

# Orphans And Other Children Made Vulnerable By HIV/AIDS In South Africa: A Factsheet

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## Who are the children most affected by HIV/AIDS in South Africa?

The term 'OVC' (orphans and other vulnerable children) is widely used both nationally and internationally to refer to children who are made vulnerable in the context of HIV/AIDS. While this term refers to orphans and other vulnerable children, in reality the international response to HIV/AIDS to date focuses primarily on children who have been orphaned, and makes a range of assumptions about the needs of these children, which are very often based on western ideas of family form and care arrangements<sup>4,11</sup>.

According to the latest official figures released by the Department of Health<sup>1</sup>, an estimated 5.3 million people in South Africa were HIV-positive at the end of 2002, including 2.95 million women between the ages of 15 and 49 years. Given the scale of the pandemic in South Africa, it is safe to say that most children are in some way affected by HIV/AIDS. However, certain categories of children are more affected than others.

**1** The October 2002 antenatal survey<sup>1</sup> reported that 26.5% of pregnant women attending public sector antenatal clinics were HIV-positive in 2002, with the highest prevalence (36.5%) observed amongst women in KwaZulu Natal. It is estimated that during the same year, 91 271 babies became infected with HIV through mother to child transmission.

**2** The number of children who acquire HIV through sexual abuse is not known, however what is known is that this number could be significantly reduced with the immediate provision of post exposure prophylaxis to rape survivors.

**3** Projections of the number of children who are likely to be orphaned are calculated using various mathematical models, one of which is the 'ASSA' model. Based on ASSA model calculations, actuaries estimate that in July 2003 there were approximately 990 000 children (under the age of 18 years) in South Africa who had lost a mother (maternal orphans) and around 2.13 million children who had lost a father (paternal orphans). Projections derived from the same models predict that by 2015 in the absence of any major treatment intervention or behaviour change, roughly 3.05 million children under 18 will be maternally orphaned and 4.51 million paternally orphaned, of whom almost 2 million children will have lost both parents (double orphans). This equates to a total of 5.6 million

children under the age of 18 having lost one or both parents by 2015, with the majority of parental deaths being AIDS-related<sup>2</sup>. The single most effective intervention for reducing the predicted number of orphans is the full roll-out of antiretroviral treatment (ART). The provision of ART to all HIV-positive adults who need treatment would roughly halve the predicted number of orphans<sup>3</sup>.

**4** Contrary to widespread belief, the majority of children orphaned by AIDS are not HIV-positive. The use of insensitive terms such as the term 'AIDS orphans' fuels misconceptions about children who have been orphaned, and promotes an inappropriate response to their needs.

**5** For most children who are orphaned as result of AIDS (especially those who are cared for and/or financially supported by their biological parents), orphanhood is a process which begins long before the death of a parent and which is characterised by different challenges at different times. The needs of children living in households with sick adults and/or sick siblings are seldom recognised or adequately addressed in policy and programmes<sup>4</sup>. With over 5 million HIV-positive South Africans, an estimated 500 000 children currently have a mother who is terminally ill with AIDS<sup>2</sup>. This figure represents only a small proportion of the total number of children living with adults and siblings who are HIV-positive.

Research repeatedly demonstrates the vulnerability of children living with caregivers who are terminally ill. In addition to experiencing many of the same challenges faced by children who have been orphaned, these children commonly assume responsibility for the care of the sick in the household, often without access to basic necessities such as water, disinfectants, gloves, bedding etc<sup>4</sup>.

**6** In AIDS-affected communities, where levels of mortality are increasing, it is not only those who are 'directly' affected by HIV/AIDS who bear the burden of illness and death. Poverty is amplified way beyond those whom HIV/AIDS directly afflicts and whole neighbourhoods face increased demands on 'informal' networks of care and support<sup>4</sup>. Key areas of need identified by children who are affected by HIV/AIDS are poverty (and the associated difficulties with access to services such as education and health care) and abuse. There is a vast overlap between the difficulties experienced by these children and those experienced by the majority of poor children in South Africa. Universal poverty relief and child protection mechanisms are therefore critical components of an effective response to the needs of children in the context of HIV/AIDS.

## Who is caring for children who have been orphaned?

In considering the frightening projections and defining an appropriate response, it is crucial to consider the care arrangements of children in South Africa generally as well as those who have been orphaned:

**7** There is a long history in South Africa of children – and especially children living in circumstances of poverty – not being constantly parented by either one or both of their biological parents. The majority of these children live with other adults as caregivers for at least periods of their lives (ie. living with 'social' rather than biological parents). This continues to be the case, both for children who face orphanhood *as well as those who do not*. Children frequently experience a sequence of different caregivers, and many children are brought up without paternal figures, or live in different households to their biological siblings<sup>1</sup>.



For example, 2002 General Household Survey (GHS) data indicates that of the almost 15 million children under 18 whose parents were recorded as *alive*, only 45% were living with both parents at the time of the survey, while 36% were living with their mother and not their father, 3% with their father and not their mother, and 17% were living with neither parent. The majority of those children not resident with their parent(s) were resident with relatives<sup>2</sup>.

**8** Similarly, the majority of children who are orphaned (maternal, paternal, or double) are cared for by their relatives. Because of the characteristically non-nuclear nature of South African households, in many instances children remain in their homes upon the death of their parent(s), with a continuum of care provided by other adults with whom they are resident at the time<sup>2,4</sup>.

**9** There are interesting differences between the care arrangements for paternal and maternal orphans. General Household Survey (GHS) data from 2002 suggests that about ¾ of children whose fathers have died, live with their mothers (71%). But less than one third of children whose mothers have died live with their fathers (27%). In the main, maternal orphans live with other relatives<sup>5</sup>.

**10** Only very small numbers of orphaned children find themselves living without any resident adult caregiver in so-called 'child headed households' or on the streets. Research conducted in South Africa<sup>6</sup> and systematic investigation in several other countries (including in some of those where the HIV/AIDS pandemic is more advanced than in South Africa) have confirmed that child-headed households are rare<sup>6,7</sup>. Important to note is that research

indicates that child headed households, while clearly existing in small numbers, are frequently a transitional/temporary household form<sup>4,8</sup>. For example, a group of siblings may live in a child headed household for a short period of time, just after the death of an adult and prior to other arrangements being made for their care.



**11** To date no reliable evidence exists to support the frequent claim that orphans are likely to find themselves living on the streets<sup>9</sup>.

**12** A common response to increasing numbers of orphans in South Africa is the establishment of residential facilities. This response is based in part on incorrect assumptions about the circumstances of children who have been orphaned.

While in some instances residential care presents the only feasible alternative for a child, research documents a number of important issues to consider with regard institutional care:

- The long term residential care of children has been associated with poor developmental outcomes<sup>10</sup>.
- Children and caregivers are generally reluctant to resort to this form of care, but in some instances consent to it because families are unable to provide adequately for the children<sup>4,10</sup>. This emphasises the pressing need for improved poverty alleviation mechanisms and support for households<sup>4</sup>.
- Children raised in institutions are left with no 'home' upon reaching the age of 18, the cut-off age for most residential facilities.
- Institutions are prohibitively expensive to run. For the same costs, far more children can be supported within communities than in residential care.
- Residential facilities/institutions established specifically for orphans, or 'AIDS orphans' risk increasing the stigma and discrimination associated with HIV/AIDS<sup>4</sup>, in particular where these are set up as 'villages' that operate separately from surrounding communities.

Contrary to popular perception therefore, the majority of children who have been orphaned in South Africa are not without adult care, support, supervision or socialisation<sup>4,9</sup>. The majority of children who have been orphaned are being cared for by relatives, many of whom live in impoverished households within poor communities. Household level support - in the form of cash grants and access to free / subsidised services - would greatly enhance the capacity of relatives to care for vulnerable children and would help to ensure that the needs of these children are adequately met and that their rights are upheld. ●

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