489	43 686	65.7%
Gauteng	262 302	38.3%	100 462	73 795	73.5%
KwaZulu-Natal	444 452	63.8%	283 560	103 422	36.5%
Limpopo	289 615	68.4%	198 097	112 961	57.0%
Mpumalanga	146 232	59.4%	86 862	49 154	56.6%
Northern Cape	33 117	50.8%	16 823	8 357	49.7%
North West	149 796	60.4%	90 477	38 014	42.0%
Western Cape	162 308	25.3%	41 064	29 671	72.3%
Totals	**1 921 657**	**Average: 59%**	**1 128 054**	**533 274**	**Average: 47.3%**

Source: Leatt, 2003.

Many eligible children and households do not receive grants either because they are unaware of their entitlement or lack the documentation,[42] time and resources necessary to access the social support system. Administrative delays in processing grant applications, as well as the poor attitude of some administrative personnel, also often deny families the grants to which they are entitled under South African law.[43] With the number of children to have lost one or both of their parents to AIDS alone expected to peak at 5.6 million by 2015,[44] it is unlikely that this situation will improve in the absence of fundamental change to the system.[45] Indeed, recent estimates produced by the Children's Institute in South Africa suggest that less than half of all children under 18 will receive support by 2017.[46]

This is likely to be compounded by the orientation of the system towards children in adult care, which results in large numbers of the most vulnerable children being hidden from the state's view. These include street children, child labourers, children of illegal immigrants, children living in child-headed households and children over the qualifying age. Where such children are

minors, they are not entitled to receive child support grants on their own behalf and receive little, if any, assistance through current statutory child support systems.

Children affected by HIV/AIDS may also face particular problems in accessing state support. As already mentioned, movement is a survival strategy adopted by many poor households and often increases substantially in response to adult illness or death, as children are sent away to live with relatives who can better provide for them, household members leave in search of work or relatives join the household in order to provide care. Children affected by HIV/AIDS are particularly mobile, often moving several times both before and after their parents' death.

Given that it may take several months or even years for a grant application to be processed, and that children are required to remain resident with the guardian stipulated in the application, such movement is likely to hamper efforts to obtain grants on these children's behalf. The death of parents, and the subsequent movement of children, may also result in the loss of documents such as birth certificates, or complicate efforts to obtain such documentation.

Turning to problems associated with the specific structuring of the grants, the CSG is only payable in respect of a maximum of six children per household if they are not the biological children of the applicant. Given that single households often take in several children in addition to their own, the grant does not offer much assistance to the many families caring for large numbers of children.[47] This may act as a disincentive for relatives to take orphaned children into their families.

There are also a number of weaknesses associated with the FCG. Despite growing international recognition of the need to keep orphaned children in their families and communities, a disproportionate amount of the child welfare budget is being spent on supporting caregivers who are usually unrelated to the child.[48] Under the current system, foster care placements are also required by law to be reviewed every two years. This not only makes the grant expensive[49] and labour intensive to administer, it also adds enormously to the workload of already over-stretched and under-resourced social workers—resulting in administrative delays, non-adherence to legal reporting requirements[50] and, ultimately, the capacity to absorb only a limited number of children into the

system. The disparity between the CSG and the FCG also encourages caregivers, who would anyway be providing care, to have children formally placed in their care by the court.

As Meintjies et al argue, this ties orphaned children and caregivers 'in need of cash' to a labour intensive, surveillant and costly child protection system aimed at providing care and protection to children who are without support, or who suffer abuse or neglect.[51] In so doing, such a system not only inappropriately targets scarce resources, it fails to address the predominantly material needs of families and children affected by HIV/AIDS.

Choice of care provision for orphans

When parents die there is no ideal placement for the children, just better or worse options. Enabling siblings to remain together in the care of family members they already know and are prepared to accept as new, permanent caregivers is the best option and maintaining orphans in families should be our highest priority.

Providing support to families under stress is the best way to achieve this and programmes such as those described earlier have the advantage of being less costly, both financially and in terms of the emotional cost to the child.

Adoption or fostering

If it is impossible for children to be maintained in their family of origin, the next best option is care within another family, through fostering or adoption by a non-relative. In Western societies, a clear distinction is usually made between adoption and fostering. The former is a type of family placement in which the rights and responsibilities of one set of parents are legally and permanently transferred to another set of caregivers.

Fostering is a less permanent form of substitute care which does not involve the transfer of parental rights and responsibilities. In practice, this distinction can become quite blurred, especially in African countries where legal adoption is often neither available nor accessible. In this context, new and innovative approaches to community foster care are being developed (see Box 1). These need to be assessed and, if found effective, replicated.

Box 1: Community family care

This model of care was pioneered by the Durban Child Welfare Society in South Africa. The aim is to provide relatively affordable, family-type care for up to six children in their communities of origin, or a similar social context. Under this model the community selects, assesses and trains an appropriate community member who becomes full-time 'mother' to the group of children. Sibling groups are accommodated and new 'families' are created for children who have no contactable relatives.

In contrast to regular foster care, where the house belongs to the foster family, either the state or an NGO provides the accommodation. Wherever possible, a small allowance is paid to the community-mother and she is assisted in accessing the available foster care grants. The created family is linked to all available community support systems and is monitored in the same way as a traditional foster care placement.

The model has proven appropriate in an urban context where abandonment of children is a serious concern.

Source: UNICEF/Child Protection Society, Zimbabwe, 1999.

Institutional care

Institutional responses to the crisis, such as orphanages, will never be able to address the scale of the orphan problem. They are also much more expensive to maintain than assisting families to care for children. Research by the World Bank in Tanzania, for example, found that institutional care was about six times more expensive than foster care, while cost comparisons in Uganda showed the ratio of operating costs for an orphanage to be 14 times higher than those for community care. Other studies have found a ratio of 1:20 or even 1:100.[52] Orphanages also run counter to local traditions and fail to meet children's social, cultural and psychological needs.

Children need more than good physical care. They need the affection, attention, security and social connections that families and communities can provide. Countries with long-term experience with institutional care for children have seen a number of problems emerge as children raised in institutions grow into adulthood and have difficulty reintegrating into society. In Ethiopia, Rwanda and Uganda, for example, evaluation of the effects of long-term residence in orphanages have led these governments to adopt policies of de-institutionalisation and support for family-based care.

Should institutional care be deemed necessary, it should be short term and provided only when other levels of care are unavailable. Care in smaller, family-type community foster homes is preferable to larger institutions. Orphanages that provide dormitory-style accommodation for children of similar ages—for example, those with separate units for babies and pre-schoolers and dormitories for primary school-aged children and teenagers—are particularly damaging to children's self-esteem and development, since they fail to recreate the family-type environment children require. Efforts should also be made to improve the conditions of children already placed in residential institutions.

Overcoming problems with alternative care strategies[53]

While community care strategies are the most appropriate means of strengthening the ability of extended families to cope with orphans, few states have yet established mechanisms to strengthen extended family and community safety nets through the provision of financial and technical support. Individual and community initiatives also receive little if any formal recognition by statutory bodies. Whereas children living in institutions or placed in formal fostering are recognised in law, and their situation is regulated and supervised by social welfare agencies, there seldom exist such statutory provisions for supervision and engagement with community care initiatives. However, both children and caregivers in informal foster situations need to be recognised and protected by law. Without such legal status, informal caregivers are often unable to access the government support that does exist, act as the child's guardian, grant permission for medical procedures, represent the child in judicial acts or administer his or her affairs.

In principle, informal foster care is encouraged by social welfare authorities. Yet in practice, the majority of financial and human resources within child welfare service provision for vulnerable children is spent on alternative care strategies for the minority who have slipped through extended family and community safety nets. Relatively small amounts of money are spent on strengthening informal support mechanisms, and most social service providers are involved in case-oriented approaches and have little experience in community mobilisation or strengthening safety nets. Individual child support and foster care grants do little to strengthen community support systems and may inadvertently undermine them by promoting concepts of paid foster care (see Table 9, *over page*).

Table 9: Interventions for foster families and children in vulnerable circumstances

Intervention	*Advantages*	*Disadvantages*
Fostering	• Family members are most likely to act in child's best interest. • Family integration promotes psychological and intellectual development of children. • Fostered children are integrated into society more readily than children in orphanages.	• Discrimination in food allocation, workload, etc., may exist.
Subsidies distributed through the family	• Encourages even poor families to foster orphans with the additional costs of caring for orphans borne by the government.	• Difficult to monitor. • Subsidies sometimes benefit head of household only. • Subsidies may be shared among too many family members, thus diluting the amount of support going to the orphan. • Subsidies exclusively for the orphan may stigmatise the orphan.
Subsidies distributed through community	• Communities will better know the needs of family. • If distributed by churches, stigma may be reduced.	• May not work in urban areas where sense of community is weak. • May not work in communities where ethnic tension or discrimination exist.
School vouchers/ subsidies; health vouchers redeemed by clinics	• School subsidies are easy to monitor. • Most likely to prevent future loss of human capital.	• May entail horizontal inequity, to the extent children with parents alive but in abject poverty do not receive any subsidy.
Income-generation schemes for fostering families	• Increase short-term incentives of households to adopt children. • If successful, improves the welfare of orphans.	• Rarely succeed without tracing, follow up and leadership. • Provide no long-term incentive for caring for orphans.
Family tracing	• Being reunited with family members brings psychological benefits.	• May not be viable in post-conflict situations, in areas where large percentage of the population has died or is missing, or in war-torn economies where family members are unable to care for orphans.
Orphanages	• Better than child-headed households or being a street child. • Orphanages run by religious groups may reduce stigma and attract donor and charitable funds.	• Lack incentive to act on behalf of orphan. • May harm psychological development of orphans. • Not cost effective. • Can easily become commercial institutions rather than welfare institutions. • May not meet the emotional needs of children.

Source: Subbarao et al, 2001.

Statutory approaches to child welfare

The rationale of statutory welfare structures is that the state has a responsibility to find the 'best possible' alternative care for children through placement by professional social workers. The system for children in need of care is designed to promote legal adoption or support fostering through maintenance grants and careful supervision by child welfare officers.

Vast differences, however, exist in social welfare provision for children in different parts of Africa. As already noted, while a few countries have fairly sophisticated systems of grants, procedures and supervisory practices backed by legal instruments and relatively well staffed social welfare departments, most countries' welfare systems are rudimentary. Most of the legislation and systems in place are also based on Western models of alternative care established during the colonial era. Legally endorsed child welfare models are thus designed to protect the child being taken into care through stringent assessment procedures for prospective foster or adoptive parents. Potential caregivers must meet eligibility criteria based on education level, marital status, employment, income, accommodation, age, medical information and motivation.

The reality, irrespective of AIDS, is somewhat different. Although children are placed in institutions with the notion that these are temporary places of safety, these institutions often become children's permanent home until they reach adulthood. Furthermore, while the supervision of childcare in institutions or foster homes is the responsibility of social welfare officers, high workloads often lead to foster care 'drift' where the child, home or institution is seldom visited or monitored.

While case-oriented systems involving placement of children by social workers in carefully selected family settings may have been feasible before the current orphan crisis, the strategy is inappropriate to support the increasing number of children in need of family homes. There is thus a need for statutory systems to recognise formally the role played by families and communities in supporting children. This may require that the criteria used to determine suitability of foster parents incorporate community norms. The minimum standards set for formal fostering and adoption are too high and the procedures too complicated for many poor but willing community members.[54] The concept of 'good enough' standards—appropriate to the norms of the community in which the child lived—is worthy of consideration in developing countries, especially where 10%

or more of the entire childhood population would have lost both parents in the decade to come.

Indigenising statutory care procedures

There is clearly a need for statutory agencies to strengthen extended family and community safety nets in order to reduce the number of children who need to be placed in care by the state. This type of undertaking would demand a significant commitment of resources by social welfare agencies and would involve retraining of staff and major reorientation of social welfare systems and procedures. The process of indigenising statutory care procedures might include measures such as:

- mapping community care programmes, to better understand their extent and nature;
- promoting an awareness of the concept of foster care and adoption by families not related to the child;
- promoting the establishment and development of community care programmes, especially in areas with limited access to social welfare departments;
- simplifying assessment procedures for potential foster parents to make them more 'client friendly';
- developing appropriate assessment forms and information materials for use among community child care volunteers and informal foster parents;
- training social workers in community care supervisory skills;
- training volunteers in community care programmes in family assessment and supervision;
- reviewing legal instruments so that they recognise the existence of informal foster parents and community care programmes;
- reviewing the appropriateness of existing foster grant systems, which provide

grants to formal adult foster parents, but make no provision for informal foster parents or child-headed households; and

- establishing multisectoral committees (such as the Child Welfare Forums in Zimbabwe) with statutory provision for them to monitor community care programmes.

Conclusion

Despite large increases in orphan numbers, surprisingly small numbers of children have, up to now, slipped through the safety net provided by the extended family. Provided that coping mechanisms are not undermined, all the evidence suggests that the traditional fostering systems in Africa, supported by community programmes, will continue to meet most of these children's basic needs. Indeed, families and local communities are the frontline of the HIV/AIDS epidemic's impact and have demonstrated remarkable resilience and creativity in addressing the myriad needs of affected children. Given the extent of the HIV/AIDS epidemic, however, families and communities cannot alone absorb and support the large numbers of children expected to be left orphaned and vulnerable by the epidemic. They need to be supported to avoid these mechanisms becoming overburdened.

The current systems, procedures and approaches of case-oriented social welfare provision are, however, inadequate for coping with the future impact of the epidemic and need to be simplified and adapted if they are to protect a significant number of the children left vulnerable by HIV/AIDS. State and NGO systems of support for vulnerable children also need to recognise the central role played by families and communities in the provision of care and need to ensure that their systems of support strengthen rather than undermine extended family and community support mechanisms.

Notes

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16 K Subbarao et al, op cit.
17 USAID/UNICEF/SIDA/Study Fund Project: Situation analysis of orphans in Zambia, 2, *Data Review: analysis and enumeration using existing data*, Government of Zambia, Lusaka, 1999. This study suggests that around 5,000 street children are homeless. The remainder live with relatives or friends
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37 The means test is widely considered to be inadequate. The means test for the CSG varies according to the marital status and circumstances of the adult applying for the grant on behalf of the child. Eligibility is determined on the basis of the caregiver's own income if they are single and joint income if they are married. The cut-off level for the personal income of the caregiver and caregiver's spouse is R9,600 a year (R800 a month) for people in urban areas and R13,200 a year (R1,100 a month) for those living in a rural area or in informal housing in an urban area, irrespective of the number of children.

Despite inflation, these thresholds have not increased since 1998, when the CSG was first introduced.

38 The amounts cited for the Care Dependency, Foster Care and Child Support grants are as of the 1 April 2004.

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40 A Leatt, using SOCPEN daily records as of 30 October 203, in *Reaching Out*, working paper by the Children's Institute, University of Cape Town, 2003.

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42 Applicants must present the child's barcoded birth certificate and their own barcoded identification document to their provincial department of Social Development, together with proof of guardianship, and the child's clinic card. In a context where less than half of South African children have birth certificates, it is virtually impossible for many poor families to provide all the documentation necessary to apply for a grant (D Ewing, op cit).

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44 H Meintjies, D Budlender, S Giese & L Johnson, *Children 'in need of care' or in need of cash?* Joint working paper by the Children's Institute and the Centre for Actuarial Research, University of Cape Town, December 2003.

45 The Child Care Act of 1983 is currently under review and its successor, the Children's Bill is due to be tabled in parliament shortly.

46 H Meintjies et al, op cit. The authors calculate the reach of four different assistance options. They argue that the first option, consisting of two grants closely resembling those currently administered, would reach approximately 45% of all children under the age of 18 by 2017 (up from 29% of children in 2003). The second, which would involve placing children in the court-ordered care of relatives and later accessing a grant similar to the current FCG, would reach the same proportion. The third option, which involves a single grant similar to the CSG, would reach approximately 38% of all the children in need of the grant (up from 26% in 2003). The fourth option, a universal child support grant, would reach all children in need of assistance.

47 D Ewing, op cit.

48 Ibid.

49 In addition to monetary grants, there are costs associated with children's court inquiries, statutory supervisory services and grant administration.

50 See H Meintjies et al for a detailed discussion of these issues.

51 H Meintjies et al, op cit.

52 UNAIDS/UNICEF, 2002, op cit.

53 This section draws heavily upon material developed by delegates from South Africa and Zimbabwe attending a series of workshops entitled, Towards an African model of care for orphaned and children, UNICEF/Child Protection Society, Zimbabwe, 1999.

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CHAPTER 5

CALL TO ACTION: WHAT DO WE DO?

Stefan Germann

Introduction

The crisis of orphans and other children made vulnerable by HIV/AIDS is a catastrophe of unprecedented scale and hurt.[1] The previous chapters have presented an in-depth analysis of the situation of children in Southern Africa in general and the impact of HIV/AIDS on children in particular. The importance of resilience and coping was highlighted and mechanisms of formal and informal support to orphans and other children made vulnerable by HIV/AIDS were illustrated. As important as this wealth of information and analysis is, unless it leads to decisive action at family, community, national and international level, this monograph will amount to little more than interesting intellectual stimulation. As Nelson Mandela recently challenged us:

> Of course, we need to do careful planning and deliberation about the actions we shall take, but any moment spent on deliberations that does not lead to decisive action in support of orphans and other children made vulnerable by HIV/AIDS is a moment tragically wasted.[2]

This chapter is a call to action for all members of society collectively to mitigate the long-term consequences of HIV/AIDS for both children and society in Southern Africa. To this end, this paper first considers the issues policy makers should be aware of in designing interventions. It highlights programmatic responses used successfully to date in the region, before finally bringing together the lessons learned from such programmes. However, although this paper focuses on children affected by HIV/AIDS, it is important to note that the programme responses shared below do not singularly target such children, but aim to improve the quality of life of all vulnerable children in the community.

Why is urgent action needed?

The orphan and vulnerable children crisis is big, rapidly growing and long term.[3]

Current responses are inadequate and while families and communities in the region are currently managing to absorb many of the impacts of the epidemic, without appropriate intervention such mechanisms are likely to become increasing unable to cope. Many of the developmental gains of the past few decades also stand to be undermined and the Millennium Development Goals will not be met if HIV/AIDS is not substantively addressed in the SADC region.[4]

Long-term impact

In history, large-scale orphaning has been a short-term, sporadic problem mainly caused by war, famine or short-term disease. HIV/AIDS, however, is transforming orphaning into a large-scale, long-term, 'chronic' problem that will extend through at least the first half of the 21st century.[5] This is likely to have major implications for both the children left orphaned and vulnerable by HIV/AIDS and the societies in which they live.

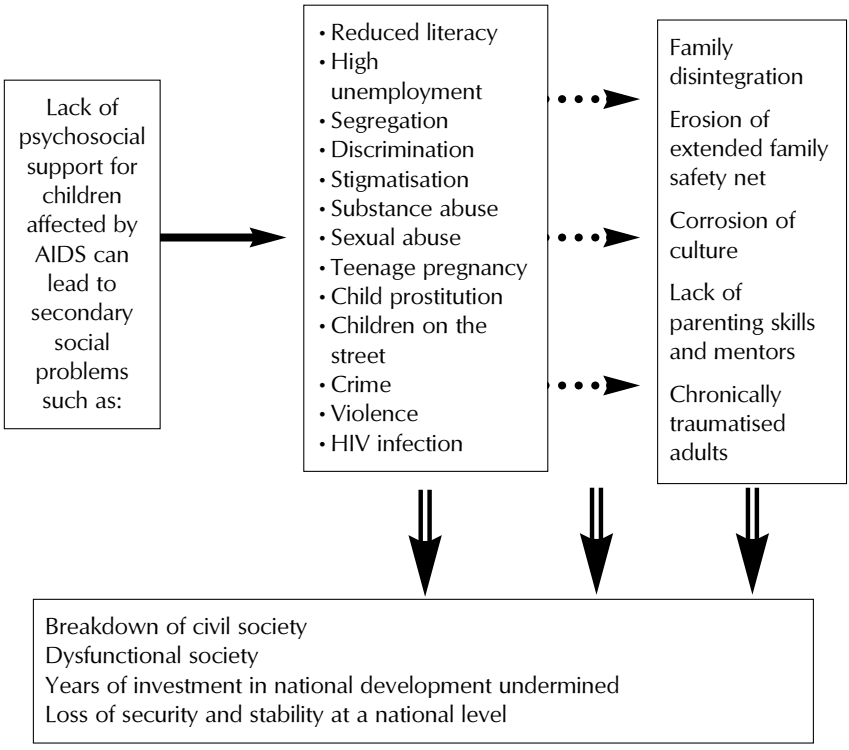
The epidemic harms children through its impact at all levels of society. HIV/AIDS is creating and exacerbating not only physical poverty but also emotional, psychological and social poverty in the lives of HIV/AIDS-affected children. Every human need if unsatisfied can create poverty and any poverty can degenerate into destructive pathology that may have personal, familial and societal implications for a nation's security and stability.[6] The situation is made worse as the impacts are bi-directional, leading to a vicious cycle; as societies are destabilised, the situation for individuals and communities deteriorates further.

The death of parents due to AIDS can lead to serious psychosocial consequences for children, as they lose nurturing, family stability, social connectivity and often their economic income base. Furthermore, because children often suffer multiple losses—losing several family members as a result of AIDS-related death, as well as siblings, friends, familiar surroundings, schooling opportunities and even their childhood and hope in the future as a result of the poverty and migration that often follow such deaths—they may suffer sequential trauma associated with continuous traumatic stress syndrome.[7]

It is difficult to predict what the long-term consequences of such psychosocial trauma for children affected by HIV/AIDS in Africa will be and there are no

longitudinal impact studies available to assist in this endeavour. Studies in developed countries, however, suggest that children with continuous traumatic stress, even of a mild form, suffer long-term negative developmental consequences.[8] Since the psychosocial impact of HIV/AIDS on children in developing countries and developed countries is similar, it may be assumed that the same applies to the long-term consequences of continuous traumatic stress.[9] In a scenario where a large number of children affected by HIV/AIDS in Africa and other parts of the world are exposed to on-going traumatic stress, failure to support children to overcome such trauma will not only jeopardise personal development but, given the scale of the problem, could also undermine years of investment in national development as such children grow to adulthood and are required to take on productive, leadership and parenting roles (see Figure 7).[10]

Figure 7: Potential long-term impact of poor psychosocial support systems

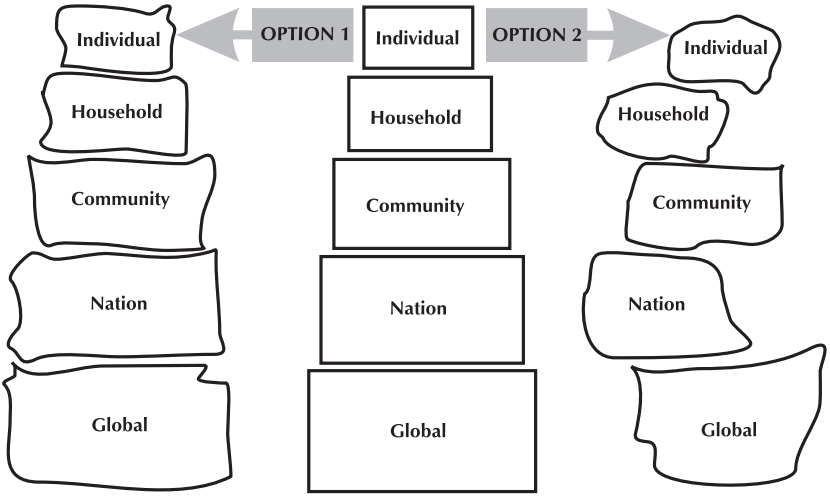


Source: REPSSI, 2001.

The 'tower of stability'

Despite such bleak predictions, societal breakdown and dysfunction are not inevitable. At every level those affected by the epidemic are responding to various degrees, and although many current responses are inadequate and weak, others are strong and innovative. The extent to which the latter are harnessed and developed at national, regional and international levels to mitigate the impact of HIV/AIDS on children will determine the degree to which HIV/AIDS will impact on society over the next 50 years. If strong mitigation strategies are put in place at every level, it will be possible to minimise the negative impacts of the epidemic on both individual children and society more broadly. Should we fail to put in place such responses, however, the implications of the epidemic could be profound. Starting from the *tower of stability*, where the foundation for individual and household well-being is a healthy community and a stable nation within a secure world, Figure 8

Figure 8: The tower of stability



"THE TOWER OF RELATIVE STABILITY"
After the impact of HIV/AIDS with mitigating responses at each level.

"THE TOWER OF STABILITY"
Before the impact of HIV/AIDS.

"THE TOWER OF INSTABILITY"
After the impact of HIV/AIDS with little or no mitigating response.

Source: REPSSI, 2002.

illustrates these alternative scenarios. It should be noted that although few societies live up to the ideal portrayed, the tower of stability represents the generally more stable situation that existed prior to the emergence of HIV/AIDS.

The need for psychosocial support for children

In recent years, a multitude of responses in support of children made vulnerable by HIV/AIDS have emerged. Unfortunately, many of these responses have been in reaction to the dire visible needs of these children, and have often regarded them as helpless victims. Such approaches are problematic for two reasons. First, they can have serious long-term consequences as they undermine children's own coping capacity and both create and reinforce a 'dependency syndrome' that may have serious long-term consequences for the SADC region. Second, such approaches tend to be biased towards children's material and formal educational needs and often fail to address the less obvious social, mental and emotional needs that children have.

Psychosocial support is an ongoing process of meeting a child's intra-personal and inter-personal development needs. This incorporates physical, emotional, mental and spiritual dimensions. Given that HIV/AIDS is creating and exacerbating not only physical poverty but also emotional, psychological and social poverty in the lives of affected children, and that such poverty can have profound personal, familial and societal implications,[11] it is imperative that psychosocial support is strategically integrated into programmes for children affected by HIV/AIDS.[12] A number of low-cost, culturally appropriate responses have been shown to improve the resilience and coping capacity of affected children.[13] Some of these practical responses are discussed below.

Good practice, programme principles and guidelines

Based on over two decades of experience in designing programmes for orphans and vulnerable children, a 'normative framework' for a scaled-up response has now largely been put in place. Drawing on good practice programmes, this section will begin by discussing this framework before outlining a simple step-by-step programme guideline for a comprehensive response.[14] It must be noted at the outset that a key commonality of good practice responses is that they do not singularly target children affected by

HIV/AIDS but work with communities to improve the quality of life of all vulnerable children.

Good practice at the local level

In response to the massive numbers of children affected by HIV/AIDS, thousands of communities have put in place responses at local level. Yet, the coverage, reach and impact of most responses have remained limited. With this in mind, the following three case studies of local responses from Tanzania, Uganda and Zimbabwe illustrate different local responses to improve the quality of life for children affected by HIV/AIDS.

The Humuliza programme in Tanzania is addressing psychosocial support needs for orphans and vulnerable children in the rural Kagera District. In March 2000, during an HIV/AIDS prevention workshop with teenage orphans, some participants decided that they wanted to start their own organisation. These youths asked two programme staff from Humuliza to support them in their endeavour. The objectives of the proposed 'orphans organisation' were to:

- assist members with accessing schooling;
- work collectively to improve the image of orphans in the community;
- start up a youth bank to provide small-scale credit and saving mechanisms; and
- ensure mutual assistance in the case of illness and death of family members.

They choose the name *Vijana Simama Imara* (VSI), meaning 'Youth Standing Firm'. Contrary to the common view that organised orphans would become more stigmatised and alienated, interviews among adult community members have shown a positive reaction to these children. People appreciate the children's active self-reliance and praise their willingness to contribute to community development.[15] Furthermore, VSI frees children from being victims, giving them a stronger position in the community and influencing local power relationships in their favour. Indeed, as an organised body VSI is currently negotiating with local authorities on behalf of its members for reduced taxes, access to education and free medical services.

This programme example demonstrates that children are able to participate and take leadership in positively influencing their environment and improving their quality of life. This confirms findings from West Africa, which have documented the successful conceptual shift from 'projects for children' to 'projects with children', in the form of children's trade unions.[16]

In Zimbabwe, *The Salvation Army's Masiye Camp* began a programme in 1998 for children infected or affected by HIV/AIDS. The camp facilitates and provides psychosocial support to orphans and vulnerable children and youth in sub-Saharan Africa through coping, capacity-building and life-skills training activities.[17] Based on the tradition of 'initiation camps', where young people in many African societies are initiated into adulthood, these activities take the form of ten-day camps for boys and girls of various ages. Local youths are trained as camp counsellors to facilitate psychosocial support for these children.

The experiences of the children who visit the camp confirm that the prolonged illness and subsequent death of a parent (or, worse still, both parents, as is often the case with HIV/AIDS) causes severe trauma and can stunt children's development. Indeed, many of the children who visit the camp have poor life skills and show symptoms of psychosomatic disturbances, depression, low self-esteem, disturbed social behaviour and hopelessness. However, the experience of Masiye Camp has also shown that the resilience and coping capacity of these children can be enhanced using relatively simple, direct and culturally appropriate psychosocial support mechanisms.[18]

Since its inception, over 4,300 children have participated in Masiye's life skills camps, and case-based documentation of the children participating in these camps shows that they have had a significant impact on the coping capacity of such children.[19] Experience would also seem to support research findings to the effect that young people who are drawn in to providing psychosocial support and care for other children are likely to adopt less risky sexual behaviour.[20]

In addition to such individual initiatives it was recognised early on that networking and collaboration are key strategies in mitigating the effects of HIV/AIDS. A good example of such networking was the *Uganda Community-Based Association for Child Welfare (UCOBAC)*, established in the early 1990s. This organisation focused on facilitating collaboration and information exchange, and also provided capacity-building and training in such areas as

Box 2: A teenager's voice from Bulawayo

I am 17 years old and head our household of three. My two younger brothers are still going to school. Our father died in 1998 after our mother died the year before. My father was a tailor in the informal sector and trained me when I was still young. He left behind a sewing machine and some material. However, after the loss of my father I did not touch these things.

I attended a Teenage Parenting and Household Management course offered by Masiye Camp for the members of child-headed households. During this course we had sessions on small business skills and informal sector market analysis. The activities I participated in at the camp, as well as being with others who face the same difficulties as me, gave me new confidence and trust.

When I returned home, I took out my father's sewing machine and started to sew some clothes and school uniforms. After two weeks I boarded a bus to the rural areas and sold these items. There I bought some bags of dried mopane worms. Back in town I managed to sell these at a nice profit, which I used to buy more material and to pay school fees for my younger brothers. The camp really helped me and it makes me proud to support my little brothers.

programming for vulnerable children, proposal writing and the national and international legal and policy environment.[21] It was started with support from UNICEF and a number of international NGOs.

With a secretariat in Kampala, UCOBAC established affiliate groups of small NGOs and CBOs in most of Uganda's districts, and helped to link these affiliates to information and resources in the capital as well as giving them a voice to input into the development of national policy concerning children. UCOBAC also developed a 'grants bank' approach that helped to link donors with grassroots efforts to assist vulnerable children. The organisation did not channel funds itself, but through its district affiliates helped donors to identify and support small projects. It also played a monitoring and support role for such projects. Unfortunately, however, this network collapsed when UCOBAC was pressured by a donor to take on an implementation role and the organisation began to function as a regular NGO rather than as a network.[22]

Good practice at the national level

Namibia and Zimbabwe represent good examples of national responses to the challenge faced by countries to respond to large numbers of children affected

by HIV/AIDS. In the case of Namibia, extensive stakeholder participation facilitated the development of a comprehensive national orphans policy, while relatively early in epidemic Zimbabwe introduced a national strategy which focused on community-based orphan care and discouraged institutionalisation of children.

Presently, demographic projections suggest that by 2010 over 156,000 children will be orphaned in Namibia, the majority of them (76%) by AIDS. This represents nearly 20% of all Namibian children. Over 62,000 of these children will be double orphans. Compared with other countries in the region, Namibia was relatively slow in responding to the issues of AIDS-related orphaning and the vulnerability of children orphaned by AIDS. Once these issues were recognised as posing a major challenge to national development, the government of Namibia responded effectively by engaging all major stakeholders in a national situation analysis of orphans and vulnerable children in 2002.[23]

Key partners from civil society, such as the Namibian Chapter of Catholic AIDS Action, supported the government in its national response—using the experience gained from supporting over 6,000 orphans to formulate national policy.[24] A permanent Orphans and Vulnerable Children Task Force was also established, which engaged key government ministries in thinking and planning around the vulnerable children issue. Key areas of focus included:

- policy formulation and law review;
- access to education;
- access to social services and getting resources to the community level;
- health, nutrition and food security;
- psychosocial support; and
- a range of crosscutting issues, such as gender and HIV/AIDS prevention.[25]

The end product of these consultations was a multi-sectoral approach to the national orphan crisis. This process also clearly demonstrated that with the political will and commitment of the political leadership, a comprehensive national policy and plan of action for orphans and vulnerable children can be developed in a short space of time (in this case, less than 24 months).

Zimbabwe presently has more than 1,018,000 orphans; the majority orphaned as a result of AIDS.[26] As early as 1993, Zimbabwe held its first national

conference on orphans and other children made vulnerable by HIV/AIDS.[27] A direct result of this consultation was the formation of national, provincial and district child welfare forums to co-ordinate government, NGO and civil society responses in support of children affected by HIV/AIDS. Under the guidance of this National Child Welfare forum, a national orphan care policy was formulated and adopted by Cabinet in 1999. The policy is built around the Zimbabwean cultural adage that a child belongs not only to his/her immediate family but also to the community at large, and clearly promotes extended family and community care for orphans. It draws its strength from the collective efforts of families, communities, NGOs and government in monitoring the situation of children and responding to their needs.[28] The policy discourages institutional responses.

Inspired by the achievements of the 2002 Eastern and Southern Africa Regional Workshop on Children Affected by HIV/AIDS, a steering group was established to organise a national stakeholders' meeting aimed at formulating a plan of action to achieve the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS goals on orphans and vulnerable children (discussed later in this chapter).[29] In June 2003, over 250 participants, including 50 children and youth, came together in a co-ordination and planning workshop to draft the national plan of action for orphans and vulnerable children.[30] This in turn led to the formulation of a national orphan policy, signed into effect by the minister of Social Welfare in 2002, which is to be operationalised by the National Plan of Action. The weakness of this process is that other key ministries have not been engaged in the endorsement process.

Good practice at regional level

Good practice responses at regional level are few. However, the collaborative effort of a number of organisations are worth mentioning, notably the Hope for African Children Initiative (HACI),[31] the Regional Psychosocial Support Initiative (REPSSI)[32] and the Eastern and Southern Africa Regional ad hoc Task Force on Orphans and Vulnerable Children, operating under the auspices of UNICEF.[33]

The *HACI* was initiated in 2001. It was born of a recognition that the enormous challenges faced in supporting children affected by HIV/AIDS could best be addressed by collective action and consists of a unique partnership between five international organisations, namely CARE, Plan International, Save the

Children, the Society for Women and AIDS in Africa and the World Conference on Religion and Peace.

Over the next few years the initiative will focus on ten countries in Africa, with four main strategic objectives, namely to:

- build awareness and reduce the stigma that affects children affected by HIV/AIDS;
- extend the life of parent–child relationships;
- prepare families for transition and support parents as they plan the best possible future for their children; and
- improve access to education and skills as the basis for enabling children to attain better livelihoods in the future.

In contrast to many orphan and vulnerable children programmes managed by international NGOs, which often have overheads in the region of 20–30%, the initiative has committed itself to spending at least 80% of its funding in support of community programmes, with a further 10% of its funding earmarked for regional advocacy work. It is envisaged that less than 10% of its income will be used to cover administrative and overhead costs.[34] This marks an important shift in practice, as the magnitude of the HIV/AIDS problem requires that maximum resources and support are channelled directly towards children.

REPSSI was formed after a specific need for advocacy around these issues was identified by participants at two regional workshops held in 2000 and 2001.[35] Four organisations—the Salvation Army Africa, *Terre des Homes* (Switzerland), the Southern Africa AIDS Training (SAT) Programme and the International HIV/AIDS Alliance—provide the platform for this initiative.

REPSSI started in 2002 and is presently working with more than 50 key NGO partners in the SADC region, with the goal of scaling up psychosocial support for children affected by HIV/AIDS. In this regard, REPSSI facilitates the joint development of training and resource materials that can be used to build psychosocial programme capacity at all levels. Through its partners in the region, the programme also aims over the next five years to provide

psychosocial support to more than 300,000 children affected by HIV/AIDS. In collaboration with SADC itself, REPSSI also aims to develop the capacity of the SADC Human and Social Development cluster by financing an orphans and vulnerable children programme officer post within the SADC secretariat.

The *Eastern and Southern Africa Regional ad hoc Task Force on OVC*, was established in 1998 and brings together UN agencies, international NGOs, governments and donors, with the aim of co-ordinating collective efforts to increase care and support to orphans and vulnerable children across the region. In addition to organising a regional consultation on orphans and vulnerable children in Lusaka in 2003, this task force organised the 2002 Regional Workshop on Children Affected by AIDS, mentioned earlier. Held in Namibia, this workshop critically reviewed national progress in meeting the UNGASS goals concerning orphans and vulnerable children and sought agreement on how to develop national plans of action for such children.

The workshop required the co-operation of more than nine agencies to successfully plan, implement and fund it, and demonstrated the willingness of such organisations to work together and follow the call of former USAID HIV/AIDS Programme Director, Dr Paul De Lay, who stated that "the impact of HIV/AIDS on children and their families is so vast that it is only by working together that we can begin to respond to this crisis of unprecedented magnitude".[36]

Programme principles and strategies

On the basis of years of programme experience in different settings—including the lessons learned from the initiatives highlighted above—UNICEF, UNAIDS and USAID have over the past five years provided leadership in developing a set of principles and strategies for use in programming for orphans and vulnerable children. These principles are guided by global human rights principles and the Convention on the Rights of the Child, and provide a normative framework for action in support of children affected by HIV/AIDS. They suggest that organisations working in support of orphans and vulnerable children should aim to:

- strengthen the protection and care of orphans and vulnerable children within their extended families and communities;

- strengthen the economic coping capacity of families and communities;
- enhance the capacity of families and communities to respond to the psychosocial needs and rights of both orphans and other vulnerable children and their caregivers;
- link HIV/AIDS prevention activities and care and support for people living with HIV/AIDS to efforts to support orphans and other vulnerable children;
- focus on the most vulnerable children and communities, not only those orphaned by AIDS;
- give particular attention to the roles of boys and girls, men and women, and address gender discrimination;
- ensure the full involvement of young people;
- strengthen schools and ensure access to education;
- reduce stigma and discrimination;
- accelerate learning and information exchange;
- strengthen partners and partnerships at all levels and build coalitions among key stakeholders; and
- ensure that external support strengthens and does not undermine community initiative and motivation.[37]

In emphasising the holistic support of children, these principles represent a broader international shift from a 'needs-based' to a 'rights-based' model of support, which focuses on the whole child and promotes the effective realisation of all their rights. Under this model, providing for the needs of a few children in a context where thousands have their rights violated is simply not good enough, and programmes are challenged to shift from a service-delivery approach to an advocacy and community-mobilisation approach to fulfilling the rights of all children affected by HIV/AIDS.[38]

Step-by-step programming guideline

Based on the above programming principles, the International Federation of Red Cross and Red Crescent Societies developed practical step-by-step programming guidelines for communities across Africa to respond to the psychosocial implications of HIV/AIDS.[39] These guidelines are based on recognition that in order to mitigate successfully the negative impacts of the epidemic, all communities in severely affected countries will need to develop community-based orphan care responses. The 12 steps described below cover the key aspects of community-orientated advocacy, support and care for orphans and vulnerable children. As with all guidelines, they can and should be adapted to local socio-economic and cultural contexts.

- *Step 1: Consult with and sensitise the community:* Responses in support of orphans and vulnerable children need to be sustained for at least the next 40 years. Community ownership of programmes for orphans and vulnerable children is therefore essential. Before starting a care and support programme, it is necessary to ensure that the community is involved in and committed to sustaining such a programme.

- *Step 2: Analyse the situation:* It is important to understand the local context, both in terms of culture and other key factors such as the number of children affected and how communities respond to such children.[40] It is also important that communities are fully involved in the situation analyses conducted prior to introducing new projects and programmes. Participatory methodologies that include data collection, processing and analysis by community members can be used to ensure such participation.

- *Step 3: Become good advocates for orphans and vulnerable children:* Once communities have assessed their situation and planned their response, selected volunteers are ideally placed to become good advocates for orphans and vulnerable children at community level. Such volunteers can act as 'lay child advocates' and can both visit orphans in their households and advocate for access to education, health care, nutrition and psychosocial support on their behalf.

- *Step 4: Work to reduce stigma and discrimination:* It is important to ensure that children continue to feel accepted and part of the community: do not refer to children as 'AIDS orphans' or 'OVC' as these labels further isolate

and stigmatise them; target all vulnerable children in severely affected communities—not just orphans.

- *Step 5: Make sure you work with the whole household and integrate family care:* Integrating home-based care and orphan care programmes is crucial. Children belong to the family and not even the best care and support programme should seek unnecessarily to change this situation. Removing children from familial care should only be considered as a last resort in instances where children suffer neglect or abuse.

- *Step 6: Help children in child-headed households and keep siblings together:* Where children have lost parents it is of great importance that, wherever possible, siblings stay together. Keeping siblings together preserves their sense of identity and shared family history and helps to maintain access to family assets such as a home and land.

- *Step 7: Provide psychological, emotional and social support:* The material and educational needs of children often overshadow a dire need for psychosocial support. However, unless adequate community-based psychosocial support is provided, other forms of support will not sustain the healthy development of children.

- *Step 8: Help children to remain healthy and provide access to primary health care:* Access to health care is a basic human right and children affected by HIV/AIDS need to be helped to access vaccination, health education and other health services available to them in their community.

- *Step 9: Work with schools and religious groups:* Probably most important of all is to ensure that children remain in school, not only because education ensures children a better future, but because schools and teachers are a key community resource. Schools and religious groups can play a vital role in identifying and supporting orphans and vulnerable children, while the extensive coverage of these two institutions combined makes working through them one of the most effective ways to reach large numbers of children.

- *Step 10: Help children to learn about HIV/AIDS prevention:* Due to the vulnerable circumstances in which many children affected by HIV/AIDS live,

they are often at higher than average risk of contracting HIV. It is therefore imperative that all orphan support and care programmes integrate effective HIV awareness and prevention components.

- *Step 11: Help the family to resolve legal matters related to the children's future:* Insecurity of tenure and dispossession of assets constitute tremendous sources of vulnerability for children affected by HIV/AIDS. Legal support in the writing and execution of wills, as well as information about inheritance and property issues, are vital in mitigating the impact of HIV/AIDS on families and children. Children and their surviving relatives also often need advice on the bureaucratic processes relating to such issues.

- *Step 12: Monitor and evaluate initiatives:* It is essential to monitor and evaluate programmes continually. This requires documenting programmes right from the start, so that one can monitor progress and, if necessary, adjust one's response. It is important to strive towards improving the quality of one's response and learning from the experience of established programmes that can assist in achieving such improvements.

Call to action

An understanding of the responses, principles and strategies discussed above will not result in change unless this knowledge translates into the political commitment to drive decisive, large-scale action.

The following section will look at commitments made in response to orphans and other children made vulnerable by HIV/AIDS during both the UNGASS on HIV/AIDS in June 2001 and the Africa Leadership Consultation on urgent action for children held in September 2002.

UNGASS goals related to children

At its concluding session, the UN General Assembly adopted a Declaration of Commitment which obliged its member states to a range of actions to address the HIV/AIDS crisis. This declaration acknowledges that children orphaned and affected by HIV/AIDS need special assistance and articles 65, 66 and 67 relate directly to children orphaned and made vulnerable by the virus. These articles urge states to do the following:

> 65. By 2003 develop, and by 2005 implement, national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;
>
> 66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatisation of children orphaned and made vulnerable by HIV/AIDS;
>
> 67. Urge the international community, particularly donor countries, civil society, as well as private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa;[41]

By signing the UNGASS Declaration of Commitment on HIV/AIDS, all Southern African leaders pledged to accelerate their response to the orphan crisis. Yet despite this expression of commitment, the actual response to date has been "limited in scale, fragmented and shamefully short of what is required to halt this preventable tragedy. The challenge, therefore, is to revise this situation".[42]

In response to this challenge, Nelson Mandela and Graca Machel, in collaboration with the UN Secretary-General's Special Envoy for HIV/AIDS in Africa, Stephen Lewis, convened a meeting in Johannesburg for African Leadership in September 2002. Under the banner of 'Urgent action for children on the brink', the consultation sought to develop priorities for a scaled-up emergency response to growing numbers of children and young people orphaned and affected by HIV/AIDS in Africa. Key issues raised during the consultation are summarised in Table 10 (*over page*). Such consultations have in the past few years created a growing consensus among governments, UN agencies and civil society on a number of practical action points.[43] They highlight the importance of:

Table 10: Key points from African Leadership consultation[44]

Area	*Key points*
Demographics	HIV/AIDS is changing the demographic profile of nations, with potentially enormous implications for parenting and care. There is an urgent need to analyse both these changes and their long-term implications for societies in the region.
HIV prevention	Reducing new HIV infection is clearly the most effective means of preventing orphaning due to AIDS.
Care and support	It is essential to keep mothers alive as long as possible, as protecting the mother's health keeps families intact, delays orphaning and enhances child survival, development, growth and care.
Leadership	Governments have a critical role to play in providing leadership and should be held more accountable for doing so. To date most governments in Southern Africa, together with most civil society and international agencies, have failed to meet the challenge of orphans and other children made vulnerable by HIV/AIDS. Public discussion about HIV/AIDS and its consequences for children needs to be increased.
Planning	It is of concern that there is almost no reference made to children and young people affected by HIV/AIDS in the planning documents of regional bodies, such as SADC, or within documentation of NEPAD. The issues surrounding children affected by HIV/AIDS need to be included in both these documents and in national Poverty Reduction Strategy Papers (PRSPs).

- *Strengthening the engagement of parliamentarians and religious leaders:* There is need for parliamentary debates on the issues surrounding orphans and vulnerable children in order to sensitise national leadership and engage politicians to shift vulnerable children issues to the centre of public policy and action. Religious leaders also need to be engaged to achieve large-scale social mobilisation in support of the traditional African concept of 'everyone's child'.

- *Documenting, monitoring and reporting country progress:* By signing the UNGASS Declaration on HIV/AIDS, governments in the region committed themselves to acting on the declaration's goals concerning orphans and vulnerable children. Part of this commitment involves documenting and monitoring progress made in achieving these goals. In April 2003, an

international technical consultation on national orphans and vulnerable children programme indicators was held in Gabarone, Botswana. This technical consultation agreed on ten basic indicators for reporting the progress of national programmes.[45] Within two years countries in the region will be expected to use these indicators to collect data, through demographic health surveys and other data collection tools, and to report to the UN Secretary General on progress made to achieve the UNGASS goals concerning orphans and vulnerable children.

- *Universal access to education:* Free primary school education is needed more than ever. Education is fundamental in order to secure the future of orphans and vulnerable children. The HIV/AIDS epidemic and its impact on children is a humanitarian crisis and requires bold crisis responses. Collectively, there is a need to advocate for the channelling of funds directly to schools in order to support universal access to primary education.[46]

- *Children and young people's participation:* Presently most responses to orphans and vulnerable children are reactive and treat children as helpless victims in need of our assistance. This approach has potentially negative long-term consequences as it creates a new generation of adults dependent on 'hand-outs'. Young people must participate in policy formulation, programme planning and implementation at both the local and national level, not only because their experience and perspectives are crucial in developing an appropriate response, but because such involvement develops their belief in their own abilities and enables them to contribute at an early age towards national development.

- *Resource mobilisation:* In order to avoid unnecessary competition for resources, there is need for resource requirement frameworks at national and regional levels. In this regard, there is a need at national level to cost national plans of action for orphan and vulnerable children support. There is also a need to strengthen or establish effective mechanisms to support community-based responses, and to scale-up the implementation of successful mechanisms.

- *Strengthening partnerships, co-ordination and co-operation:* The magnitude of the challenge is so great that no single response will be adequate. It is vital that role players at all levels work together or work better together; we must

look for synergies and complementarities in all aspects of our work in support of children.

- *Capacity building at all levels:* There is no 'quick fix' to the orphan and vulnerable children issue. We need critical analysis of both capacity gaps and opportunities for strengthening our capacity at the local and national level—for example, what is required to support teachers and who can strengthen their capacity to respond to the problem of orphans and vulnerable children in their communities?

This paper has demonstrated that efforts to mitigate the impact of HIV/AIDS on children at local, national and regional levels can be effective. It is equally apparent, however, that the current scale of these responses is insufficient to reverse the negative impact the present situation has on countries in the region. Progress in the action areas highlighted above is critical if we are to respond effectively in supporting children left orphaned and vulnerable by HIV/AIDS.

Conclusion

The HIV/AIDS epidemic will cause major social changes in Southern Africa, and will most likely change the face of communities and societies in ways that we now find hard to imagine. In particular, the long-term consequences of the trauma many children will experience could be severe if adequate psychosocial care and support are not provided to all children affected by HIV/AIDS in the region.

Examples of good practice at the local, national and regional level clearly demonstrate that community institutions, governments and international agencies can put in place effective programmes to improve the quality of life for orphans and other children made vulnerable by HIV/AIDS. Yet despite the proven utility of such programmes and the proliferation of guiding principles and simple step-by-step guidelines, the coverage, reach and impact of the response to date remains very limited. This is in part due to the fact that most agencies have been overwhelmed by the complexity and scale of the challenge posed by children affected by HIV/AIDS. It is also due to the general failure to mobilise effectively decision makers and opinion leaders, as well as the collective inability to ensure that resources reach the families and communities providing assistance to children.

The Declaration of Commitment on HIV/AIDS adopted by the UNGASS on HIV/AIDS provides a clear mandate for governments to ensure care and support for the millions of children affected by HIV/AIDS in the region. However, unless these written commitments lead to decisive action by all stakeholders at all levels, it will not be possible to mobilise the necessary human and financial resources to address this crisis of unprecedented magnitude.

Notes

1 UNICEF, statement by C Bellamy, UNICEF executive director during Africa Leadership Consultation—Urgent Action for Children on the Brink, Johannesburg, 10 September 2002.
2 UNICEF, statement by Nelson Mandela during Africa Leadership Consultation, op cit.
3 UNAIDS, UNICEF & USAID, *Children on the Brink 2002: A joint report on orphan estimates and orphan strategies*, July 2002.
4 T Barnett & A Whiteside, *AIDS in the twenty first century: Disease and globalization*, Palgrave Macmillian, Hampshire and New York, 2002.
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CHAPTER 6

CONCLUSION

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At the beginning of this monograph it was noted that many of the arguments linking AIDS-related orphaning to insecurity and instability are based on a particular vision of what orphanhood generally entails. The picture painted conjures up images of hordes of traumatised, unwanted children being cast to the very fringes of society; suffering wanton neglect and abuse and, ultimately, being left to fend for themselves in a world where life is often 'short, harsh and cheap'. As noted repeatedly in the preceding papers, this is undeniably the case for some children and, in the absence of comprehensive, context-appropriate responses, may be for many children in the future. The contributions to this monograph also highlight that for most this is not the case and that the situation is more complex than suggested by many of the arguments to date. Several important issues can be noted:

Orphanhood is a complex phenomenon

Empirical data on the state and nature of orphanhood in Southern Africa is relatively limited. Data highlighted in the preceding papers nevertheless suggests that, irrespective of HIV/AIDS, many children are not raised in the ideal, stable family environments that much of the literature seems to take as its starting point. Large numbers of children grow up in single parent households, usually headed by women, and fathers are often absent. The reality of children being sent away from their natal home in order to access care or resources is not new. Fosterage and community-based family care have historically formed important support mechanisms in the region and both adults and children move in and out of households in response to the changing circumstances and needs of families. Even in the absence of parental death, children are often fostered, with the extended family most often providing care.

It also suggests that while orphaning is on the increase, and will have risen exponentially in most countries in the region by 2010, relatively few children would presently seem to be living in situations of extreme vulnerability. As

noted by Foster in his paper, it is difficult to obtain accurate estimates of the numbers of children living in extremely vulnerable situations, but the available evidence suggests that less than 2% to 3% of all orphans live in environments where they are completely without support or are exploited. Indeed, although increasing numbers of orphans are beginning to place stress on traditional coping mechanisms such as the extended family, they are still remarkably intact and surprisingly small numbers of children have so far found themselves without the support they have historically provided.

Children are most likely to be orphaned during adolescence and often do not lose both parents. As noted by Richter, the likelihood of becoming an orphan increases with age. Children over the age of ten are most likely to become orphans, yet are generally not targeted by programmes and interventions in support of affected children. The South African data also indicates that a small proportion of children are double orphans and children most often have a surviving parent. As mortality among men is still higher than among women of comparable ages, this tends be their mother. Fewer than half of all maternal orphans in South Africa live with their surviving father and the widespread abdication of paternal responsibility is clearly a major gap in potential resources for affected families and children.

It is often difficult to determine where the effects of HIV/AIDS begin and end

The papers in this monograph all agree that many children in the region are going to be negatively affected by HIV/AIDS. Children may experience a range of impacts including economic need, reduced levels of care, poor health and nutrition, new responsibilities and work and school drop out, as well as psychosocial impacts such as abuse, trauma, stress and a loss of social connectivity. They may also be placed at greater risk of infection.

Such impacts may all be aggravated by both the nature of the virus itself and the environment in which children live. HIV infection tends to cluster within families, making it likely that children will experience repeated illnesses and deaths. As noted by Germann, they may also experience repeated losses as they are lose siblings, friends, familiar surroundings, schooling opportunities and even their childhood as a result of the poverty, stigma and migration that often result from AIDS-related illness and death.

Several papers, however, point to the messiness of these effects. Richter notes that the effects of the epidemic on children are likely to vary considerably by age. Preschool-aged children, for example, are likely to suffer poorer levels of growth and health, while effects among older children are likely to manifest in terms of education, work and psychosocial outcomes. She also argues that while there is a strong, cyclical association between HIV/AIDS and poverty, high levels of ambient poverty often make it difficult to determine the causality of these effects. The conditions in many poor communities mean that few, if any, of these effects are specific to children affected by HIV/AIDS. It is also impossible to isolate and exclude the effects of conditions that pre-date the death of a caregiver.

Killian and Foster also recognise that HIV/AIDS increasingly impacts on almost everyone in severely affected communities, even households without HIV-positive members. As noted by Killian, South African children living in high-prevalence communities are excessively anxious about death and may reflect obsessively about illness and mortality. The prevailing myth that HIV/AIDS can be cured by sleeping with a virgin may in some cases also increase children's risk of sexual abuse—although there is little concrete evidence available to shed light on this issue. As argued by Foster, children may also be affected when families provide money to support sick relatives, mothers leave home to provide care for AIDS-affected relatives, or their standard of living deteriorates as relatives move in following the death of their parents.

'Affected' children are not habitually treated differently to 'unaffected' children

In line with the above point, the authors also argue that the experience of orphans and children affected by HIV/AIDS is often not qualitatively different from that of other poor children. This is not to say that no children find themselves in situations that dramatically set them apart from their peers. Cases of abuse, mistreatment or exploitation of fostered and orphaned children have been reported. Many children have also been left to fend for themselves; to cope with adult problems without the benefit of adult support. The argument is simply that children are generally not treated differently by others on the basis of their orphaned or fostered status.

Foster argues, for example, that although studies have demonstrated that

orphans are disadvantaged compared to non-orphans in other families, few have demonstrated significant differences in the ways relatives treat their own biological children compared to fostered children. He argues that although such cases undoubtedly occur, it seems for the most part that relatives go to considerable lengths to keep orphans in school, including borrowing money through informal networks and selling their own assets. Richter notes a study by Case and her colleagues which found that fostered orphans are less likely to attend school than co-resident children in the same household, but agrees with Foster that there is little available evidence to suggest that caregivers habitually treat orphans in their care differently from other children.

Not all children are equally vulnerable

Three of the four papers also suggest that while some children are left in precarious circumstances as a result of parental illness and death, many children remain linked into support networks of various kinds. For example, Foster argues that while many child-headed households receive little support from relatives who are already struggling to feed, clothe and educate their own children, not all child-headed households are equally vulnerable. He gives the example of Swaziland, where large numbers of child-headed households have formed as a coping mechanism in the context of the epidemic. He argues that the high prevalence of child-headed households in Swaziland is a consequence of traditional extended family living arrangements, which enable child-headed households to live in supported situations.

He also notes that, despite appearances, many street children also benefit from adult support. He draws the distinction between children *on* the street and *of* the street. Where children live *on* the street, they help to provide for their own survival and that of others by working on the street, but generally return home at night. Despite potentially deteriorating family relationships, familial ties are still in place, and the children continue to view life from the perspective of their families. Children *of* the street constitute a smaller number of children who live, work and sleep on the street, alone and without support.

Negative experiences do not necessarily result in negative psychosocial outcomes

The risk and resilience literature highlighted by Richter and Killian indicates that

while HIV/AIDS stands to exacerbate the multitude of risks faced by children in poor communities, children are often remarkably successful in overcoming such difficulties. A key point made by both authors is that although the epidemic is likely to increase poverty and social fragmentation—and thus the risk environment in which children operate—such effects will not automatically translate into widespread psychosocial maladjustment. Indeed, studies suggest that only about one-third of children exposed to severe adversity will suffer negative psychosocial outcomes. This is obviously not an insignificant proportion but highlights that while there is a very real need for appropriate interventions to support vulnerable children, there is not a neat, linear relationship between adversity and a negative outcome.

They note that the impact of risk factors is mediated by a range of factors, including personality and temperament, learned coping style, age of exposure, the availability of caring adults and social supports in their environment and, critically, opportunities for recovery afforded by achievements, new relationships, changing circumstances and the like. The implications of negative experiences are thus as much a result of the circumstances surrounding the experience, and the way it is interpreted, as the nature of the experiences *per se*; and long-term maladjustment is dependent on the availability of conditions for recovery as much as, or more than, the form or severity of precipitating stresses.

The likelihood of maladjustment is increased when adverse conditions are cumulative or endure over time, or when children are given few opportunities for support and hope, but relationships with caring others and access to supportive networks and social institutions can present opportunities for recovery.

They argue that children tend to seek out these positive experiences—even in conditions of great difficulty. Experience gained from working with street children, displaced children and children in conflict and disaster situations suggests that even on the street, in conflict, under abusive and dehumanising conditions, children seek out bonding experiences with adults and engage their support. It also suggests that even low levels of support in childhood enable quite dramatic compensatory responses in children. Richter argues that these formative influences may therefore be absent only in children deprived of any adult supervision or support, subjected to cruel and dehumanising treatment,

or reared in institutions over a long period of time. She argues that a very small proportion of children affected by HIV/AIDS will find themselves subject to such conditions.

Richter also notes that where children do suffer negative effects as a result of their exposure to difficulties, these are unlikely to habitually manifest themselves in ways that would affect the security of communities and states. She argues that three groups of determinants—poverty; separation, loss and bereavement; and cruel and impersonal care—may be associated with poor psychosocial adjustment. Children exposed to such determinants are likely to exhibit physical or internalised conditions, such as poor growth and health, decreased motivation, increased passivity, impoverished frames of reference, lower cognitive performance, anxiety, rumination, depression, social isolation, guilt and low self-esteem. Only children exposed to cruel and impersonal or abusive care are likely to experience more externalising conditions such as a reduced capacity for affection and compassion, acting out and more aggressive coping styles.

Effective responses are being put in place

Given these dynamics, several of the papers also draw attention to the fact that effective responses to the challenges posed by the epidemic are being developed. Foster notes that over the past two decades, communities throughout Africa have begun to add additional layers to their community safety nets by providing material, educational, emotional and psychosocial support to children affected by HIV/AIDS.

These community-based support initiatives have been established largely in the absence of significant external facilitation or financial support and are often initiated by churches, mosques, other religious groups, women's groups and CBOs. Such initiatives support vulnerable children by enabling families to continue to provide care for orphans.

Germann also notes examples of a number of local, national and regional level initiatives which have successfully helped to mitigate the psychosocial impacts of the epidemic on children and families. Such initiatives are still relatively few in number and have been limited in their reach and impact, but illustrate that valuable, cost-effective responses can be, and have been, put in place.

Implications for current thinking

In conclusion, few would dispute that the HIV/AIDS epidemic and the growing numbers of orphans that will be its legacy poses a notable humanitarian and developmental challenge. Millions of children will lose caregivers and will suffer the economic, physical and psychosocial implications of both the prolonged illness of these caregivers and their deaths. What is open to question is whether the impacts of the epidemic will play out in such a way that children themselves pose a significant threat to stability and security in the Southern African region. Although by no means an exhaustive review of the available evidence, the papers in this monograph highlight issues that suggest that we may want to be more cautious in drawing the linkages between large-scale orphaning and crime and instability.

Certainly, potential linkages exist between HIV/AIDS, insecurity and instability. The epidemic is likely to increase social fragmentation and, most importantly, poverty. Poverty in turn not only increases the risk of children becoming infected with the virus, but also exposes them to high levels of psychosocial risk. It is thus likely that a certain number of children affected by HIV/AIDS will suffer negative psychosocial outcomes; that some will be exploited and abused, will be victimised and may themselves perpetrate crime and violence. This is obviously undesirable and every effort should be made to address the underlying vulnerabilities that expose children to such conditions. Yet, not all children are equally vulnerable and there exist a number of factors that will determine whether children at risk suffer such outcomes. As noted by Bray, context is important and although there is need for a great deal more research in this area, the context suggests that such outcomes may more often be the exception than the rule. Moreover, in a context where ambient levels of poverty are already high, few if any of these outcomes will be confined to children affected by HIV/AIDS (even if such a category can be defined).

Families and local communities have to date demonstrated remarkable resilience and creativity in addressing the myriad needs of affected children and surprisingly few have been left in situations of extreme vulnerability. Given the extent of the HIV/AIDS epidemic, however, it is likely that traditional coping mechanisms will become increasingly stressed. It is important that mechanisms be put in place to support vulnerable children, families and communities. The contributions to this monograph suggest that community institutions,

governments and international agencies can, and have, put in place effective programmes. The lessons presented by such initiatives need to be heeded and decisive action taken by stakeholders at all levels to mobilise the human and financial resources necessary to implement such responses successfully.