

# ORPHANS OF THE HIV/AIDS EPIDEMIC

## *The time to act is now*

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### BACKGROUND

One of the most tragic consequences of the HIV/AIDS epidemic is the huge number of children orphaned as a result of parents dying from AIDS. (Some of these children are HIV-positive themselves - having been infected by their mothers either at birth or through breast milk.)

In South Africa up to now the number of these orphans has been increasing quite slowly and from a low base - and hence has attracted relatively little attention to date. South Africa's AIDS epidemic is still in its early stages relative to other African countries, and the levels of orphanhood seen elsewhere in Africa have yet to be experienced in this country. As the epidemic matures and AIDS mortality increases, the number of orphans is predicted to rise dramatically.

Currently there are more people infected with HIV in South Africa than in any other African country - and ultimately we are likely to have to look after amongst the highest number of AIDS orphans.

South Africa will face significant costs in the long term if we do not plan to look after these orphans now - such costs include increased juvenile crime, reduced literacy, and increased economic burden on the state. Orphaned children are not only traumatised by the





loss of parents (whose physical deterioration they may often have witnessed), they may lack the necessary parental guidance through crucial life-stages of identity formation and socialisation into adulthood.<sup>1</sup> The impact on the ability of these children to eventually participate constructively in social and economic life is likely to be significant, and will no doubt increase levels of juvenile crime. Psychosocial effects will be worsened by accompanying threats to the basic survival (food, housing, education, health care) and security (protection from exploitation and abuse) frequently experienced by orphans.<sup>1</sup>

Many of these costs can be reduced if action is taken now. Models of community-based care must be further developed, and forms of state assistance to those caring for orphaned children must be expanded.

It is imperative that the number and profile of orphans expected in future be understood if successful strategies to provide and care for them are to be developed. A recent study<sup>2</sup> has estimated the number of orphans using the ASSA2000 AIDS and Demographic model of the Actuarial Society of SA.<sup>a</sup> The focus of this study was primarily on 'maternal orphans' (those whose mothers have died), but it also estimated the numbers of 'dual orphans' (children that have lost both parents) and 'paternal' orphans.

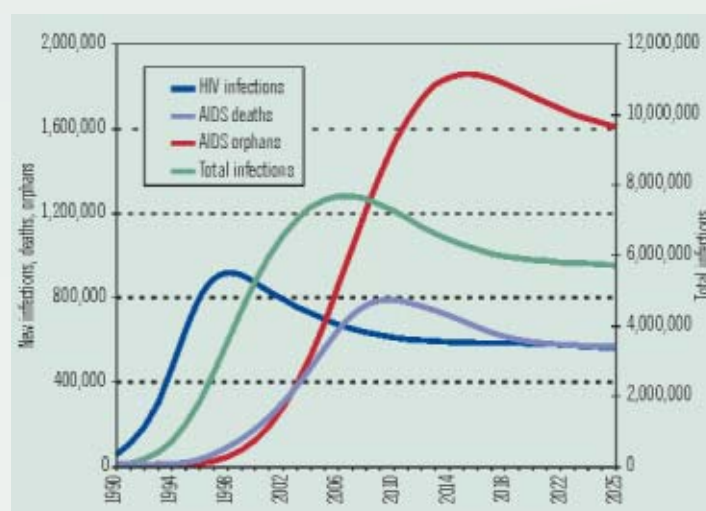
<sup>a</sup>*This model is publicly available and can be downloaded free of charge from [www.assa.org.za/aidsmodel.asp](http://www.assa.org.za/aidsmodel.asp)*

## MASSIVE CHALLENGE OF AN ORPHAN GENERATION

The number of orphans is emerging as a massive challenge - and the time to act is now. To appreciate the impact and the long-term nature of the challenge, it is useful to consider the HIV/AIDS epidemic as a series of 'waves' (Figure 1). The first wave - people newly infected with HIV (the incidence) - has already peaked (in about 1998), at about 930 000 infections a year. This is followed by the wave of prevalence (the total number of people infected with HIV), which is projected, assuming no change in behaviour nor in interventions, to peak in about 2006 at between 7 and 8 million infected. The next wave - the AIDS deaths - is expected to peak soon after this in about 2010, at about 800 000 deaths a year. That in turn will be followed by the wave of AIDS orphans,<sup>b</sup> which is expected to peak at about 1.85 million in around 2015. This clearly illustrates that the rise in orphans is one of the most tragic long-term consequences of the epidemic.

<sup>b</sup>*Defined here as children under fifteen whose mothers have died from AIDS.*

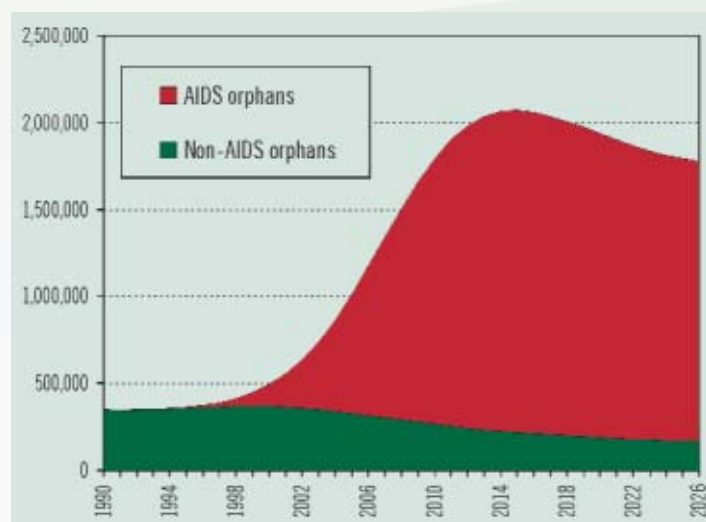
**Figure 1: Waves of the AIDS epidemic.**



It should be noted that HIV-positive orphans constitute a relatively small part of the orphan population, since about two-thirds of babies born to HIV-positive parents will not be infected, and because most infected children do not survive long enough to make up a sizeable proportion of the orphans.

Figure 2 shows numbers of AIDS orphans (those whose mother died while HIV-positive) as against 'non-AIDS' orphans (those whose mothers were HIV-negative when they died) over time. Projections indicate that the number of non-AIDS orphans will gradually decline - mainly as a result of greater numbers of mothers dying of AIDS, and declining levels of fertility. However, the number of AIDS orphans is expected to rise enormously over the next decade, peaking at about 1.85 million in 2015.

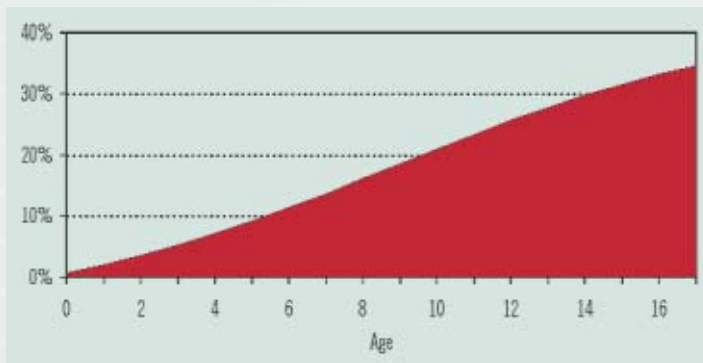
**Figure 2: Numbers of AIDS orphans and non-AIDS orphans**



Without significant changes in sexual behaviour or interventions, about 15% of all children under the age of 15 are expected to be orphaned by 2015. This percentage varies significantly with regard to age (Figure 3). The older a child is, the greater the chance that their mother has died during the time they have been alive. So, for children born in the last 12 months the percentage is close to zero, but at over 15 years of age the percentage is well over 30%. By 2015

more than 30% of all children between the ages of 15 and 17 will have lost their mothers.

**Figure 3: Percentage of children maternally orphaned in 2015.**



#### Alternative definitions of orphans

The most commonly used definition is children under the age of 15 whose mothers have died. But orphans do not cease to have need of parenting on reaching 15. In addition, the loss of a father also has a significant impact.

AIDS modellers and demographers typically use age definitions with cut-off points of 14, 15, 18 or 21 years.<sup>3</sup> The Constitution defines children as being persons under the age of 18, and most policy makers would agree that children under this age should not be expected to be self-supporting. Using age 18 as a cut-off results in a much *higher* estimate of orphans than using 15. The number of maternal orphans under the age of 18 is likely to peak at roughly 3.1 million in 2015, as opposed to 1.85 million using 15 years as the cut-off.

To aggravate this, orphanhood may in practice begin long before the death of a parent. This will happen where there is a sole parent and that parent becomes sick with AIDS. Often the household is without income and the parent is no longer able to support the child. This and the trauma of watching the parent slowly dying are the first stresses the orphan has to face. Studies of AIDS orphans show that they have low self-esteem and tend to display more aggression, anxiety and depression than other children.<sup>4</sup> Children alienated from or abandoned by their extended families are more likely to become street children and engage in antisocial behaviour or prostitution.

Regardless of the definition used, the number of orphans is likely to peak at around 2015 - at roughly 2 million in the case of maternal orphans under 15, and 3 million in maternal orphans under 18. The number of paternal orphans under 18 is expected to peak at 4.7 million in 2015, and the total number of children compromised by having lost one or both parents is likely to reach its highest level around 2015, at 5.7 million. The number of paternal and double orphans may be an underestimate of the number of children compromised, since it does not take into account fathers who are still alive but absent (i.e. no longer taking responsibility for their children).

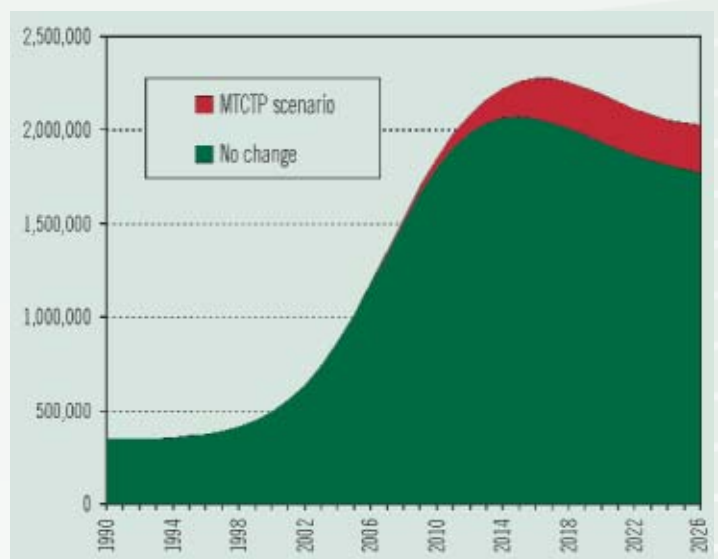
Roughly a third of all children under the age of 18 will have lost one or both parents by 2015 if there are no changes in sexual behaviour and no significant health interventions.

## IMPACT OF MOTHER-TO-CHILD TRANSMISSION PREVENTION PROGRAMMES

In developed countries the probability of perinatal transmission of HIV can be reduced to very low levels through the provision of long-course antiretroviral treatment during pregnancy and through caesarean sections. In resource-poor settings it has been shown that giving short-course antiretroviral treatment to mothers prior to birth and to babies after birth can also be effective in reducing the probability of transmission by between 35-50%.<sup>5</sup>

It is often suggested that introducing a mother-to-child-transmission prevention (MTCTP) programme will result in a substantial increase in the numbers of orphans. Figure 4 shows the projected number of maternal orphans under the age of 15 if a MTCTP programme is introduced, compared to the levels expected if such a programme is not introduced. It is clear that if MTCTP was phased in, fewer children would be infected by their HIV-positive mothers, and hence children would survive for longer. By 2015 the total number of orphans under 15 is likely to be around 2.26 million - 200 000 more than in the absence of MTCTP. Thus a MTCTP programme will only slightly increase the number of orphans, accounting for an additional 10%.

**Figure 4: Numbers of orphans, with and without an MTCTP programme.**



## IMPACT OF OTHER INTERVENTIONS

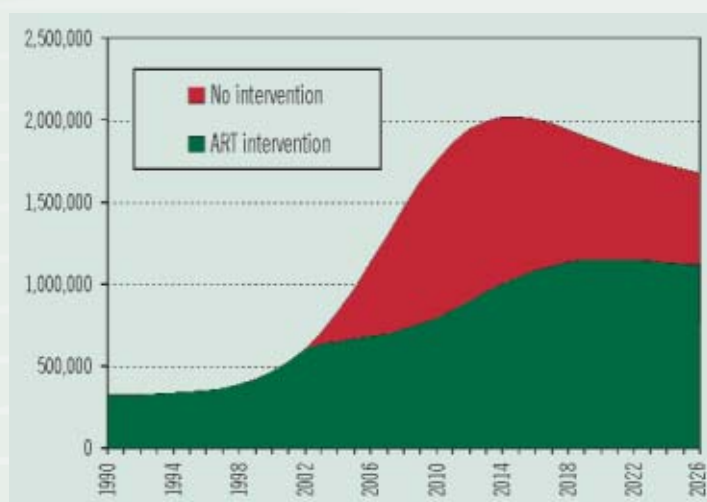
The expected number of orphans is - in the short term at least - relatively insensitive to changes in sexual behaviour patterns, condom distribution, AIDS awareness programmes, etc. These changes reduce the number of orphans substantially in the long term (by about 10% around 2015). However, such interventions are unlikely to change the fact that 12 years from now, South Africa will have close to 2 million orphans on its hands.

Although prevention programmes may not achieve a short-term reduction in the number of orphans, a significant reduction in the number and trend in number of orphaned children can be achieved through antiretroviral treatment programmes to all HIV-positive individuals who need treatment. Such programmes may succeed in extending the lives of a large number of parents to the stage where their children are self-sup-



porting. By 2015 the number of maternally orphaned children could be roughly half the number expected without any antiretroviral intervention (Figure 5), at 1.15 million. The cost-effectiveness of such interventions needs to be assessed as a matter of urgency.

**Figure 5: Numbers of orphans, with and without antiretroviral interventions.**



## POLICY RESPONSES

A number of different strategies exist and the response will have to be multipronged. However, any attempt to manage the situation is likely to require considerable expenditure by the state. Saving on short-term costs will just result in escalation of the long-term costs to society in terms of reduced literacy levels, increased crime and increased economic strain on affected households.

### *Options for the protection of orphaned and vulnerable children*

Meeting the needs of orphaned children will be a massive challenge, clearly overwhelming the *formal* (statutory) systems such as orphan, foster and residential care. It is widely acknowledged that *informal* systems are likely to shoulder the biggest share of the burden of orphan care. Most commonly, orphans will be cared for by their older siblings, grandparents or extended families. Various additional models of community-based orphan care have emerged in recent years and include:

- i Community Child Care Committees, community structures set up to identify orphaned and vulnerable children and to safeguard their rights, e.g. assisting them and their families to obtain child welfare grants, access health care, education, protecting them from abuse etc.;
- ii placing adults (usually older women) in the homes of orphaned children; and
- iii 'create a family' or 'cluster foster care' programmes where surrogate mothers are identified and hired to look after a number of orphans in homes in the community.<sup>6</sup>

### *Creating an enabling environment*

The following measures should be taken to ensure that the emotional and physical needs of South Africa's children are met in the face of rising adult mortality:

- **All forms of State support for children must be expanded.** It has been argued that the Child Care Act should be modified to allow alternative placement options for children in need of care and support.<sup>7</sup> The Care Dependency Grant should be extended to parents/guardians looking after children with chronic conditions like AIDS, and the basis for eligibility should be a 'needs test' rather than strict application of the medical definition of disability. However, this will only deal with those children accessing formal welfare systems.

The Committee of Inquiry into a Comprehensive System of Social Security for South Africa<sup>1</sup> has recommended a general widening of the social security safety net to also support those children who are likely to fall within informal systems of care by measures which include: extending access to the Child Support Grant (CSG) to all children below the age of 18 years (currently limited to children up to the age of 7 years) and providing free health care up to the age of 18 years. The current uptake of the CSG grant, however, is significantly hampered by difficulties in accessing necessary documentation such as birth and identity registration.<sup>10</sup> The evidence to date is that the children most in need are least likely to receive these grants, and mechanisms to address this have been recognised as a national priority.

- **Promote community based systems** of orphan support and care by providing support and funding for non-governmental and community-based organisations undertaking this work. The current government initiatives around home-based care could be extended to include a focus on children. However, external organisations and government agencies must be wary of undermining traditional coping mechanisms.<sup>4</sup> It must be recognised too that children are in need of support long before their parents die - interventions need to be directed at households where children are having to care for sick parents and are in need of emotional and material support.<sup>8</sup>
- **Making antiretroviral treatment freely available** to HIV-infected adults will have a dramatic effect on the numbers of orphans needing care and support. The potential impact of providing anti-retrovirals on reducing welfare costs urgently needs to be investigated.

**South Africa's capacity to provide care for these orphaned children will determine the long-term social stability of the country. Little can be done to reduce the number of orphaned children in the short term, short of introducing a national antiretroviral treatment programme.**

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