AIDS orphan crisis

How can we care for them?

By 2015 around one third of children under the age of 18 in South Africa will have lost one or both parents. **Melvyn Freeman** and **Nkululeko Nkomo** investigate the possibilities for these orphans and make important recommendations.

There is increasing concern worldwide around children who are orphaned and made vulnerable by HIV/AIDS. UNICEF (United Nations Children's Fund) has estimated that by 2010, 20 million children under the age of 15 will have lost one or both parents – mainly to AIDS. The majority of orphans will be in southern Africa.

In 2004 it was estimated that in South Africa alone just over a million children under the age of 18 years had already lost a mother – mainly to AIDS. Without major changes in sexual behaviour and no significant health interventions, by 2015 around one third of children under the age of 18 in South Africa will have lost one or both parents. Even if HIV is stabilised or decreases orphan numbers will continue to grow, reflecting the time lag between HIV infection and death.

PSYCHOLOGICAL IMPACTS ON CHILDREN

The impacts on these children is profound. Studies show that most children lose out on education, nutrition, health, relationships, shelter, human rights and access to social security. An important impact of orphanhood which has not been well documented or researched is the psychological effects.

Clearly we must avoid generalisation on psychological effects as they are mediated by genetic, biological, social and psychological factors and different children will respond differently to the loss of parents or primary caregivers. It is also important to acknowledge that many children are highly psychologically resilient and tend to cope in the face of extreme adversity. Doomsday predictions about psychological damage to a majority of children are not correct or helpful. Yet there will still undoubtedly be significant negative psychological impacts for many children.

Psychological stress for orphaned children begins long before the death of the parent. AIDS is a chronic and deteriorating condition so even before the parent dies children will have been through disrupted routines and unexpected absences of the parent probably through hospitalisation. Children also see and even nurse their parents through illness. Some children may have dropped out of school to nurse a parent or to work to bring in money for the household because of the parent's inability to work.

In addition due to illness, parents may be unable to provide the support and nurturance that children need. A study in Zambia found that 82% of people caring for children, noted changes in the children's behaviour during their parent's illness. Other studies have noted the increase in psychological distress among children during their parent's HIV/AIDS illness. The impact on children will of course vary depending on their developmental age and the availability to social support.

Following the death of a parent, most children experience trauma and grief. How much they cope at the time of death and thereafter will depend to a large extent on the support they get. Children may also experience 'double orphanhood' or even 'multiple grief' when both parents die or if other children in the household are infected with HIV. Also in cases when the second parent dies they will have no parental support to see them through the grief. Of course for many there will be other family and friends to help. But in the face of poverty, the HIV/AIDS pandemic and the number of deaths within families, the extended family may not be able to play the supportive roles that they traditionally play in African societies. The emergence of

child-headed households is one of many consequences resulting from this.

On top of the difficulties before death and the death of the parent itself, the child then has to deal with long-term survival without the emotional and material support, as well as the moral guidance of the parent. Orphans in Uganda, Tanzania, Mozambique, Zimbabwe, Congo and South Africa have all shown raised levels of psychological problems and difficulties in coping. The 'AIDS stigma' makes the problem worse.

DEALING WITH ORPHANS' MENTAL HEALTH

A few orphans may need professional psychological help to deal with parental death and learning to live without their primary caregiver. Most, however, will not need counseling or professional help but will need a stable and loving home where they are cared for, nurtured, stimulated, taught moral values and get life skills to deal with the world. If this cannot be provided, some children will experience anything from fairly mild to serious long term mental health problems.

From a psychological point of view, internationally, placing children in 'orphanages' or similar child care arrangements has not been successful and is discouraged.

Fortunately in South African extended families and the spirit of 'ubuntu' allows many children to move into family settings where they get the material, social and psychological environments that children need. Of considerable concern, however, is that the extended family safety net is becoming less able to absorb the huge numbers of orphans and as the number of deaths increase this situation will get worse.

WILLINGNESS TO TAKE IN CHILDREN

It was against this background that the Human Sciences Research Council conducted a survey to find out where caregivers think their children would go if something happened to them and where they would want them to go. The study also looked at the willingness of community members to take in other children and what levels of support they would need to encourage them to do so.

The survey of 1 400 adults over the age of 18 took place in Gauteng, Free State and KwaZulu/Natal. It got the opinions of people in townships, informal settlements, as well as rural tribal and farming areas. These people included parents, grandparents and caregivers who had a children living with them; grandparents where the grandchild or children were living with their parent; fathers of children living with their mother whether the father was part of the household or not; adults in a household where there were children not directly dependent on them; adults who had brothers or sisters with children under 18 years; adults whose best friend had children; and adults with regard to children unknown to them.

In the survey, around 30% of children were not living with their biological parents. Children living with grandparents were the greatest percentage of this group (67%). The two main reasons that these non-biological adults had children staying with them was that the mother or father had passed away or was unemployed. Where these carers gave reasons for the death of the mother or father, about 30% said HIV/AIDS was the cause. This suggests that nationwide around 3% of all children are already staying with a person other than their biological parents due to AIDS deaths.

One thousand and forty nine adults reported that they had children living with and dependent on them. If something terrible happened to them, about 64% identified a family member who would look after their children. Most indicated the other parent (28,7%), followed by a grandparent (26,9%). Not surprisingly many more men than women said that they would want their partner to look after their children if they were not around. Disturbingly, a number of parents could not identify anyone who they felt could look after their children. These people either thought that the government should take care of their children or that the children would become street children or criminals.

The survey also asked adults in households what they thought would happen to children if the primary caregiver was unable to look after them. Contrary to the usual views regarding fathers, 65,6% of fathers said that they would raise the children themselves. Less surprising was the 59% of grandparents that said they would raise the children.

The survey also asked people whether they would be willing to take in a child or children unknown to them. Sixty-two percent (62%) said that they would. Significantly more women than men said they would take children in.

From the results it seems that there is a strong willingness to take in children if the need arises. However, further probing showed

that despite the good intentions, for many people, both related and unrelated to potential orphans, poverty and high unemployment created a stumbling block for taking orphans into the family. This raises the question of how families could be assisted to expand the numbers of people into their families. The survey then looked at assistance levels that could influence people's decisions to take in children. It looked at both monetary and social assistance.

INCENTIVES TO TAKE IN CHILDREN

Interestingly across the categories of possible caregivers an amount of R170 (equal to the child care support grant) was not likely to influence whether or not to take in children. However, possible 'incentives' of R600 and R1 000 were viewed as positive incentives to taking in children.

Other significant incentives were having the children's education paid for and a caregiver to 'come in now and then' to assist with looking after the child or children. In almost all of the categories, having a child's education paid for and having a trained person to assist was viewed as favourably as receiving R1 000.

Understandably people in the lower socio-economic group and the unemployed were more likely to want to take in a child if a grant was made available than those who were financially better off. Most poorer people would simply not be able to afford to take in more children without assistance and so the grant acted as an 'incentive' to their willingness to take in children. While it is possible to see the higher grants purely as a means to provide general income to the household, we believe from the results of the survey that for poorer people, assistance in taking in children is based on 'need' rather than 'greed'.

Apart from incentives other influences on whether people would take in children included the age and HIV status of the children. In particular, men were not keen to look after younger children. A number of both men and women were reluctant to take in a child if they were HIV positive.

CONCLUSION

To prevent a situation where large numbers of HIV/AIDS orphans are left in poverty and also mental health difficulties, the placement of orphans must be managed with care. Children's homes or orphanages are not a good option and incorporation into families, whether the child's extended family or another family is a far better alternative.

However, for many South Africans affected by unemployment and poverty taking in additional children will stretch their already limited resources. This will result in many poorer people not taking children into their homes. Many older people will also be stretched in terms of their own age, resources, and the numbers of children requiring a home.

The study showed that despite poverty, many people have already taken orphaned and vulnerable children into their households. There is also a great willingness amongst extended family members and others to take in millions who will need assistance in the future. Nevertheless, many households will have to get some assistance to take in additional children. An incentive of R600 or R1 000 may seem unrealistic in the light of competing demands on the country's budget. Yet when this amount is measured against the costs of other options such as orphanages (that range from R2 500 to R4 000 per child a month), providing assistance to family and local community members may be the best option from a social and psychological point of view and from an economic perspective.

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