

**Africa's Orphaned
and Vulnerable
Generations**

**CHILDREN
AFFECTED
BY AIDS**

PRE-PUBLICATION



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EXECUTIVE SUMMARY

The AIDS epidemic in Africa puts children at risk physically, emotionally and economically. All children are indirectly affected when their communities, and the services these communities provide, are strained by the consequences of the epidemic. Nurses, doctors, teachers and others can become ill and die from AIDS, affecting health care, education and other basic services.

Children are directly affected in a number of ways. They may live at high risk of HIV; they may live with a chronically ill parent or parents and be required to work or put their education on hold as they take on household and caregiving responsibilities; their households may experience greater poverty because of the disease; and they can be subject to stigma and discrimination because of their association with a person living with HIV. Children can also become orphans, having lost one or both parents to AIDS-related illnesses.

In sub-Saharan Africa, AIDS is the leading cause of death among adults ages 15–59. Although the total number of orphans from all causes in Asia and in Latin America and the Caribbean since 1990 has been decreasing, the number of orphans from all causes has risen by more than 50 per cent in sub-Saharan Africa, where an estimated 12 million children ages 0–17 have lost one or both parents to AIDS. This makes the region home to 80 per cent of all the children in the developing world who have lost a parent to the disease. Children are experiencing the greatest

parental loss in southern Africa, where HIV prevalence rates are highest.

By 2010, an estimated 15.7 million children – 30 per cent of the 53 million anticipated orphans from all causes in sub-Saharan Africa – will have lost at least one parent due to AIDS. Even where HIV prevalence stabilizes or begins to decline, the number of orphans will continue to grow or at least remain high for years, reflecting the time lag between HIV infection and death.

The experiences of orphaned and vulnerable children vary significantly across families, communities and countries. Some studies have shown that orphans and vulnerable children are at higher risk of missing out on schooling, live in households with less food security, suffer anxiety and depression, and are at higher risk of exposure to HIV. The situation is influenced by a complex mix of variables, including children's relationship to their caregivers, the wealth of their household and community, HIV prevalence in the community and an array of other factors.

In almost every country in the region, there are notable differences between the responsibilities assumed by fathers and mothers, with widowed mothers more likely to be responsible for the care of their children than widowed fathers, making children who lose their mothers less likely to live with the surviving parent compared to children who lose their fathers. Furthermore, the survival of the youngest children

(ages 0–3) is at stake when their mothers are dying or have recently died. This is true whether the mother dies of AIDS or other causes. Children of this age group are 3.9 times more likely to die in the year before or after their mother's death.

Extended families care for the vast majority of orphans and vulnerable children in sub-Saharan Africa, in many countries assuming responsibility for more than 90 per cent of all double orphans and single orphans not living with the surviving parent. Within a household, the nature of the relationship between the new caregiver and the child strongly influences the outcome for the child. Several studies have shown that the closer children remain to their biological family, the more likely they are to be well cared for and the greater the chance that they will go to school consistently, regardless of poverty level.

While families have cared for the expanding number of orphans and vulnerable children in sub-Saharan Africa, in places with advanced epidemics, there is some indication that children can end up in poorer households and that available caretakers are becoming scarcer and more impoverished.

The implications of the AIDS epidemic for generations of orphans and vulnerable children in sub-Saharan Africa are serious, but governments, international agencies, non-governmental organizations and community groups can alter the course of the response. Some challenges can be addressed by providing support to caregivers, extended families and communities. Others,

including equitable access to education and health, birth registration, foster care and inheritance legislation, also require commitment and intervention from governments.

In recent years, there has been a surge in leadership and resources for the fight against AIDS. In 2005, approximately \$8.3 billion was available for responding to the epidemic. While a long-needed influx of funds has great potential for improving the lives of millions of children affected by the disease, the multisectoral nature of HIV response makes tracking difficult at the country level, so it is not known what percentage of this money is specifically helping children.

The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, drawn up in 2004 by a broad array of partners, focuses on families, communities, services and governments, and on creating a supportive environment for children. Most countries in sub-Saharan Africa (as well as a number of countries in other regions) are now developing national plans of action for these areas.

To implement an appropriate response at the required scale, however, there must be sufficient knowledge to understand the situation of children affected by AIDS. Despite the more rigorous study of the conditions of orphans and vulnerable children in sub-Saharan Africa, and more systematic data collection, the knowledge base on the status of these children still needs to be expanded and strengthened. Our understanding is far from comprehen-

sive and needs to be improved. This is particularly pressing, given that the AIDS epidemic is now well into its third decade.

We must also step up efforts to measure the effectiveness of programmes supporting orphans, vulnerable children and their families. Improved research must be translated into better responses at scale, and more systematic monitoring systems should be set up to ensure that children's needs are indeed being met. Accelerating evidence-based HIV prevention measures for children and adults will reduce future numbers of orphans and vulnerable children. And increased access to antiretroviral therapy and treatment for HIV-related illness will help prolong the lives of parents living with HIV.

The situation of orphans and vulnerable children varies by context, and responses need to be based on situation assessments in order to reflect local realities and meet local needs. Links need to be made across sectors to ensure a comprehensive approach. In addition, research to date reveals a particular burden on female-headed and poorer households; this suggests that current assistance should prioritize vulnerable households, particularly those headed by women.

HIV continues to spread against a backdrop of poverty in sub-Saharan Africa. Rapidly accelerated and adequately resourced action that is based on the growing body of evidence can help ensure that orphans and vulnerable children grow up safe, healthy, happy and well-educated, with the chance to achieve their true potential.

INTRODUCTION

The AIDS epidemic in sub-Saharan Africa makes children vulnerable, leaves them orphaned and threatens their survival. In the most affected countries in this region, children are missing out on what they need for survival, growth and development, and progress on key national development goals is being jeopardized.

The Millennium Declaration and the Millennium Development Goals, as well as the commitments made by world leaders at the United Nations General Assembly Special Sessions on HIV/AIDS in 2001 and on Children in 2002, and at the 2006 High-Level Meeting on AIDS, set the parameters for addressing the impact of the AIDS epidemic on children. The global campaign *Unite for Children. Unite against AIDS*, launched in October 2005, called for the protection of orphans and vulnerable children as one of four priority action areas.

Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS is an update of the 2003 report *Africa's Orphaned Generations*. It incorporates new and refined estimates of the number of children orphaned in sub-Saharan Africa, as well as current research on the impact of AIDS and orphaning. Information about orphans in the region has increased significantly in recent years and research has become more rigorous. And, while information on other vulnerable children in the region lags far behind, the situation of some well-defined groups, such as children living with chronically ill parents, is now being studied more systematically.

The situation is complex, findings cannot necessarily be generalized, and assistance to orphans and vulnerable children is challenged by this complexity. *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS* is meant to shed light on the circumstances of children affected by the AIDS epidemic and to encourage action.

THE DEVELOPMENT CONTEXT FOR RESPONDING TO ORPHANS AND VULNERABLE CHILDREN

The Millennium Development Goals (MDGs), stemming from the Millennium Declaration (adopted in 2000) and reaffirmed at the World Summit in 2005, are directly relevant to children and their futures. Among the eight goals, mounting an adequate response to AIDS will be pivotal, especially in countries with high HIV prevalence, for reaching the targets.

At the United Nations General Assembly Special Sessions on HIV (2001) and on Children (2002), government leaders committed to the achievement of key goals, including the development and implementation of national policies and strategies that protect and support children orphaned and made more vulnerable by AIDS. These declarations were strengthened by the agreement among world leaders to pursue universal access for prevention, treatment, care and support in 2005 and 2006.

The consistent lack of a response for children affected by HIV led UNICEF, UNAIDS and partners to launch the global campaign *Unite for Children. Unite against AIDS* in 2005. The campaign aims to reach four measurable outcomes, including preventing HIV infection among adolescents and young people, preventing mother-to-child transmission of HIV, providing paediatric treatment, and protecting and supporting children affected by HIV and AIDS. The High-Level Meeting on AIDS (2006) brought together all sectors of the international community, governments, civil society and the private sector to implement the Declaration of Commitment on HIV/AIDS and further the goals of coordination, prevention, increased research, and care and protection for those affected.

In recent years, there has been a surge in leadership and resources for the fight against AIDS, with \$8.3 billion available in 2005 alone for responding to the epidemic in low- and middle-income countries. The impact of the epidemic on children, however, has yet to receive the priority attention it deserves.

1 THE SCALE OF THE CRISIS

Although HIV has reached nearly every part of the world, sub-Saharan Africa has been hit the hardest, and the region is home to nearly two thirds of the world's people living with HIV. It is also home to over 48 million orphans, 12 million of them orphaned as a result of the AIDS epidemic.

By the end of 2005, almost 25 million people in this region were living with HIV, including an estimated 2 million children under age 15. An estimated 2.7 million people in sub-Saharan Africa were newly infected with HIV during 2005, and approximately 2 million adults and children died of AIDS, more than two thirds of all AIDS deaths worldwide in 2005.¹ In sub-Saharan Africa, the epidemic is increasingly affecting women, who are more likely to become infected than men and are, on average, infected at a younger age.

HOW CHILDREN ARE AFFECTED

Children are indirectly affected when their communities, and the services these communities provide, are strained by the consequences of the AIDS epidemic.² Nurses and doctors may suffer from the disease, threatening health care, and the health systems they work within may be overwhelmed with new patients; teachers may become ill, disrupting education.

Children are directly affected in a number of ways. They may live at high risk of HIV; they may live with chronically ill parents or adults and be required to work or put their education on hold as they take on household and caregiving responsibilities; their households may experience greater poverty because of the disease; and they may be subject to stigma and discrimination because of their association with a person living with HIV. Children can also become orphans, losing one or both parents to AIDS-related illnesses.

WHERE CHILDREN ARE AFFECTED

In sub-Saharan Africa, AIDS is the leading cause of death among adults ages 15–59,³ and as one consequence, an estimated 12 million children ages 0–17 have lost one or both parents to AIDS. As a result, the total number of children orphaned from all causes in sub-Saharan Africa is expanding and reached 48.3 million at the end of 2005. Although the total number of orphans from all causes in Asia and in Latin America and the Caribbean has been decreasing since 1990, the number of orphans has risen by more than 50 per cent in sub-Saharan Africa (see Figure 1.1). Compared to Asia, and Latin America and the Caribbean, where 6 per cent are orphans, 12 per cent of all children in sub-Saharan Africa are orphans.

PANEL 1.1: ONE COUNTRY'S EXPERIENCE

The burden of parental death from AIDS is greatest in southern Africa. In Zambia, for example, 20 per cent of all children were orphans in 2005, over half of them due to AIDS, leaving a population of 11.7 million to support more than 1.2 million orphans. With one sixth of Zambian adults currently infected with HIV and only around 25 per cent of those in need receiving antiretroviral therapy, AIDS will continue to kill parents – it took the lives of around 75,000 adults in 2005 – and increase orphan prevalence for years to come.

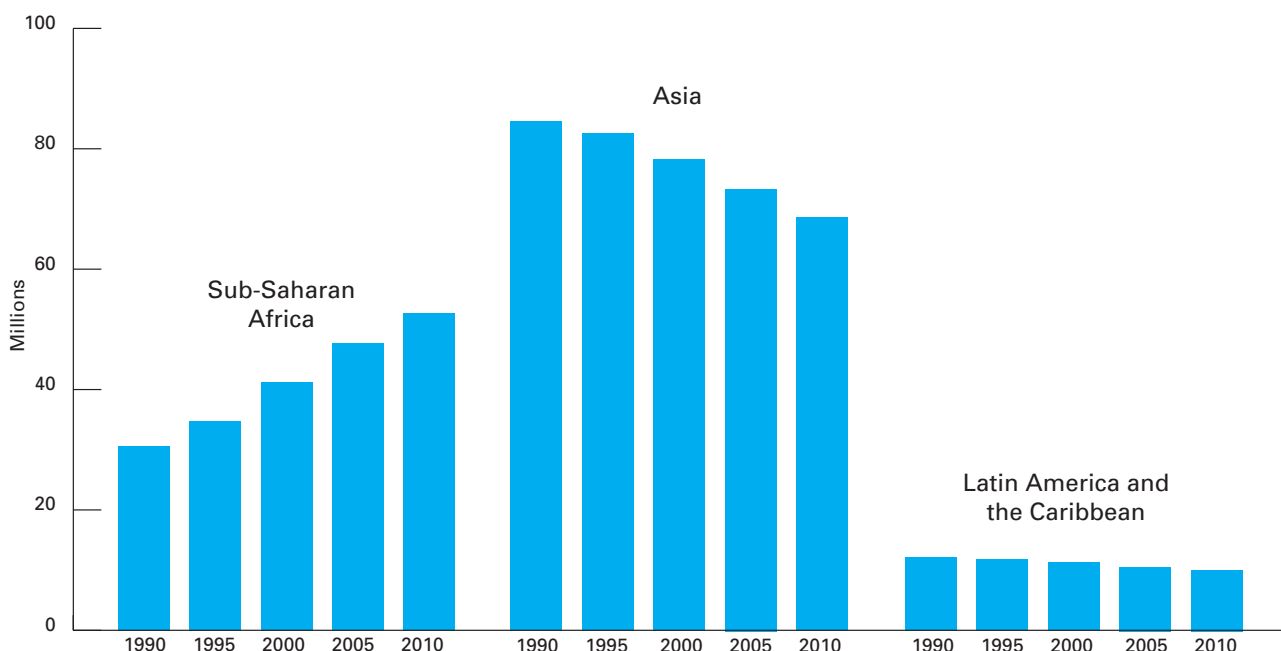
Note: The total number of adult deaths due to AIDS in Zambia is derived by taking the total number of deaths (adults and children) due to AIDS, 98,000 in 2005, and multiplying it by the regional proportion of total AIDS deaths attributed to adults, which is 0.75.

The magnitude and trends in overall orphanhoodⁱ in the countries of sub-Saharan Africa in 1995 and 2005 are presented in Figure 1.2. There are wide variations across the region in the proportion of orphaned children,

in HIV prevalence and in the role AIDS is playing in overall orphaning levels.

As the maps on page 4 illustrate, children are suffering the greatest parental loss in southern Africa, where

FIGURE 1.1: Number of orphans ages 0–17, by region, 1990–2010



Source: UNAIDS and UNICEF estimates, 2006.

ⁱ Unless otherwise indicated, the figures on orphans in this document include orphans from all causes.

PANEL 1.2: DEFINITION OF 'ORPHAN'

The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS uses the following definition for an orphan: An orphan is a child under 18 years of age whose mother, father or both parents have died from any cause. Orphans from all causes can be more specifically described as follows:

Single orphan – a child who has lost one parent.

Double orphan – a child who has lost both parents.

Maternal orphan – a child whose mother has died (includes double orphans).

Paternal orphan – a child whose father has died (includes double orphans).

HIV prevalence rates are highest. In 10 of 45 countries in sub-Saharan Africa, 7 of which are in southern Africa, 15 per cent or more of all children were orphans in 2005 (see Figure 1.3). These countries are among those

with the highest HIV prevalence rates. In 21 of the 41 countries in sub-Saharan Africa with available data, less than 20 per cent of orphaning is due to AIDS; by contrast, in 7 of the 10 countries in southern Africa with data,

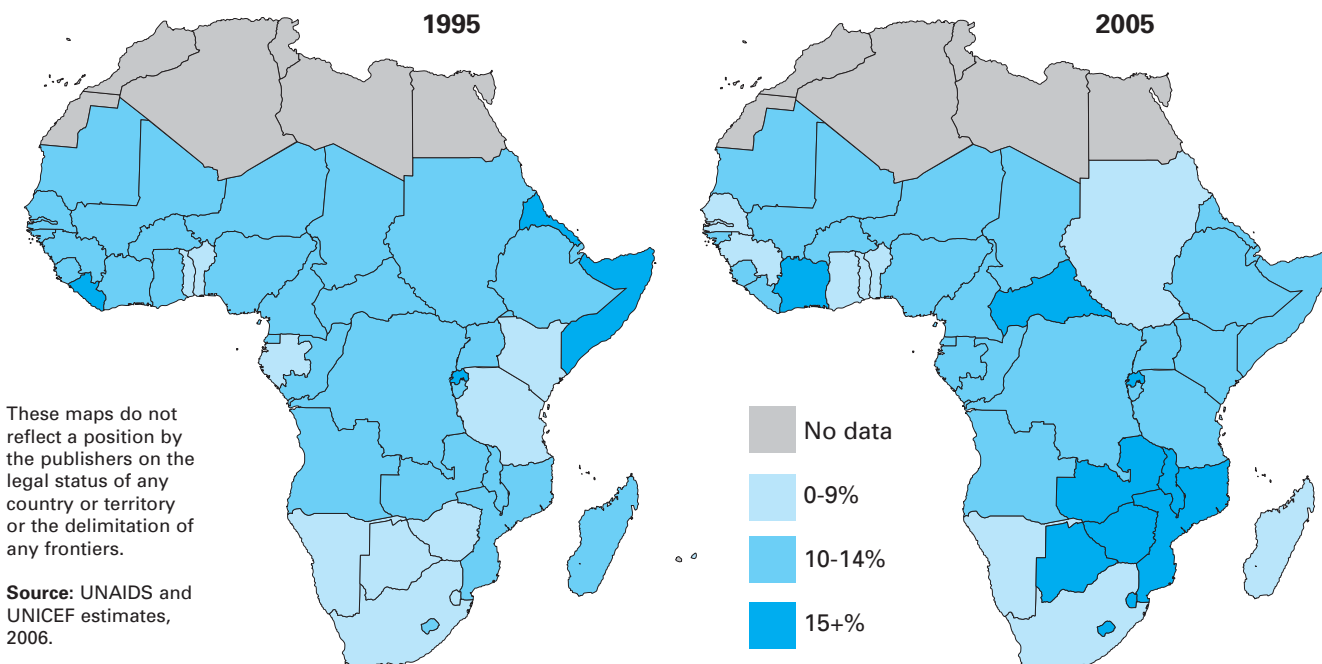
more than 50 per cent of orphaning is due to AIDS (see Table 2, page 36).

THE DYNAMICS OF ORPHANING

The number of newly orphaned children, or orphan incidence, reflects the magnitude and current impact of the crisis. While orphan prevalence estimates include all children ages 0–17 who have lost one or both parents over their lifetime, incidence reflects only those who have lost a parent during the past year. Each year, some orphans turn 18 and are no longer counted as orphans. At the same time, a new cohort of children ages 0–17 loses one or both parents. When the number of new orphans is fewer than the number turning 18, the number of orphans will decline.

In 2005, 5.5 million children in sub-Saharan Africa became orphans

FIGURE 1.2: Percentage of children in sub-Saharan Africa ages 0–17 orphaned by any cause, 1995 and 2005



These maps do not reflect a position by the publishers on the legal status of any country or territory or the delimitation of any frontiers.

Source: UNAIDS and UNICEF estimates, 2006.

from all causes, up from 3.4 million children who were orphaned in 1990 (see Figure 1.4). Some of this increase is explained by population growth; the remainder is likely due to AIDS. The number of children who will face the death of a parent is daunting.

LOSS OF A MOTHER OR FATHER (SINGLE ORPHANS)

To date, more single orphans have lost their fathers than their mothers, primarily because men have children when they are older and are more likely to die before their children are grown. In countries with high HIV prevalence, however, the number of women dying from AIDS is escalating. In one study on orphan incidence in Manicaland, Zimbabwe, researchers documented that the rate at which children are losing

their mothers is increasing and will soon exceed the rate at which their fathers are dying.⁴ In sub-Saharan Africa there are, on average, three women living with HIV for every two infected men. The discrepancy is even wider among young people ages 15–24, at the start of their reproductive years, with three women infected for every young man.⁵

Because AIDS is increasingly taking a toll on women, and because as a sexually transmitted disease it is likely to infect both parents, the pattern of orphaning is shifting and the number of double orphans is increasing.

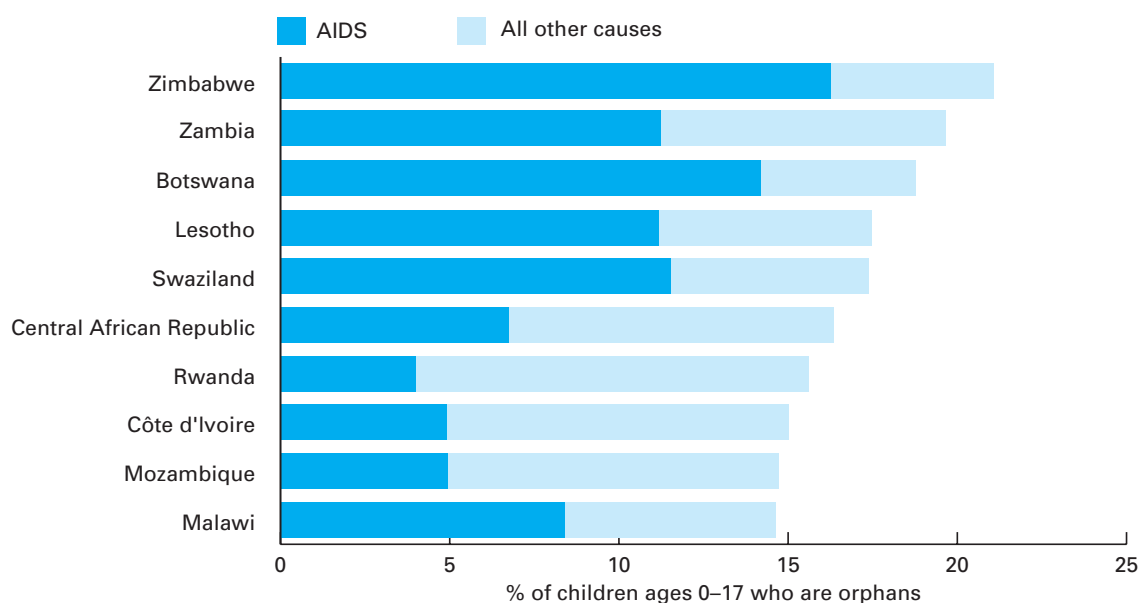
LOSING BOTH PARENTS (DOUBLE ORPHANS)

As a cause of orphaning, AIDS is exceptional, because if one parent is

infected with HIV, the probability is quite high that the other parent is also infected, putting children at a high risk of losing both within a relatively short time.⁶ Of the 9.1 million double orphans in sub-Saharan Africa in 2005, around 5.2 million, or almost 60 per cent, had lost at least one of their parents to AIDS. Without AIDS, the total number of double orphans in sub-Saharan Africa would have declined between 1990 and 2010. AIDS, however, will push the number of double orphans in the region to more than 10 million by 2010 (see Figure 1.5).

Even where the total rate of orphaning is stable, an increase in double orphans such as that caused by AIDS represents a significant worsening of the situation for affected children. Many single orphans live with the

FIGURE 1.3: Countries in sub-Saharan Africa where approximately 15% or more of all children are orphans



Source: UNAIDS and UNICEF estimates, 2006.

PANEL 1.3: ORPHAN ESTIMATES

This report includes national estimates of the number of orphaned children as previously published in *Children on the Brink*, 2000, 2002 and 2004. Refinements to the current estimates include improved measurement of HIV prevalence in some countries and revised estimates of underlying adult mortality. As in *Children on the Brink 2004*, the estimates provided in this report refer to children under the age of 18. For more detail on the estimates used in this report, see Annex, page 40.

surviving parent, although differences exist, depending on which parent survives. (See Figure 3.1, page 15). However, when both the mother and father die, the child loses all parental care and support, creating greater hardship.

AGE OF ORPHANS AND ORPHANING

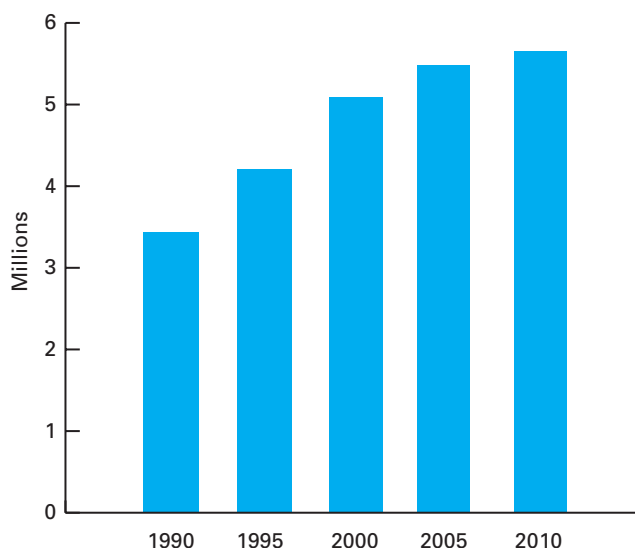
The age distribution of orphans is fairly consistent across countries. The proportion of children who are orphans and the number of double orphans increases with age. Almost half of all orphans and two thirds of double orphans are adolescents ages 12–17 (see Figure 1.7).

Among children younger than 15, data from four longitudinal research sites provide information on the child’s age at the time of parental

loss (see Figure 1.8). About 40 per cent experience the death of a parent between age 10 and 14, and around 25 per cent of these children experience a parent’s death before they reach age 5.

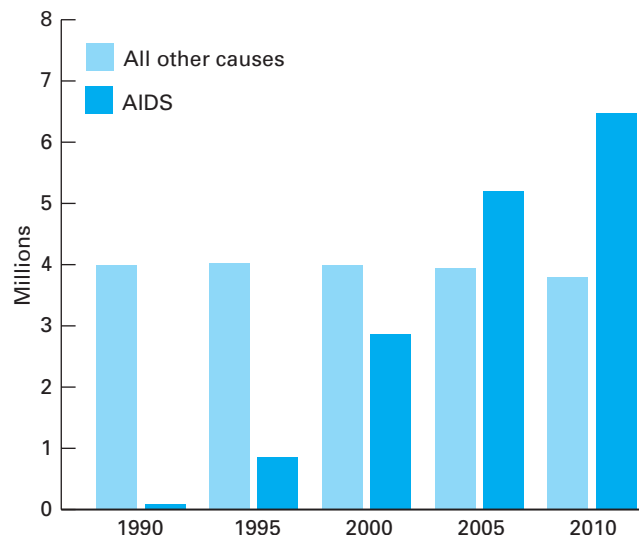
The age of orphans and their age when they were orphaned have significant implications for planning a response that meets children’s needs at varying developmental stages.⁷ Older orphans may be at risk of missing out on education, being subject to exploitative labour, and being exposed to HIV and other sexually transmitted infections. The youngest orphans – although making up a smaller percentage of all orphans (16 per cent) – are the least resilient and have the greatest need for physical care and nurturing.

FIGURE 1.4: Number of children in sub-Saharan Africa ages 0–17 experiencing the death of a parent during the year



Source: UNAIDS and UNICEF estimates, 2006.

FIGURE 1.5: Number of double orphans in sub-Saharan Africa ages 0–17, AIDS versus all other causes, 1990–2010



Source: UNAIDS and UNICEF estimates, 2006.

PANEL 1.4: WITHIN A COUNTRY, MANY DIFFERENCES IN WHERE ORPHANS LIVE

The distribution of orphans within countries is affected by many factors. For example, the higher proportion of orphans in urban areas in countries such as Ethiopia and Uganda (see Figure 1.6) might be due to higher HIV prevalence rates in urban areas in these countries. Sickness and death from AIDS or other causes can also prompt migration of children and their families from rural to urban areas or vice versa. Research suggests that urban-to-rural migration may result from circumstances such as terminally ill parents going home to villages to die, or a sense that caring for orphans might be easier in rural areas. Rural-to-urban migration may result from the economic pull of cities as widows from rural areas seek ways to support their families. Another potential reason for migration within countries may be the desire to escape stigma following an AIDS death.

Source: Ansell, Nicola, and Lorraine van Blerk, 'HIV/AIDS and children's migration in Southern Africa', Southern African Migration Project (SAMP), 2004; Ansell, Nicola, and Lorraine Young, 'Young AIDS Migrants in Southern Africa', Brunel University, April 2002; Foster, Geoff, and John Williamson, 'A review of current literature of the impact of HIV/AIDS on children in sub-Saharan Africa', *AIDS*, vol. 14, suppl. 3, 2000, pp. S275–S284; and Joint United Nations Programme on HIV/AIDS, *2006 Report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition*, UNAIDS, Geneva, May 2006, pp. 19 and 21.

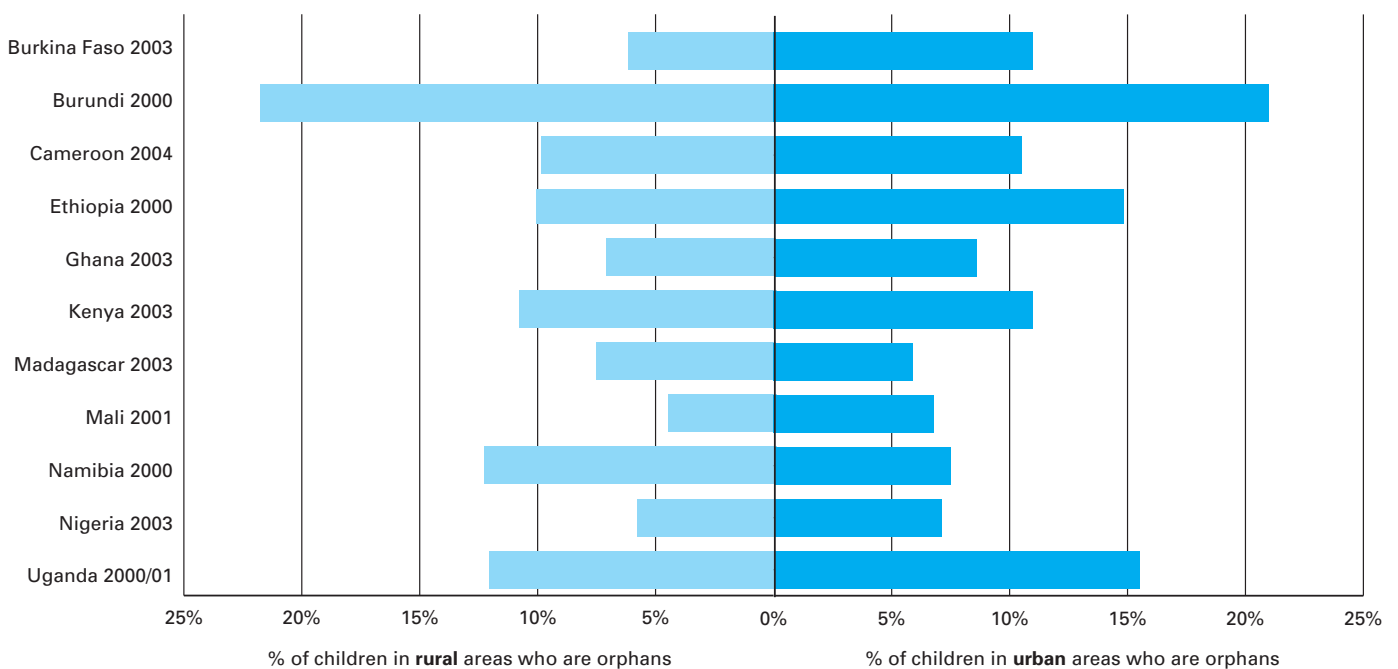
By definition, an orphan could have experienced the death of his or her parent up to 17 years earlier. Children who recently experienced the loss of a parent are likely to have

different needs and require specific responses. There is very little systematic data collection, however, that addresses needs based on the proximity to time of parental death.

CHILDREN LIVING WITH CHRONICALLY ILL PARENTS

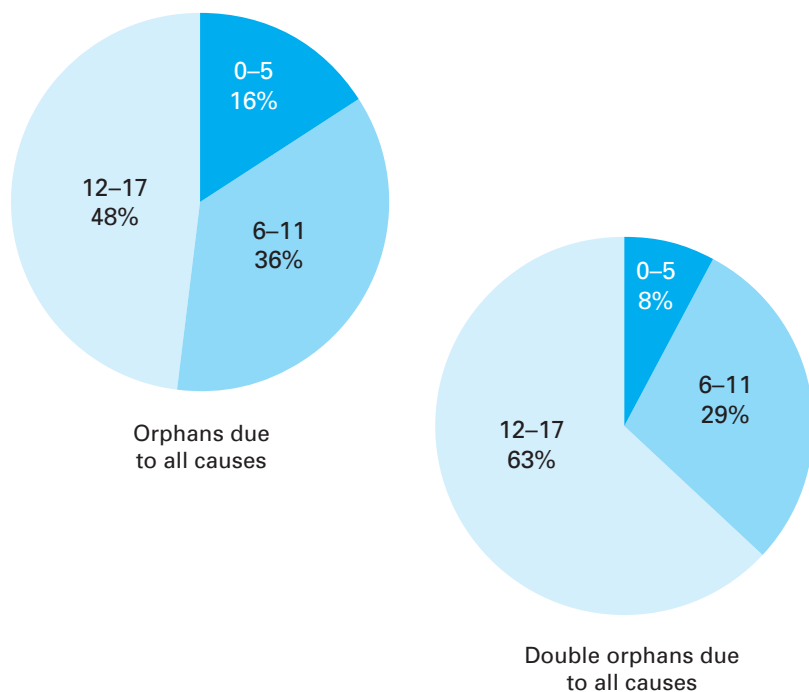
Based on the number of children who lost a parent during the past year, it can be assumed that a

FIGURE 1.6: Orphaning rates in rural and urban areas



Source: Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS), 1999–2004.

FIGURE 1.7: Age distribution of orphaned children in sub-Saharan Africa, 2005



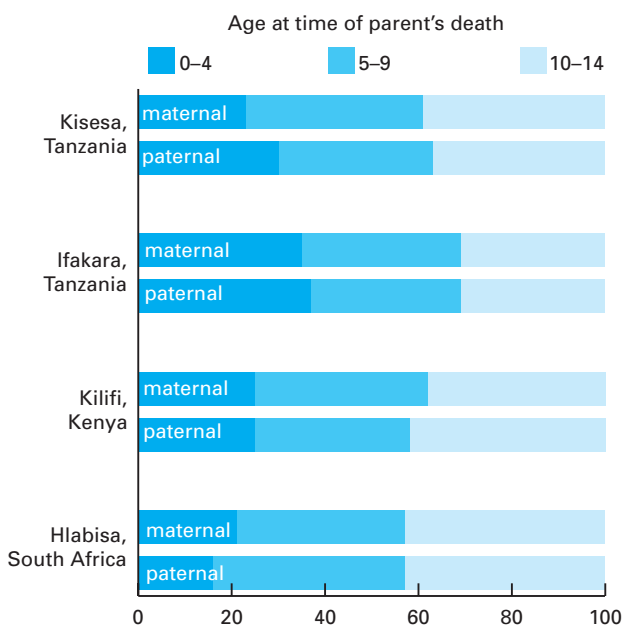
Source: UNAIDS and UNICEF estimates, 2006.

similar number will experience a death in the coming year. In countries where a significant proportion of those adult deaths is due to AIDS, these children will be coping with their parents' illness. In Zambia, for example, data from 2005 show that 11.8 per cent of children were vulnerable in 2005: They either lived in a household with a chronically ill adult, had a chronically ill parent living outside the household, or had experienced an adult death in their household in the last year.⁸

CHILDREN AFFECTED NOW AND FOR YEARS TO COME

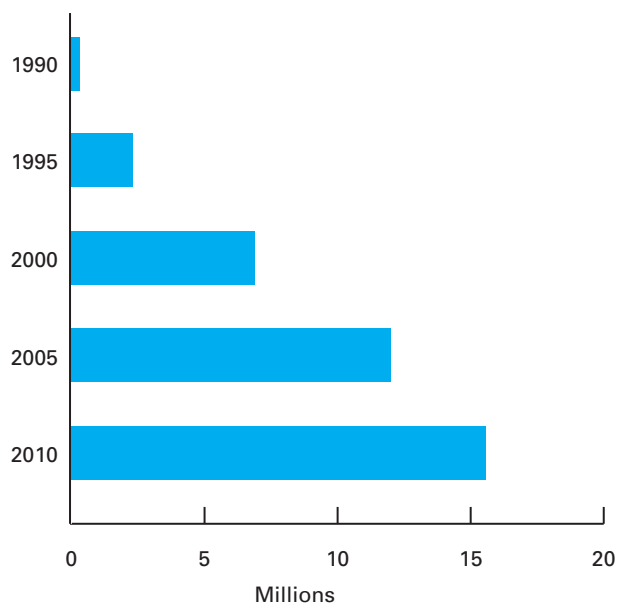
Even where HIV prevalence stabilizes or begins to decline, the number of orphans will continue to grow or at least remain high for a number

FIGURE 1.8: Percentage of children by age at time of parent's death, four districts in eastern and southern Africa



Source: Floyd, Sian, et al., UNICEF project: *HIV and orphanhood: final report on phase 3*, September 2005, UNICEF. This report concerns the third phase of a project using empirical evidence from longitudinal, community-based studies in Africa to assess the overall impact of the HIV epidemic on child welfare.

FIGURE 1.9: Number of children in sub-Saharan Africa ages 0-17 orphaned due to AIDS, 1990-2010



Source: UNAIDS and UNICEF estimates, 2006.

of years, reflecting the time lag between HIV infection and death. The crisis engendered by increasing numbers of orphans and vulnerable children is not a short-term one. Unlike many other illnesses, or accidents and violence, trends in orphaning due to AIDS can be anticipated to some extent. Projections based on HIV prevalence and current levels of antiretroviral treatment indicate that the number of orphans and vulnerable children due to AIDS in sub-Saharan Africa will continue to rise through at least 2010. At that time, an estimated 15.7 million children, or 30 per cent of the anticipated 53 million orphans from all causes in sub-Saharan Africa, will have lost at least one parent due to AIDS (see *Figure 1.9*).

In five countries (Comoros, Ghana, Mauritius, Rwanda and Zimbabwe), it is predicted that the number of orphans will stabilize or slightly decrease, while in eight countries (Chad, Gabon, Guinea-Bissau, Malawi, Mozambique, Namibia, South Africa and Swaziland) the number of orphans will increase by 15 per cent or more between 2005 and 2010.

Given the lag time between infection and death, the number of orphans may continue to grow or at least remain high for years, even where infection rates stabilize or begin to decline.

A significant increase in the number of people receiving antiretroviral

treatment could potentially reduce orphaning, although even with an extensive scaling up of antiretroviral treatment life expectancy will be lower than in an adult population unaffected by AIDS. And, as a result of earlier adult death, orphaning may continue to be higher. Projections indicate that, even if a full package of interventions is put in place (including treatment and prophylaxis, prevention of mother-to-child transmission, and primary prevention activities), the number of orphans would remain high for the next several years.⁹ Orphaning levels may also be impacted if reproductive health services are weak or unavailable.

2 POVERTY, HIV AND CHILDREN

Where poverty and HIV coexist, children and households are at risk of great deprivation. The effects – often combined – of decreased income, increased expenses and higher dependency ratios can generate impoverishment in affected families. As the AIDS epidemic takes its toll on communities, there is some indication that orphaned children can end up in poorer households, perhaps because households able to care for an additional child are becoming saturated.

DIMINISHING HOUSEHOLD WEALTH

Several studies have documented the declining wealth of households as a result of AIDS. As a household member falls ill, medical care and other expenses increase, while both ability to work and capacity to generate income are likely to decrease. In households affected by AIDS, more money is spent caring for sick members, leaving fewer resources for the children in the household. These adjustments can have a particularly harmful effect on children in poorer households, which have fewer resources to begin with.

Studies of households in Côte d'Ivoire found that when a family member has AIDS, the proportion of household budgets spent on health care is twice as much as that spent by households in a control group. This extra expenditure is particularly onerous because income in the AIDS-affected households was only half that of the control group households.¹

Even after death, funeral expenses can reduce the financial resources available to households. A study in four provinces in South Africa found that households with an AIDS-related death in the past year spent an average of one third of their annual income on a funeral.²

Recent studies in communities of Malawi, Mozambique and Swaziland reconfirm the complex interrelatedness of HIV, poverty and other economic influences.³ Using household data and a simulation model, the

researchers estimated the economic impact of AIDS in agricultural communities. In Swaziland, total community disposable income had fallen by an estimated 8 per cent over five years, with a more severe drop in directly affected households.⁴ In Kenya, double orphans were found more often in the poorest households in 2003 than in 1998 (see Figure 2.1).

HIGHER DEPENDENCY RATIOS

Households with orphans have higher dependency ratios, and in the case of grandparent-headed households they may not have substantial income to begin with. The dependency ratio, defined here as the number of children ages 0–17 plus adults age 60 or over, divided by the number of adults ages 18–59, indicates the number of people in a household who

In households affected by AIDS, more money is spent caring for sick members, leaving fewer resources for the children in the household.

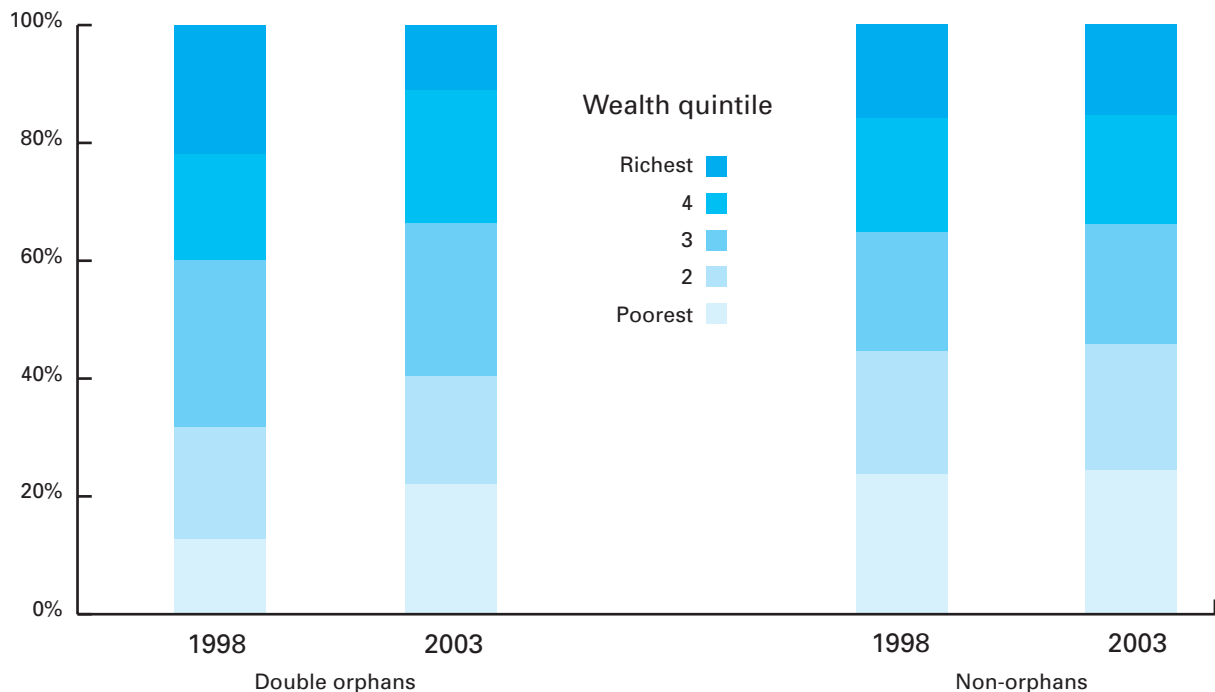
must rely on each adult for food security and livelihoods. For example, a ratio of 1.6 means that for each productive adult, there are 1.6 people who must be supported. Households with orphans (due to AIDS or other causes) most often have higher dependency ratios than other house-

holds (see Figure 2.2). Among households with orphans, those headed by females and with double orphans have the highest dependency ratios of all (see Figure 2.3).

PROPERTY DISPOSSESSION

Few people in poorer communities in sub-Saharan Africa make official wills, increasing the risk that a deceased person’s property will simply be taken by family members or by other members of the community. A 2005 review in Rwanda found that the legal system (and sometimes children’s guardians) did not always protect orphans’ rights to land, despite existing laws on children’s inheritance rights and guardians’ responsibilities.⁵ Several studies documenting the problems orphans (and widows) have with dispossession come from

FIGURE 2.1: Distribution of double orphans and non-orphans by household wealth, Kenya, 1998 and 2003



Sources: Demographic and Health Surveys (DHS) for Kenya, 1998 and 2003.

PANEL 2.1: ONE WOMAN'S STRUGGLE

A Human Rights Watch study documented the personal impact of AIDS on a family. A 40-year-old woman living in a slum in Nairobi, Kenya, cares for eight orphans in addition to her seven biological children. The orphans, from two different sets of parents, did not inherit any property because their relatives took everything when the parents died. The orphaned children came to their new caretaker with only the clothes they were wearing. With the money this woman earns from selling vegetables, she sends the eight orphans to an unregulated 'informal school' in the slums. The hardest thing, she says, is sending them to school on an empty stomach.

Source: Interview in Human Rights Watch, *Letting Them Fail: Government Neglect and the Right to Education for Children Affected by AIDS*, *Human Rights Watch*, vol. 17, no. 13 (A), New York, 2005, p. 36.

Uganda. Although this country's legislated inheritance rights are among the most progressive in sub-Saharan Africa, difficulties remain for women and children because claims are hard to make and poorly enforced.⁶

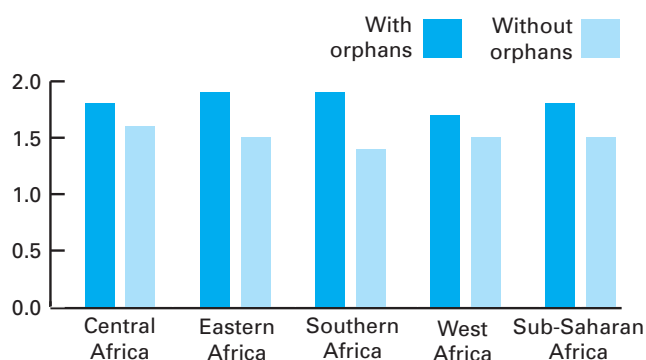
MATERIAL NEEDS OF ORPHANS AND VULNERABLE CHILDREN

Households that receive orphans or vulnerable children need to provide basic necessities for the additional children. Some families may have sufficient income to cope; others may

rely on the extended family or community for support. But support from family, neighbors and community members may not be sustainable.

Recent studies in Malawi, Rwanda, Zambia and Zimbabwe found that

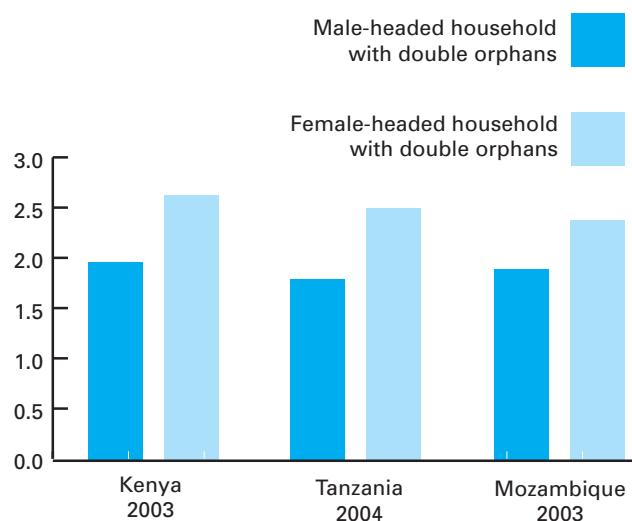
FIGURE 2.2: Average dependency ratios among households with and without orphans



Source: Monasch, Roeland, and J. Ties Boerma, 'Orphanhood and childcare patterns in sub-Saharan Africa: An analysis of national surveys from 40 countries', *AIDS*, vol. 18, no. 2, 2004, pp. S55-S65.

Note: The dependency ratio in this calculation is defined as the number of individuals ages 0-17 or 60 and over, divided by the number of individuals ages 18-59.

FIGURE 2.3: Average dependency ratios in female- and male-headed households with double orphans



Source: Demographic and Health Surveys (DHS) for Kenya 2003, Tanzania 2004 and Mozambique 2003.

Note: The dependency ratio in this calculation is defined as the number of individuals ages 0-17 or 60 and over, divided by the number of individuals ages 18-59.

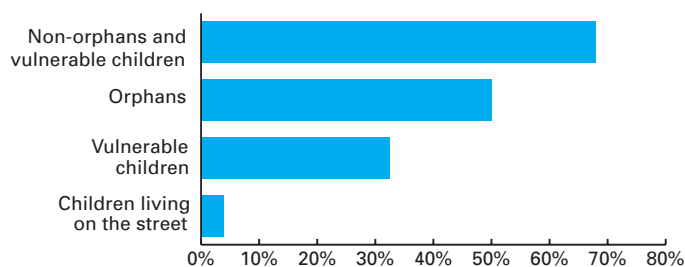
orphans and children with chronically ill caregivers are worse off with regard to possession of basic material goods (a blanket, shoes and an extra set of clothes) than other children.⁷ As Figure 2.4 shows, orphans and vulnerable children in Blantyre, Malawi, were less likely to possess those items than other children. The same finding held true when comparing orphans and children who live in a household with an ill adult or recent adult death with other children in Zimbabwe⁸ (see Figure 2.5). Studies in three provinces of South Africa found that material needs

were cited as the highest priority for households with orphans, and finding the money to pay for essential needs was the greatest constraint.⁹

There is some evidence that orphans may experience discrimination within the household. One recent study in Mozambique documented discrimination in allocation of resources in poor households against children who are not direct biological descendants of the household head.¹⁰ Qualitative research carried out in Malawi and Lesotho found that children who had migrated to another household and

also experienced the death or sickness of a parent reported being given different food from other children in the household, being beaten and overworked, and having received inadequate clothing.¹¹ This was particularly true when resources were scarce. Analysis based on 19 Demographic and Health Surveys in 10 sub-Saharan countries found evidence of intra-household discrimination against orphans as manifested by investment in schooling, with orphans having lower enrolment rates than non-orphans in the same household.¹²

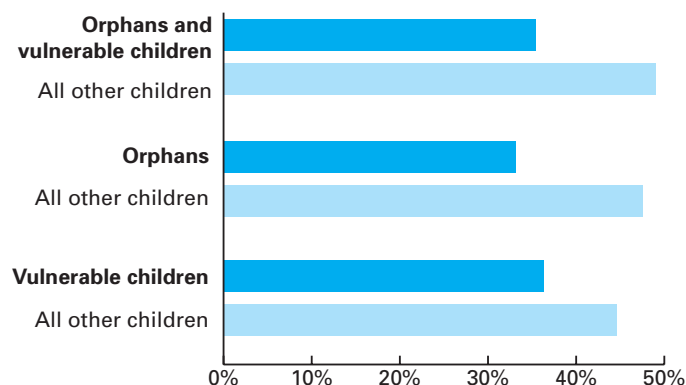
FIGURE 2.4: Percentage of children ages 5–17 with basic material goods (blanket, shoes and two sets of clothing), Blantyre, Malawi, 2004



Source: UNICEF, 'Report on the pilot survey on orphans and other vulnerable children in Blantyre, Malawi.' UNICEF Malawi, June 2005.

Note: In this study, an orphan is a child who has lost one or both parents. A vulnerable child is one whose parent has been ill for at least 3 of the past 12 months, who lives in a household where an adult (ages 18–59) died in the past 12 months or where at least one adult (18–59) was ill for at least 3 of the past 12 months. 'Children living on the street' are those who slept on the street the night before the survey.

FIGURE 2.5: Percentage of children ages 5–17 with basic material goods (blanket, shoes and two sets of clothing), 21 districts in Zimbabwe, 2004



Source: UNICEF and Ministry of Public Service, Labour and Social Welfare, Zimbabwe, *Survey on Orphans and Other Vulnerable Children in Rural & Urban High Density Zimbabwe 2004/2005*, Harare, 2005, p. 31.

Note: In this study, an orphan is a child who has lost one or both parents. A vulnerable child is one who lives in a household where at least one adult (ages 18–59) died in the past 12 months or where at least one adult (ages 18–59) was ill for at least 3 of the past 12 months, or who lives in a household headed by an individual under 18.

3 FAMILY STRUCTURES

In many sub-Saharan countries, extended families have assumed responsibility, with little public support,¹ for more than 90 per cent of all double orphans and single orphans not living with the surviving parent.² The countries where extended families' resources are already stretched will experience the largest increase in AIDS deaths, orphanhood and vulnerability over the coming years. As the numbers of orphaned and vulnerable children rise, families are increasingly strained to meet the growing need for childcare.³

THE EXTENDED FAMILY

When one parent has died, many orphans stay with the surviving parent. Table 3.1 shows the proportion of single orphans living with a surviving mother or father in seven countries with recent data. In these countries, up to two thirds of paternal orphans stay with their mother. However, around half or fewer of maternal orphans live with the surviving father. A 2004 review of household survey data showed similar results – that children who lose their mothers are less likely to live with the surviving parent, compared to children who lose their fathers.⁴

FEMALE-HEADED HOUSEHOLDS

Not only are women more likely to look after their own children, they are also more likely to take care of orphans. In three countries, the percentage of orphans who have lost their mothers and are subsequently living in female-headed households has increased since the early 1990s (see *Figure 3.1*). Female-headed households generally assume care of more orphans than male-headed households.⁵ As a result, female-headed households with orphans have the highest dependency ratios (see *Figure 2.3, page 12*).

OTHER RELATIVES AS CAREGIVERS

When both parents die, analysis of data from 13 countries showed that other members of the extended family typically care for the double orphans and single orphans not living with the surviving parent.⁶ But the person who assumes primary responsibility within

the family differs between countries (see Figure 3.3). In Kenya, 51 per cent of double orphans and single orphans not living with the surviving parent are being raised by their grandparents; in Burkina Faso, 57 per cent are raised by other relatives, including aunts and uncles. Research across

26 sub-Saharan countries found that care for double orphans is concentrated in those households with fewer other children. Boys who are double orphans are more likely to live with their grandparents; girls who are double orphans are more likely to live with 'other relatives'.⁷

GRANDPARENTS AS CAREGIVERS

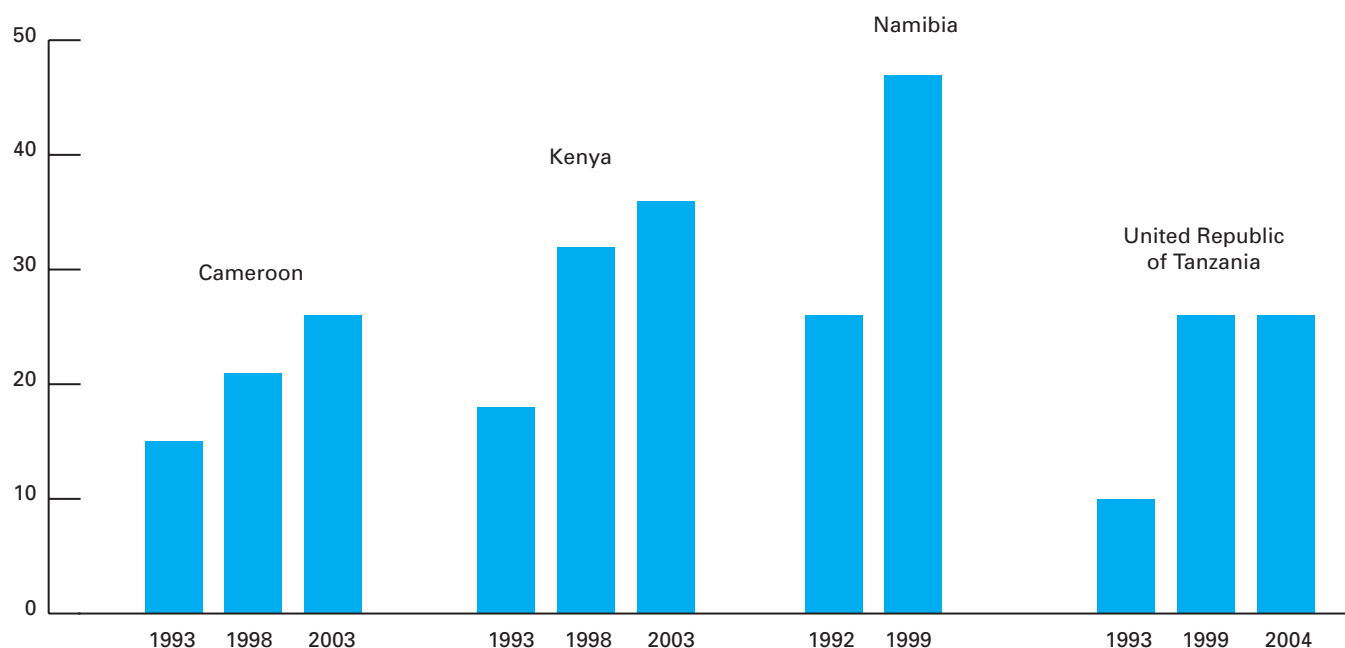
Recent data analysis across 24 sub-Saharan countries documented a strong association between AIDS-related mortality within a country and the probability of finding an older adult living with a double orphan.⁸ Figure 3.2 illustrates the change in

TABLE 3.1: Living situations of orphans and non-orphans

| | % of non-orphans living with mother | % of paternal orphans living with mother | % of non-orphans living with father | % of maternal orphans living with father |
|------------------------------|-------------------------------------|--|-------------------------------------|--|
| Burkina Faso | 90 | 60 | 88 | 52 |
| Cameroon | 81 | 65 | 73 | 37 |
| Ghana | 82 | 62 | 62 | 35 |
| Kenya | 90 | 63 | 70 | 27 |
| Mozambique | 85 | 56 | 70 | 25 |
| Nigeria | 87 | 59 | 83 | 50 |
| Tanzania, United Republic of | 84 | 57 | 72 | 31 |

Source: Demographic and Health Surveys (DHS), 2003 and 2004.

FIGURE 3.1: Percentage of maternal orphans ages 0–14 living in a female-headed household



Source: Demographic and Health Surveys (DHS) 1991–2004.

the proportion of orphans looked after by grandparents in five countries.

Research in Malawi found that orphaned children expressed a preference for their grandparents over other adult relatives and community members as their primary caregivers.⁹ Across 10 countries in sub-Saharan Africa, orphans living with their grandparents were found to fare better in school attendance than those living with other relatives.¹⁰ Grandparents often already have a role in the care of their grandchildren,¹¹ but they have fewer economic resources than adults in prime working age and so may require external support. Also, because of their age, grandparents may not survive until children in their care reach 18; these children will again experience loss and a transition to new caregivers.

SEPARATION OF SIBLINGS

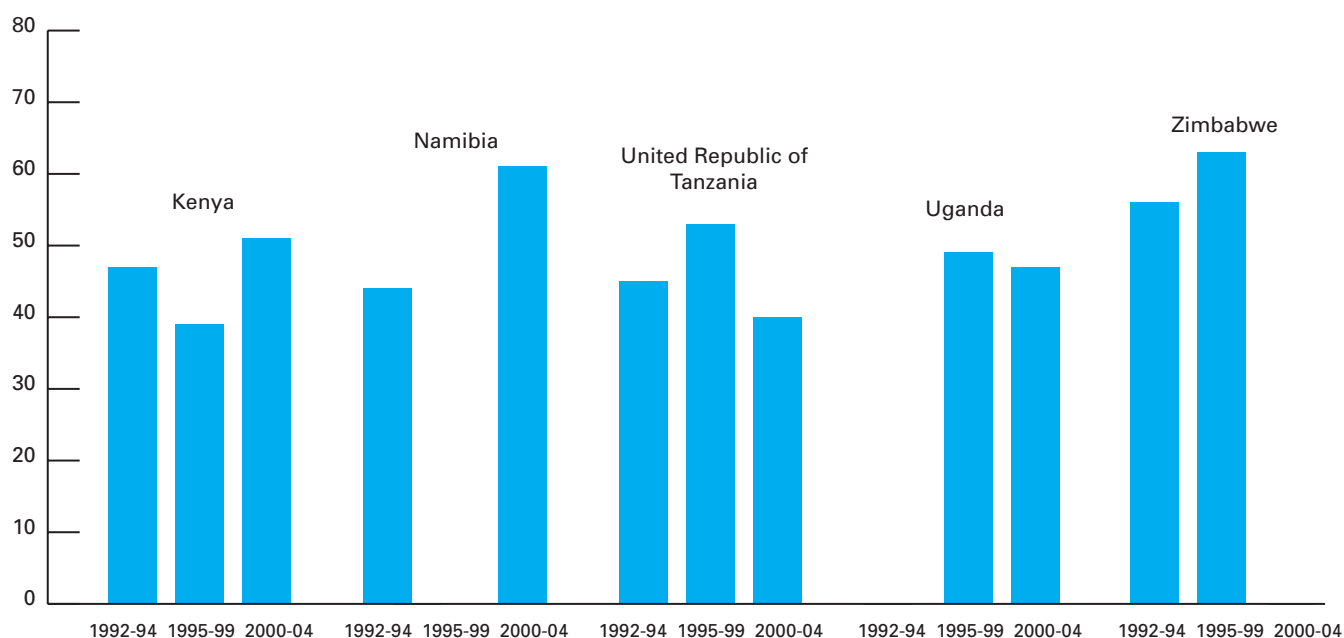
Data on sibling separation is scarce, but orphaned siblings may be placed in different homes as a way of distributing the burden of care. One retrospective survey in Karonga, Malawi, found that only 4 per cent of non-orphans under age 15 were separated from their siblings under 15. But 15 per cent of paternal orphans, 21 per cent of maternal orphans and 8 per cent of double orphans did not live with their siblings.¹² In Zambia, 30 per cent of orphaned and vulnerable children were found to be living away from some or all of their siblings under age 18, while 15 per cent of children not classified as orphaned or vulnerable were living away from their siblings.¹³ Research from a study in Zambia revealed that the separation

of siblings was a significant determinant of emotional distress for orphans in an urban sample.¹⁴

CHILD-HEADED HOUSEHOLDS

As evident in Figure 3.3, there are very few households – less than 1 per cent in the countries listed here – headed by children under age 18.¹⁵ Even in Zimbabwe, where HIV prevalence and the proportion of orphans are exceptionally high, the proportion of child-headed households was found to be only 4 per 1,000. Research in that country suggests that child-headed households were more frequently established if a teenage child experienced in childcare was living in the household or if a relative lived nearby who could provide supervision.¹⁶

FIGURE 3.2: Percentage of double orphans and single orphans (not living with surviving parent), ages 0–14, cared for by their grandparents



Source: Demographic and Health Surveys (DHS), 1992-2004.

It is a great testament to the response of extended families that so few orphans are living on their own. However, those child-headed households that do exist can be expected to have greater needs and vulnerabilities than households headed by an adult. Children in these situations may be less able to earn sufficient money, protect themselves, deal with the legal system or make good food decisions.

EXTENDED FAMILIES UNDER PRESSURE

As stated in *Africa's Orphaned Generations* (2003), the extended family will continue to be the central social-welfare mechanism in most parts of sub-Saharan Africa. These networks will face increasing burdens as adults continue to die and the number of orphans and vulnera-

"It wasn't supposed to be like this. These children's parents were supposed to be taking care of me. Now they are dead and I am nursing their children."

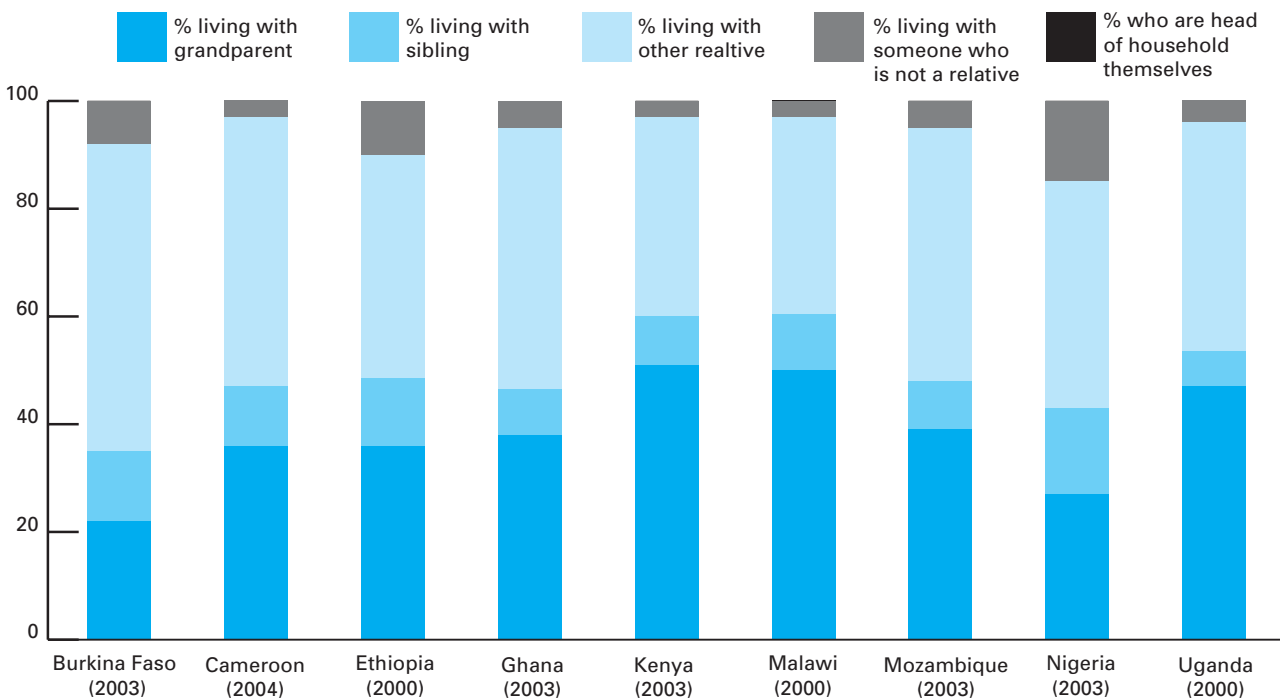
– Akeyo, 74 years old, looking after 10 grandchildren in Kenya

Source: HelpAge International and International HIV/AIDS Alliance, *Forgotten families: Older people as carers of orphans and vulnerable children*, HelpAge International/International AIDS Alliance, Brighton, 2003.

households and communities, or that caring for orphans is stretching them to a breaking point, suggests a single cataclysmic event. As discussed in this report, the true picture is much more complex, is associated with chronic poverty and adult HIV prevalence, and is extended over a longer term.

ble children increases. To say that orphanhood due to AIDS has overwhelmed the capacity of families,

FIGURE 3.3: Percentage of double orphans and single orphans (not living with surviving parent), ages 0–14, by relation to head of household



Source: Demographic and Health Surveys (DHS), 2000–2004.

4 THE IMPACT OF THE CRISIS ON CHILDREN

The illness and death of a parent from any cause is a crisis for each child left behind. These children may experience anxiety and depression, lose out on their education, and, as they grow, may be at greater risk of HIV and other infections, as well as exploitation and abuse.

AIDS illness and death in a family are traumatic, and are particularly difficult for children. But the full impact of a parent's death is largely determined by each child's circumstances – the wealth of their household and community, the child's relationship to caregivers, their age during their parent's illness and death, and an array of other factors.

AIDS AFFECTS CHILDREN LONG BEFORE PARENTS DIE

The vulnerability of children orphaned by AIDS begins well before the death of their parent (or parents). The effects often commence with the onset of a parent's illness and may include impoverishment; the emotional suffering, neglect and increased burden of responsibility associated with a parent's illness; and the stigma and discrimination associated with HIV that can isolate and demean a child. Specific health and education repercussions experienced by children with chronically ill parents are described below. Combined, these effects may limit a child's opportunities, immediately and over the long term.

THE LOSS OF PARENTS AND THE IMPACT OF ALTERNATIVE CARE

When a mother, father or both parents die, their children are denied the love, nurturing and protection of their biological parents that play such a critical role in early life and development.

Orphaned children must often move to a new home, sometimes making multiple moves. The extended family, in which aunts and uncles are frequently viewed as parental care-

givers, provides important benefits and protection for these children in sub-Saharan Africa. However, as found in southern Africa, such moves can be traumatic in the short term. If orphans feel ill-treated in their new homes or there are changes in the caretaker's circumstances, these arrangements can fail and the child may be forced to move again.¹

Within a household, the relationship between the new caregiver and the child strongly influences the outcomes for the child. Several studies have shown that the closer children remain to their biological family, the more likely they are to be well cared for. In Uganda, for example,

it was found that as the biological relatedness of the caregiver became more distant, the prospects for the child's survival were reduced.² Anthropological research from Cameroon suggests that fostering arrangements are likely to be more stable and satisfactory if the parent and foster caregiver had a close personal relationship prior to the onset of fostering.³ These findings underscore the importance of succession planning and of parents selecting and preparing future caregivers.

THE IMPORTANCE OF A FAMILY ENVIRONMENT

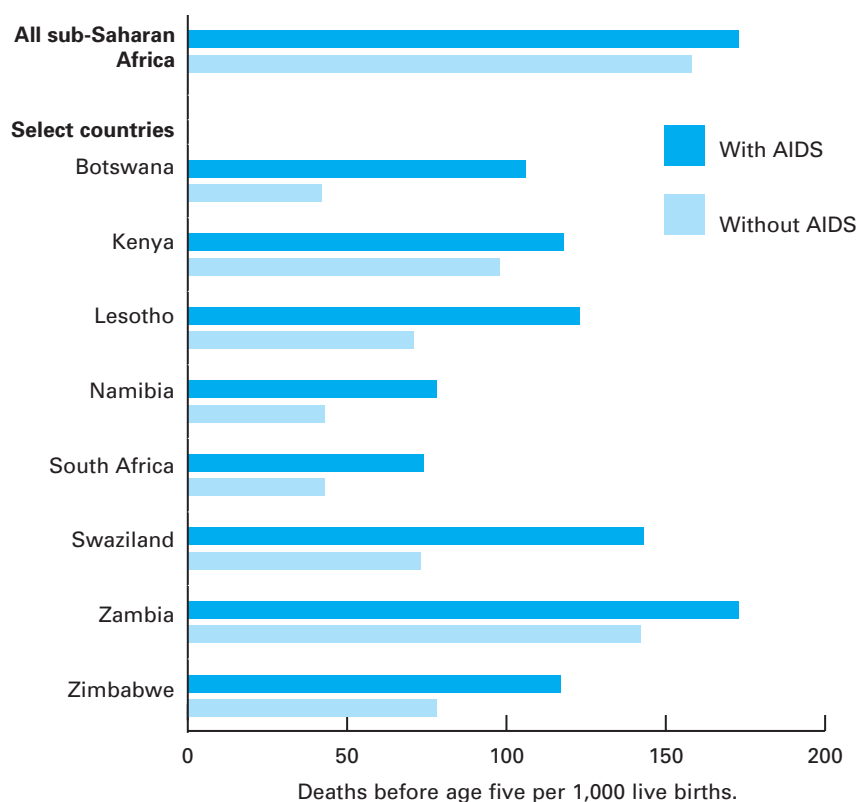
Studies in sub-Saharan Africa have repeatedly observed the importance

for children of growing up in a family environment and reaffirm that institutional care for children should only be considered as a temporary option or a measure of last resort (see panel 4.1).⁴

SURVIVAL, HEALTH AND NUTRITION

The survival of young children (ages 0–3) is at stake when their mothers are dying or have recently died. Children of this age group are 3.9 times more likely to die during the two years surrounding a mother's death.⁵ This is true whether the mother dies of AIDS or other causes. But when she is HIV-positive, her young children have a markedly higher risk of dying because they are in jeopardy of having been infected with HIV in utero, during childbirth or through breastfeeding.⁶

FIGURE 4.1: Under-five mortality rate estimates with and without AIDS, 2000–2005, select African countries



Source: World Population Prospects 2004, UN Population Division.

AIDS has become so prevalent in parts of sub-Saharan Africa that trends in under-five mortality are changing. Research in the region between 1990 and 1999 found that under-five mortality attributed to AIDS increased from 2 per cent in 1990 to 7.7 per cent in 1999; this includes only the direct impact of HIV on child survival, not the indirect effects. Because of this, the authors of this research state that their estimates "almost surely underestimate the total effects of HIV/AIDS on under-five mortality."⁷ Individual sub-Saharan countries have experienced much greater losses due to AIDS. Figure 4.1 depicts under-five mortality with AIDS compared to an estimate of under-five mortality in the absence of AIDS. In countries with the highest HIV prevalence, AIDS has made a dramatic

PANEL 4.1: RESIDENTIAL FACILITIES FOR ORPHAN CARE

There is much that remains unknown about the number of children in residential care in sub-Saharan Africa because estimates are available for only a limited number of countries. There are, however, 7,500 children in residential facilities in Liberia and 5,000 in Zambia, according to government estimates.ⁱ Although few countries maintain data on private institutions, reports indicate that the number of privately funded residential facilities has grown rapidly in recent years. A study in Zimbabwe found that between 1994 and 2004, 24 new institutions were built and the number of children in residential care doubled.ⁱⁱ Another study across six countries found that 35 per cent of the residential care facilities it identified had been established since 1999.ⁱⁱⁱ

There are many reasons residential facilities are not an appropriate primary response for orphans. Studies have documented some of these reasons, including:

- High staff turnover rates that make it difficult to sustain a caring environment.^{iv}
- High child-to-staff ratios that exacerbate the 'care deficit'.^v
- Difficulties in reintegration during early adulthood, due in part to community stigma.^{vi}
- Frequent failure to respond adequately to the psychological needs of children.^{vii}
- Higher costs compared to community-based care and greater challenges to scaling up.^{viii}
- Lack of government standards and monitoring of the care provided.^{ix}
- Worse outcomes physically and mentally for children living in residential care facilities, as documented through research in western countries.^x

If private donors continue to channel resources into residential facilities – as trends in sub-Saharan African suggest – then it will be more likely that families, communities and governments will turn to these facilities as a first resort for orphans and vulnerable children. To provide the best possible care for orphans and vulnerable children, much greater efforts by governments are needed to establish and promote community-based care options.

difference in under-five mortality rates. Research in Kenya found that the health status of orphans under five living in their communities was similar to that of non-orphans.⁸ In one study in Uganda, illness was reported more often for orphans than non-orphans; however, there was no discrimination by caregivers in seeking treatment for orphans compared to other children.⁹ It is important to note that research on the health of young orphans is limited by the small number of orphans under the

age of 6 (around 16 per cent of all orphans) and that continued monitoring is warranted. As the burden of orphans grows, caretakers may find it more difficult to provide for the health needs of all children in the household.

Some studies show that, as orphans grow older, they face higher risks than non-orphans of acquiring sexually transmitted diseases, including HIV. Two studies in Zimbabwe documented a higher rate of reproductive

health problems among girls who are orphans than among non-orphan girls. In one large population survey, 15- to 18-year-old girls who were orphaned and girls with infected parents were found to have higher rates of HIV infection, symptoms of other sexually transmitted infections and pregnancy than non-orphan girls (see Figure 4.2).¹⁰ In another study, researchers in urban Zimbabwe looked at orphaned and non-orphan girls ages 15–19 and found that orphans had a higher risk of HIV

infection and herpes, and maternal and double orphans had the highest infection rates.¹¹

Research on the nutritional status of orphans has produced conflicting results and is limited by the small number of young orphans in whom nutritional impacts are likely to be most pronounced. Research in Malawi¹² and analysis of national survey data on children ages 12–59 months in 40 countries¹³ found no differences in the nutritional status of orphans and non-orphans. In contrast, other studies showed that orphans in the United Republic of Tanzania were found to be short for their age,¹⁴ and in Kenya they were found to be underweight for their height.¹⁵

Household food security is an important indicator of longer-term nutritional prospects. The situation from this perspective is more troublesome. In rural Kenya, crop production dropped

by 68 per cent in households where the male head of household had died.¹⁶ In a study of households in the poor suburbs of Dar Es Salaam, United Republic of Tanzania, it was found that orphans were more likely to go to bed hungry than non-orphans.¹⁷ In Malawi, households with more than one orphan were much more likely to report food insecurity with moderate to severe hunger than households with no orphans. The data suggest that while households can manage to absorb one orphan without significant impact, they cannot continue to care for additional orphans without affecting their food security.¹⁸

Health care systems in Africa are often weak as a result of underfunding, lack of capacity and migration of medical professionals out of the region, among other reasons. In areas with high morbidity due to AIDS, health facilities can become overwhelmed with patients at the same time that health providers

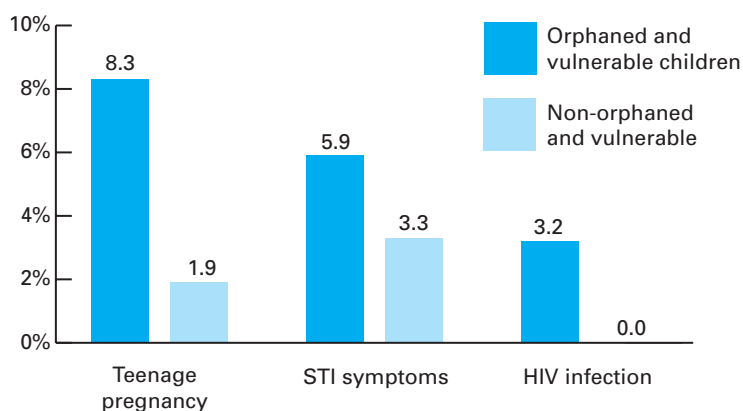
are getting sick and dying of AIDS. As a result, the health, nutritional and survival prospects of orphans and all children in these areas are diminished.

MISSED OPPORTUNITIES IN EDUCATION

Education for All is a crucial development goal and is increasingly recognized as a key strategy for HIV prevention.^{19, 20} One important concern is that orphans will acquire less education because they may have caregivers who cannot afford the costs of schooling, they may be needed for economic activities, or their caregivers may have less interest in their welfare.²¹ There are different types of missed opportunities in education, including lack of enrolment, interrupted schooling and poor performance while in school. Research on the education experience of orphans is complex, and findings are varied, based on a wide array of factors.

School enrolment rates for orphans compared to non-orphans differ significantly across countries. Where enrolment disparities between orphans and non-orphans exist, they are usually dwarfed by the differences in enrolment between children from wealthier households and those from poorer households. Where orphans are particularly underenrolled compared to other children, obstacles may not be financial. In many countries there is a significant gender gap, with girls enrolled less often than boys, but this gap does not appear to be more prominent among orphans.²² In terms of continuity of schooling and appropriate grade for age,

FIGURE 4.2: Percentage of women ages 15–18 with HIV infection, teenage pregnancy or STI symptoms, by status as orphaned or vulnerable, Manicaland, Zimbabwe, 2004



Source: Gregson, S., et al., 'HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe', *AIDS Care*, vol. 17, no. 7, pp. 785–794, October 2005.

Note: In this study, an orphaned or vulnerable child is a person below age 19 who is an orphan, or has a parent who is HIV-infected or seriously ill, or lives in a household that has experienced death in the past 12 months.

orphans are found to be at a disadvantage in some countries. An analysis of data from eastern Africa shows that double orphans ages 6–10 are half as likely to be at the correct educational level as non-orphaned children; double orphans ages 11–14 are two thirds as likely to be at lower levels.²³ Longitudinal evidence from South Africa shows that maternal orphans are at lower education levels than other children of the same age and also compared to other non-orphans with whom they live.²⁴

Missed opportunities for education may begin prior to the death of a parent and even before the onset of illness. A recent analysis of population survey data from Kenya found that children of HIV-positive parents are significantly less likely to attend school than children of HIV-negative parents.²⁵ Research in rural Tanzania documented that children with ill parents are more likely to have their schooling interrupted and to spend fewer hours in school prior to that death than other children.²⁶

After a parent's death, the hazards of missing school appear to be greatest for double orphans, as shown in Figure 4.3 (see also Table 4, page 38). The contrast between the attendance of double orphans and non-orphans (living with at least one parent) is most pronounced in countries where attendance is already low.²⁷ One study in Uganda found that while nearly 14 per cent of primary-school pupils with both parents alive stopped attending at some point, the proportion of double orphans missing a term

was far higher, at 27 per cent. The difference was even greater in secondary school, with 16 per cent of non-orphans and 43 per cent of double

One determining factor for orphans' schooling is the relationship between the child and the head of household. The closer the biological tie, the greater the chance the child will go to school.

orphans missing a term.²⁸

The same survey in Uganda found that some orphans said their school performance had deteriorated, partly because of the need to engage in income generation and partly because of anxiety. Survey data from Kenya, the United Republic of Tanzania and Zimbabwe show that even for non-orphaned children, the probability of attending the appropriate grade is very low. Only about half of primary-school-age children and a third of secondary-age schoolchildren are at the appropriate grade for their age. The odds are even lower for children who have lost one parent and are lowest of all for those who have lost both.²⁹

One determining factor for orphans' schooling is the relationship between the child and the head of household.

The closer the biological tie, the greater the chance the child will go to school consistently, regardless of poverty level. The closest relatives, including mothers and grandparents, appear to make substantial financial sacrifices and other commitments to ensure their children attend school. Research conducted across 10 countries in sub-Saharan Africa found that living with more distant relatives was the primary factor in lower orphan enrolment.³⁰

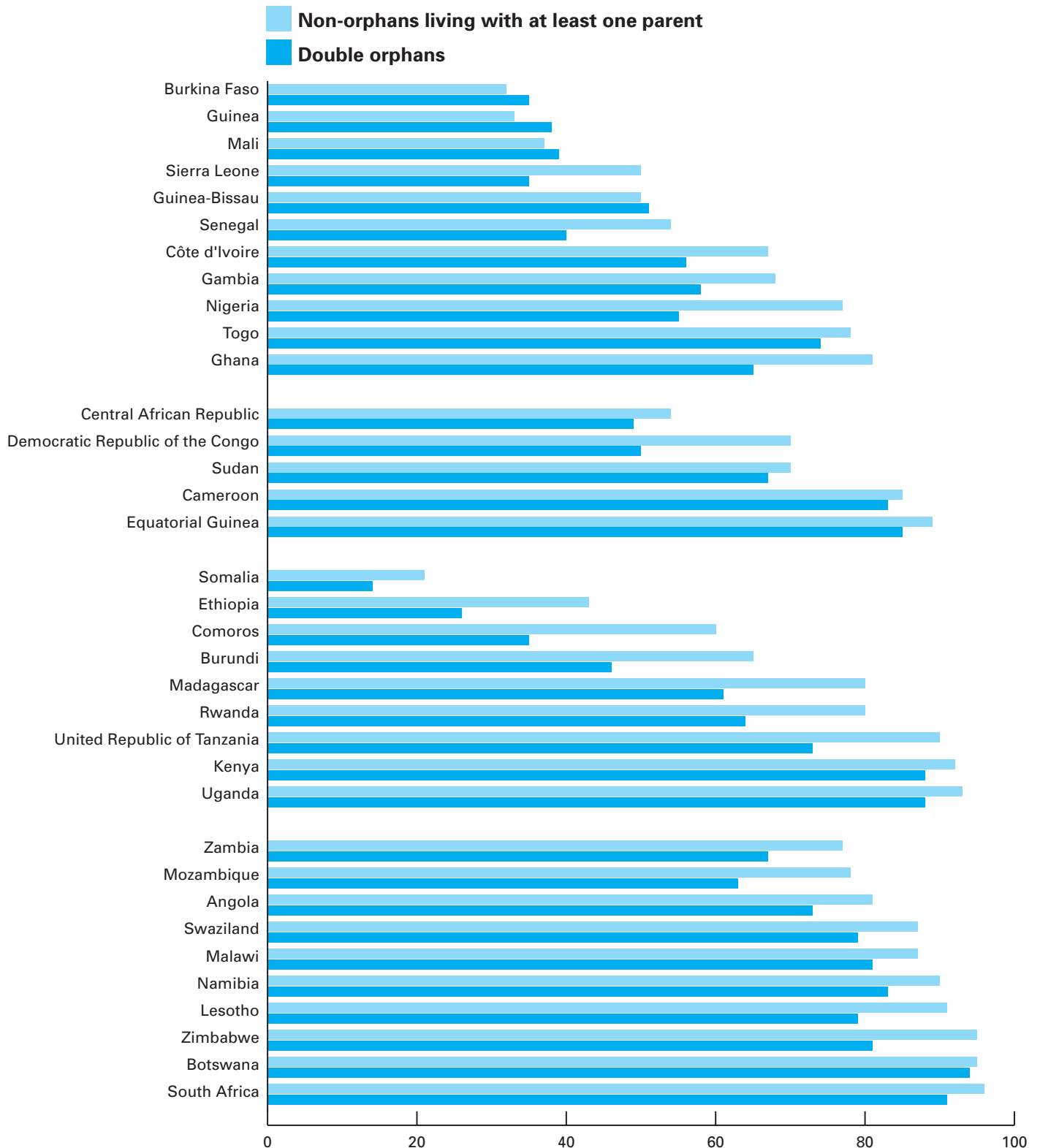
PSYCHOLOGICAL AND EMOTIONAL WELL-BEING

The psychological and emotional well-being of children orphaned and made more vulnerable by AIDS is threatened by a number of different pressures.

Children in households affected by AIDS are witnessing, or in some cases caring for, their parents or other caregivers dying of AIDS. This painful process is often compounded by the stigma and discrimination attached to HIV and to being an orphan. Children may be rejected by their friends and schoolmates or relatives. One teenager from South Africa described the effect: "Even my friend told me she won't eat with me again. One told me right to my face that I've got AIDS and should stop going to school and stay at home. I would feel terrible. Cry deep down. I would sit alone and cry alone. People would be staring at you saying nothing, even those who used to be happy when they see you were not anymore."³¹

The material, health and education

FIGURE 4.3: Percentage of children ages 10–14 who are in school, comparing non-orphans (children living with at least one parent) with double orphans



Source: Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS), 1998–2004.

impacts described in previous chapters also threaten the psychological and emotional well-being of a child. While material impacts are easier to measure, and thus have received predominant attention in the literature, there is some evidence concerning the psychological and emotional effects of parental AIDS illness and death on children.

A study of children orphaned by AIDS in rural Uganda documented higher levels of anxiety, depression and anger, along with inactivity, feelings of hopelessness and thoughts of suicide. In this study, 12 per cent of orphans affirmed a wish that they were dead, while only 3 per cent of non-orphans expressed such feelings³² (see Figure 4.4).

A study in the suburbs of Dar es Salaam also reported significant problems among 41 children ages 10–14 who had been orphaned by

AIDS. In this group, only eight were still living with the surviving parent. The children were asked a series of questions that correspond to ‘internalizing’ problems – reflecting anxiety, pessimism or a sense of failure, which are all symptoms of depression. The orphans had significantly more problems than non-orphans, with girls more likely to internalize problems than boys.³³

LOW RATES OF BIRTH REGISTRATION

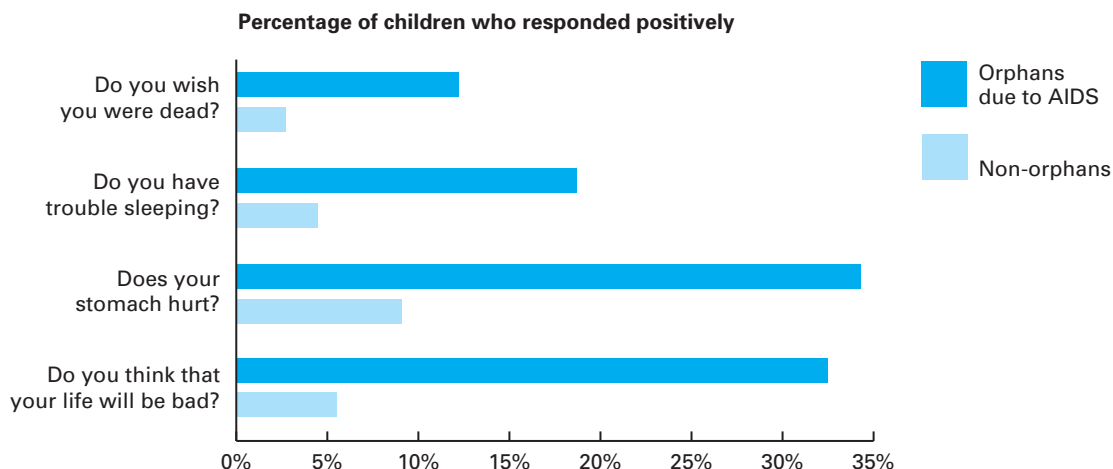
Birth registration is an essential service for all children, but many children are still unregistered.³⁴ It is especially critical for orphans, both as a means of identification and a requirement for obtaining access to public services and welfare. In sub-Saharan Africa, around two thirds of births go unregistered. As shown in Figure 4.5, a number of countries badly affected by AIDS have especially low levels of birth registration

(see Table 5, page 39 for rates in other countries).

ADDRESSING THE WHOLE CHILD

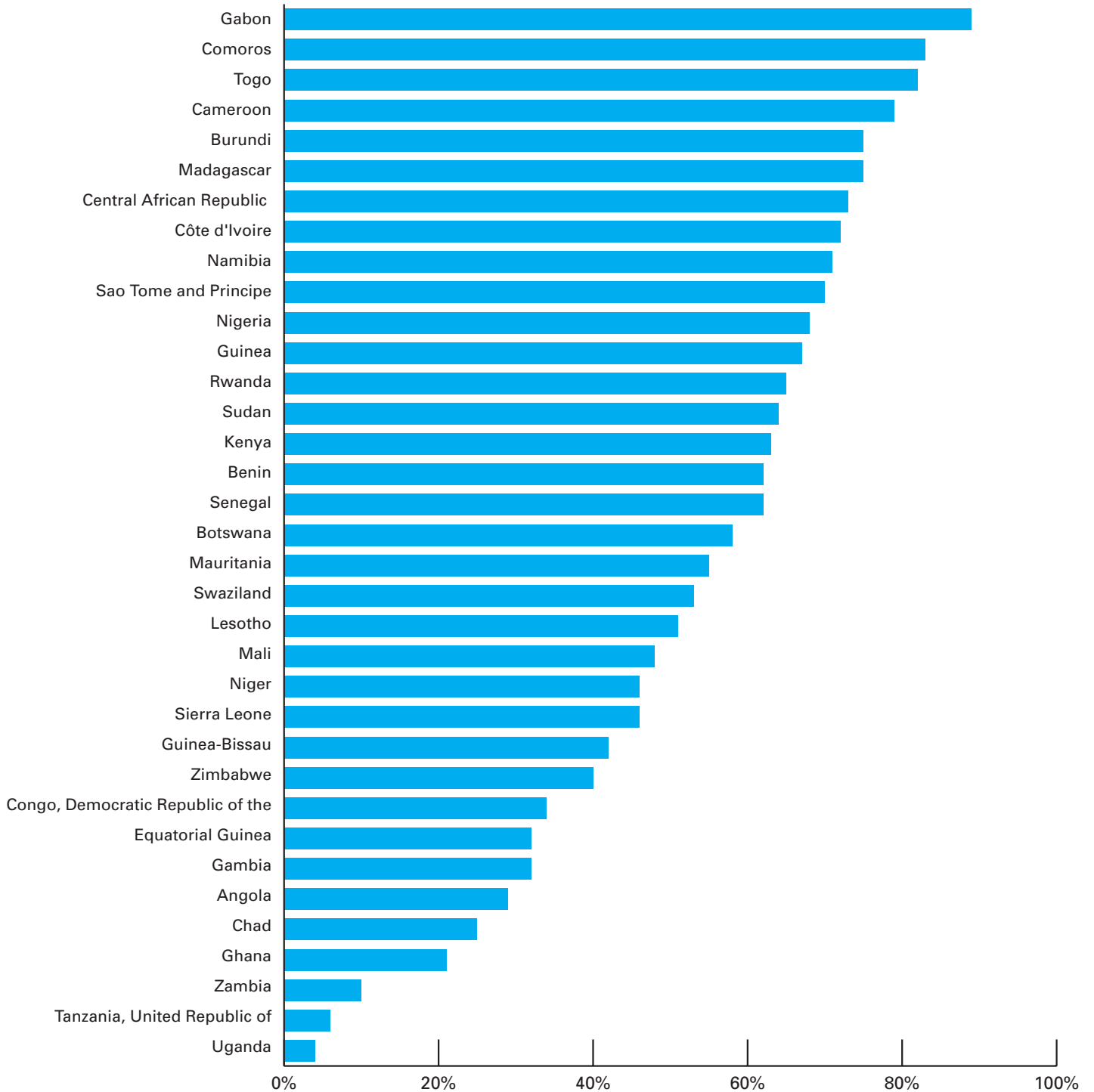
Responding to the needs of children orphaned and made more vulnerable by AIDS requires an understanding of the wide range of possible impacts and the variables that mitigate them. As described above, themes are emerging from the growing research and can help guide response efforts. Some of the challenges can be addressed by supporting caregivers, extended family and communities. Others, including equitable access to education, health, birth registration, foster care and inheritance legislation, also require government-level commitment and intervention. And efforts to increase awareness and reduce stigma and discrimination must be embraced by all. To be fully effective, responses must take into consideration the whole experience of the child and the caregiver at every stage of

FIGURE 4.4: Responses of orphans due to AIDS and non-orphans to questions about symptoms of depression, Bushenyi district, Uganda



Source: Atwine, Benjamin, Elizabeth Cantor-Graae and Frances Bajunirwe, 'Psychological distress among AIDS orphans in rural Uganda', *Social Science & Medicine*, vol. 61, 2005, pp. 555–564.

FIGURE 4.5: Percentage of children under age five whose birth was registered at the time of the survey (1999–2003)



Source: Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS), 1999–2003.

5 SUPPORTING AFRICA'S ORPHANED AND VULNERABLE CHILDREN

Immediate, scaled-up and sustained support to vulnerable households and communities is necessary to improve the lives of Africa's orphaned and vulnerable children. This entails reducing the stigma and discrimination associated with HIV, and ensuring that these children have equal access to basic services and are protected from human rights abuses. These efforts must be taken now and in tandem with accelerated prevention and treatment.

PRIORITIZING ORPHANS AND VULNERABLE CHILDREN

In recent years, there has been a surge in leadership and resources for the fight against AIDS. In 2005, approximately \$8.3 billion was available for responding to the epidemic in low- and middle-income countries.¹ This influx of funds has great potential for improving the lives of millions affected by the disease, but the impact of the epidemic *on children* has yet to receive the priority attention it deserves.² What's more, the multi-sectoral nature of response to the epidemic makes tracking difficult at the country level, so it is not known what percentage of funds globally dedicated to responding to the epidemic is applied towards improving the lives of children.

A number of factors have affected the response to orphans and vulnerable children: other challenges that compete for attention, a scarcity of public funds, and the stigma and silence that often surround AIDS. Furthermore, the situation of the millions of orphans and vulnerable children is not clearly visible because they are dispersed across many countries, where extended families and communities are shouldering the strain, largely without public assistance.

This is now changing. National governments in sub-Saharan Africa are putting plans into place to achieve internationally agreed-upon goals for orphans and vulnerable children. International agendas and funding plans for the fight against AIDS have started to reflect the needs

of children. A number of donor governments have recently committed substantial resources to the fight against AIDS, including money targeted at reducing the impact of the epidemic on children.

GLOBAL AND NATIONAL COMMITMENTS

In September 2000, a large gathering of world leaders adopted the United Nations Millennium Declaration, an ambitious agenda for reducing poverty and improving lives across the globe. At the 2005 World Summit, the commitment to the Millennium Declaration was reaffirmed. All eight of the Millennium Development Goals, including the Goal to halt and begin to reverse the spread of HIV/AIDS, have a significant impact on the lives of children.

The United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 boosted leadership, awareness and support in response to the HIV/AIDS crisis. This was reinforced at the Special Session on Children in 2002. Countries resolved to achieve key goals by 2005 and 2010, including the development and implementation of national policies and strategies that support children orphaned and made vulnerable by HIV/AIDS.³

More recently, this commitment has been strengthened with the pledge of leaders at the 2005 Group of Eight meeting in Gleneagles, Scotland, to work towards universal access for HIV prevention, treatment, care and support by 2010.⁴ The group's communiqué stated, "We will also work

with ... [partners in Africa] to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support." The UN resolution following this commitment specifically mentions providing "enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV/AIDS

Much work remains to be done to ensure that responses to orphans and vulnerable children are included in broader national development instruments and agendas.

and other health issues, in particular orphaned and vulnerable children and older persons."⁵

The global campaign *Unite for Children. Unite against AIDS*, launched in October 2005, is an unprecedented advocacy effort to ensure that children's needs are prominent in the fight against AIDS.

In June 2006, at the High-Level Meeting on AIDS held at the United Nations, countries agreed to make addressing the impact of HIV on children a priority. The meeting declaration noted the need to promote child-oriented HIV/AIDS policies and programmes, and increase protection for children orphaned and affected by

HIV/AIDS.⁶ The declaration also committed to supporting the social security systems that protect children affected by and living with HIV.

NATIONAL RESPONSES

In July 2003, after a review of progress towards UNGASS goals for HIV, the UN Secretary-General strongly urged all member states with generalized epidemics to "develop and implement national strategies that address the needs of the growing number of children orphaned and made vulnerable by the epidemic."⁷

During 2004, an index of efforts for the response to orphans and vulnerable children was applied through self-assessment to 36 countries in Africa. Although limited by the self-reporting nature of the index, the results clearly showed that most countries have some organized efforts and many countries have made strides in their response. The areas of greatest achievement were national planning, coordination and consultation of stakeholders, and government commitment. The weakest areas were found to be legislative review and policy development for the protection of orphans and vulnerable children (see *Table 5, page 39*).⁸

Sixteen of the most affected countries in eastern and southern Africa* undertook a process of rapid assessment, analysis and action planning for a national response. After completing a situation assessment, each government, in collaboration with international partners, developed a national plan of action with costs

* The Central African Republic, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zimbabwe and Zambia

attached. Strategies for monitoring and evaluating these plans are now being developed. Eleven of these countries have submitted proposals to finance activities for orphans and vulnerable children and/or their caregivers to the Global Fund on AIDS, Tuberculosis and Malaria.⁹

As these 16 countries resource and implement their plans, another 10 sub-Saharan countries* initiated the process in June 2005. This second phase incorporates lessons learned from the first 16 countries, including the need for greater participation by civil society and more emphasis on budget development and monitoring.¹⁰

Much work remains to be done to ensure that responses to orphans and vulnerable children are included in broader national development instruments and agendas. An assessment of poverty reduction strategy papers in Africa found little mention of orphans and vulnerable children although the numbers are significant in some countries. Furthermore, poverty reduction strategy papers in general were often not backed up with money and, even where identified, the areas of response related to orphans and vulnerable children were not allocated specific budgets or assessment indicators.¹¹

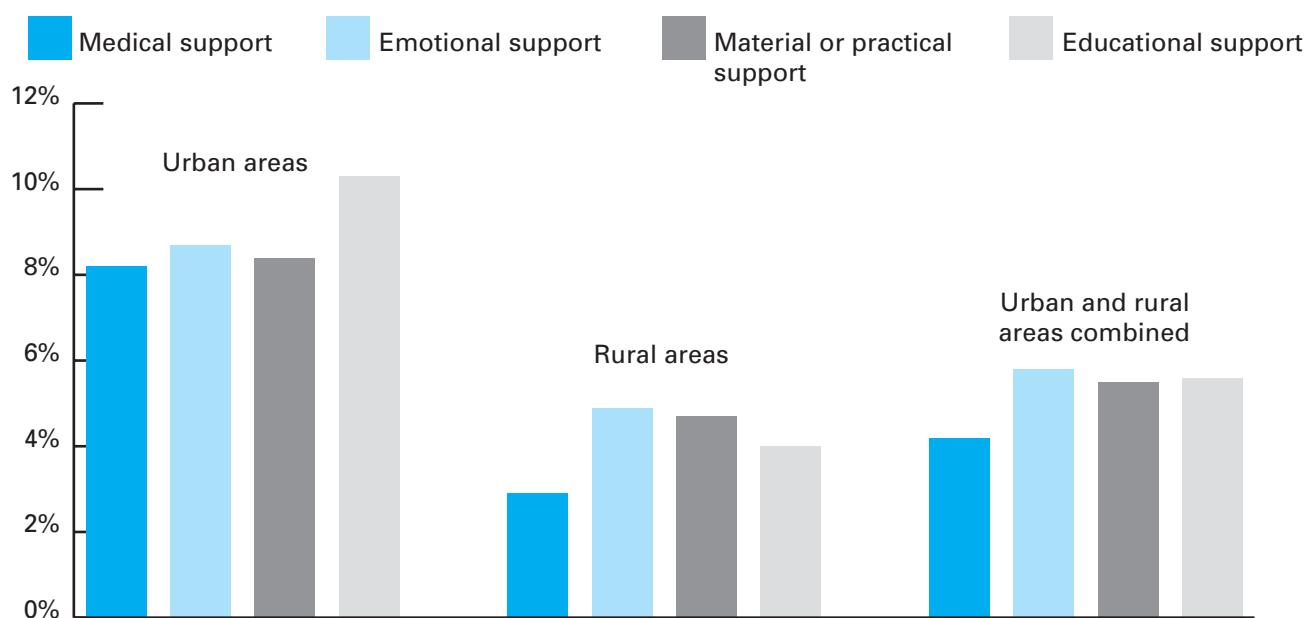
Including orphans and vulnerable children in these broad agendas will

help to ensure long-term, multi-sectoral government commitment. An effort to systematically mainstream HIV/AIDS responses into poverty reduction strategies and national HIV plans is currently being supported by UNAIDS, the United Nations Development Programme and the World Bank.¹²

TRANSFORMING PLANS INTO ACTION

Although steps have been taken to meet the needs of orphans and vulnerable children, coverage remains extremely limited, despite tremendous efforts by community and faith-based organizations. For example, a national survey in the United Republic of

FIGURE 5.1: Percentage of orphaned and vulnerable children whose households are receiving free external support, United Republic of Tanzania



Source: Tanzania HIV/AIDS Indicator Survey 2003–2004, Tanzania Commission for AIDS & National Bureau of Statistics, United Republic of Tanzania, and ORC Macro, Calverton, Maryland, USA, March 2005.

Note: In this study, orphaned and vulnerable children are those ages 0–17 years whose mother or father has died, or whose mother or father has been ill for at least 3 months of the past 12 months. Educational support is reported only for children ages 5–17.

* Angola, Burkina Faso, Burundi, Democratic Republic of the Congo, Djibouti, Eritrea, Ghana, Madagascar, Somalia and Sudan (southern)

Tanzania documented low levels of specific types of external support in both urban and rural areas (see Figure 5.1).

During 2004, inter-agency consensus was achieved on a global framework for responding to growing numbers of orphans and vulnerable children. Based on mounting research and years of programming experience, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* put forward five broad action areas. These action areas guide collective efforts to scale up comprehensive support for orphans and vulnerable children in sub-Saharan Africa. Most countries in sub-Saharan Africa, as well as a number of countries in other regions, are now developing national plans of action for these five areas:

1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other

support: This action is intended to prevent and mitigate the impact of AIDS on family structures and caring capacity. With more than 90 per cent of orphans cared for by their extended families, the welfare and resilience of the family is of central concern. Interventions to strengthen family capacity include prolonging the lives of HIV-infected parents and children, improving young children's health and nutrition, improving economic resilience, providing psychosocial support, building childcare capacity, supporting succession planning, and strengthening the life and survival skills of young family members.

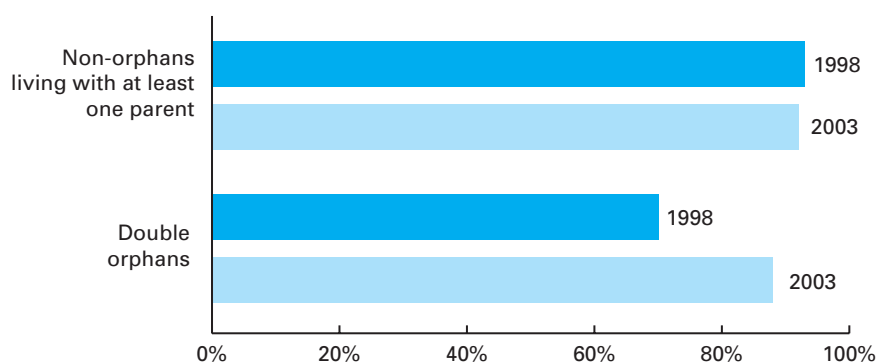
A wide array of family support activities is being undertaken by non-governmental organizations, community-based organizations, faith-based organizations and governments throughout sub-Saharan Africa, but coverage remains limited. Evaluation of programme effectiveness, along with evaluation and planning for scale-up, are urgently needed.

2. Mobilize and support community-based responses: When extended families cannot adequately provide for the basic needs of their children, the community becomes the source of essential support. In high-prevalence countries, such as Malawi, Rwanda, Swaziland and Tanzania, children and households are being supported through community-level interventions.^{13, 14} Community-based responses involve engaging local leaders and their communities in creating mechanisms to monitor vulnerable children and households; facilitating community dialogue on HIV to reduce stigma and discrimination; organizing cooperative family support activities (such as day care, youth clubs, relief labour for ill adults, food assistance and psychological support); and creating community care options for children without any family support.

3. Ensure access for orphans and vulnerable children to essential services, including education, health care and birth registration: The research described in this document indicates that access to essential services for orphans and vulnerable children varies significantly across countries, and even within countries. Local situation assessment is essential to determine coverage and equity.

As illustrated by the data on education, birth registration and other services, countries with very high HIV prevalence often have generally low access to services. In these settings, strategies that improve access for all children may benefit orphans and vulnerable children in particular. In coun-

FIGURE 5.2: Impact of universal primary education policy on school attendance, 10- to 14-year-olds, Kenya



Source: Kenya Demographic and Health Surveys (DHS), 1998 and 2003.

Note: Kenya implemented the Free Primary Education programme in January 2003.

tries where general access to services is high and orphans and vulnerable children are specifically discriminated against, more targeted strategies are warranted.

By eliminating school fees, such countries as Kenya and Uganda¹⁵ have increased school enrolment in general and decreased disparities

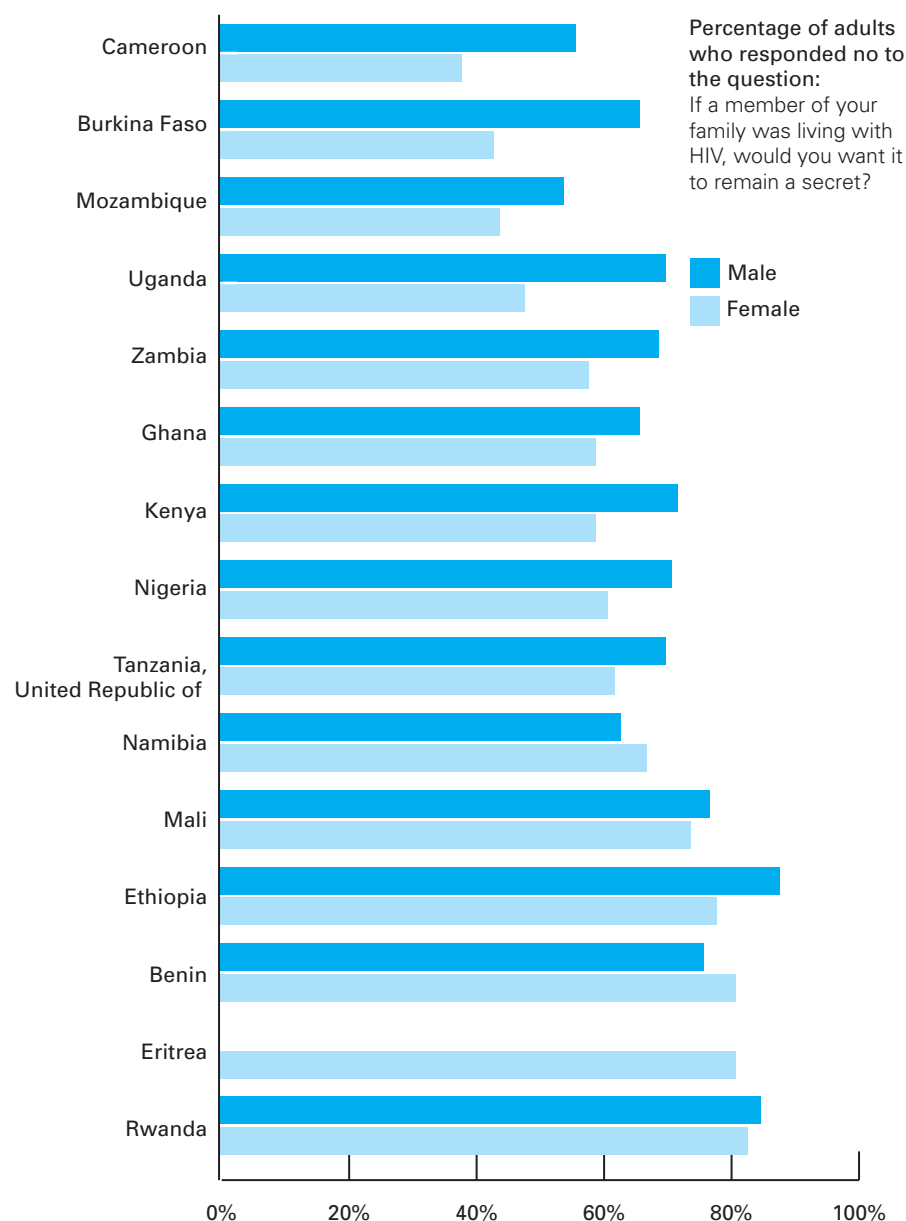
between orphans and non-orphans (see Figure 5.2 for data on Kenya). Factors leading to school fee elimination include political commitment, backed by increases in government and donor spending on education; improved training, professional development and support for teachers; and a strong education policy framework.¹⁶

All governments need to ensure that children have the legal documents that allow them to enrol in school and to receive available support from the government. Other financial and non-financial barriers to education are being addressed by assisting with fees for uniforms, books and other items; making education more relevant by incorporating life skills; allowing and encouraging local groups to start community schools; and providing school meals. School feeding programmes have been used effectively in southern Africa and can have the double benefit of enhancing children's nutritional status (if the children would otherwise skip meals), as well as attracting and keeping children in school.¹⁷

4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities: As described above, governments in sub-Saharan Africa are stepping up efforts to protect orphans and vulnerable children by developing national plans and increasing resource mobilization. The responsibilities of governments for vulnerable children cut across many sectors, and there is a need for much greater linkage, for example, between health and social welfare programmes.

A promising strategy currently gaining momentum in high-prevalence countries of east and southern Africa is to strengthen social protection measures through channels including education, public work and unconditional cash transfers for poor and vulnerable households. A recent review found

FIGURE 5.3: Willingness to disclose HIV status of family member



Source: Demographic and Health Surveys (DHS), 2000-2004.

that these initiatives show evidence of some success.¹⁸ Many of the programmes documented showed potential to reduce the vulnerability of households and increase access to services. These programmes must be further evaluated, assessed for cost-effectiveness, and integrated into a comprehensive social protection framework as part of national planning and scaling up.

5. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV and AIDS: Data recently collected through large population-based surveys in sub-Saharan Africa show male and female openness about AIDS at the family level. In nearly all countries with data, more than 50 per cent of both men and women responded that they would not want a family member's positive HIV status to remain secret (see *Figure 5.3*).

This level of openness creates opportunities for early identification of individuals and households in need of support. Disclosure and acceptance by families also has the potential to reduce negative attitudes and fears about close contact with people who are living with HIV. It is an important step in the creation of a more supportive environment.

Reducing stigma and discrimination at scale requires increased access to information, aggressively challenging harmful myths and a transformed public perception of HIV. Assessing the level of discrimination and false

perceptions in a community is useful for initiating this process.

CONCLUSION

The implications of the AIDS epidemic for generations of orphans and vulnerable children in sub-Saharan Africa are serious, but governments, international agencies, non-governmental organizations and community groups can alter the course of the response.

Some challenges can be addressed by providing support to caregivers, extended families and communities. Others, including equitable access to education and health, birth registration, foster care and inheritance legislation, also require commitment and intervention from governments.

To implement an appropriate response at the required scale, however, there must be sufficient knowledge to understand the situation of children affected by AIDS. Despite the more rigorous study of the conditions of orphans and vulnerable children in this region, and more systematic data collection, the knowledge base on the status of these children still needs to be expanded and strengthened. Our understanding is far from comprehensive and needs to be improved. This is particularly pressing, given that the AIDS epidemic is now well into its third decade.

We must step up efforts to achieve this, and, equally important, to measure the effectiveness of programmes supporting orphans, vulnerable children and their families. Improved research must be translated into better responses at scale, and more system-

atic monitoring systems should be set up to ensure that children's needs are indeed being met.

Accelerating evidence-based prevention measures for children and adults will reduce future numbers of orphans and vulnerable children. And increased access to antiretroviral therapy and treatment for HIV-related illness will help prolong the lives of parents living with HIV.

As described in this report, the situation of orphans and vulnerable children varies by context, and responses need to be based on situation assessments in order to reflect local realities and meet local needs. Links need to be made across sectors to ensure a comprehensive approach. In addition, research to date reveals a particular burden on female-headed and poorer households; this suggests that current assistance should prioritize vulnerable households, particularly those headed by women.

Since the publication of *Africa's Orphaned Generations* in 2003, HIV continues to spread against a backdrop of poverty in sub-Saharan Africa. The focus has shifted to cover vulnerable children, as well as orphans. Rapidly accelerated and adequately resourced action that is based on the growing body of evidence can help ensure that orphans and vulnerable children grow up safe, healthy, happy and well-educated, with the chance to achieve their true potential.

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CHAPTER 4

Panel 4.1

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CHAPTER 5

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STATISTICAL TABLES

TABLE 1
ESTIMATED NUMBER OF ORPHANS BY REGION, YEAR, TYPE AND CAUSE

| Region | Year | Population aged 0–17 | % of children who are orphans | Children orphaned during the year | Maternal orphans ^a | Paternal orphans ^a | Double orphans ^a | Total number of orphans ^a | Total number of orphans due to AIDS | Children orphaned by AIDS as % of all orphans |
|--|------|----------------------|-------------------------------|-----------------------------------|-------------------------------|-------------------------------|-----------------------------|--------------------------------------|-------------------------------------|---|
| Sub-Saharan Africa | | | | | | | | | | |
| | 1990 | 271,600,000 | 11 | 3,400,000 | 13,600,000 | 21,400,000 | 4,100,000 | 30,900,000 | 330,000 | 1 |
| | 1995 | 309,900,000 | 11 | 4,200,000 | 16,000,000 | 24,000,000 | 4,900,000 | 35,000,000 | 2,300,000 | 7 |
| | 2000 | 348,500,000 | 12 | 5,100,000 | 20,500,000 | 27,900,000 | 6,800,000 | 41,500,000 | 7,000,000 | 17 |
| | 2005 | 387,000,000 | 12 | 5,500,000 | 25,500,000 | 31,900,000 | 9,100,000 | 48,300,000 | 12,000,000 | 25 |
| | 2010 | 427,000,000 | 12 | 5,700,000 | 28,500,000 | 34,800,000 | 10,300,000 | 53,100,000 | 15,700,000 | 30 |
| Asia | | | | | | | | | | |
| | 1990 | 1,095,200,000 | 8 | 9,100,000 | 30,800,000 | 60,900,000 | 6,400,000 | 85,200,000 | – | – |
| | 1995 | 1,117,700,000 | 7 | 8,800,000 | 28,800,000 | 60,200,000 | 5,900,000 | 83,100,000 | – | – |
| | 2000 | 1,145,100,000 | 7 | 8,400,000 | 25,800,000 | 57,700,000 | 4,800,000 | 78,600,000 | – | – |
| | 2005 | 1,141,700,000 | 6 | 8,000,000 | 22,900,000 | 54,800,000 | 4,000,000 | 73,700,000 | – | – |
| | 2010 | 1,129,000,000 | 6 | 7,700,000 | 20,300,000 | 52,000,000 | 3,400,000 | 68,900,000 | – | – |
| Latin America and the Caribbean | | | | | | | | | | |
| | 1990 | 184,500,000 | 7 | 1,300,000 | 3,700,000 | 9,300,000 | 750,000 | 12,300,000 | – | – |
| | 1995 | 189,800,000 | 6 | 1,300,000 | 3,500,000 | 9,400,000 | 690,000 | 12,200,000 | – | – |
| | 2000 | 192,300,000 | 6 | 1,200,000 | 3,100,000 | 8,900,000 | 600,000 | 11,400,000 | – | – |
| | 2005 | 193,800,000 | 6 | 1,200,000 | 2,800,000 | 8,500,000 | 500,000 | 10,700,000 | – | – |
| | 2010 | 194,200,000 | 5 | 1,200,000 | 2,500,000 | 8,100,000 | 420,000 | 10,200,000 | – | – |
| Total | | | | | | | | | | |
| | 1990 | 1,551,200,000 | 8 | 13,800,000 | 48,000,000 | 91,600,000 | 11,300,000 | 128,400,000 | – | – |
| | 1995 | 1,617,400,000 | 8 | 14,300,000 | 48,200,000 | 93,600,000 | 11,500,000 | 130,300,000 | – | – |
| | 2000 | 1,686,000,000 | 8 | 14,800,000 | 49,400,000 | 94,500,000 | 12,300,000 | 131,600,000 | – | – |
| | 2005 | 1,722,400,000 | 8 | 14,700,000 | 51,200,000 | 95,200,000 | 13,700,000 | 132,700,000 | 15,200,000 | 11 |
| | 2010 | 1,750,200,000 | 8 | 14,600,000 | 51,300,000 | 95,000,000 | 14,100,000 | 132,200,000 | 20,200,000 | 15 |

Source: UNAIDS and UNICEF 2006.

^a Children are defined as maternal or paternal orphans regardless of the survival status of the other parent. Thus the estimates of maternal and paternal orphans include double orphans. The total number of orphans = maternal orphans + paternal orphans - double orphans.

TABLE 2

ESTIMATED NUMBER OF ORPHANS IN SUB-SAHARAN AFRICA BY COUNTRY, TYPE, AGE AND CAUSE

| | Total orphans, 2005 | | | | Orphans by type, 2005 | | | | Orphans by age group, 2005 | | | Projections for 2010 | |
|-----------------------------------|-------------------------|-------------------------------|-------------------------------|---|-------------------------------|-------------------------------|-----------------------------|---------------------------|--|---|--|---------------------------------|--------------------------------------|
| | Total number of orphans | % of children who are orphans | Number of orphans due to AIDS | Children orphaned by AIDS as % of all orphans | Maternal orphans ^a | Paternal orphans ^a | Double orphans ^a | Children orphaned in 2005 | % of children aged 0-5 who are orphans | % of children aged 6-11 who are orphans | % of children aged 12-17 who are orphans | Total number of orphans in 2010 | Orphans as % of all children in 2010 |
| West Africa | | | | | | | | | | | | | |
| Benin | 370,000 | 8 | 62,000 | 17 | 160,000 | 250,000 | 44,000 | 44,000 | 3 | 9 | 15 | 400,000 | 8 |
| Burkina Faso | 710,000 | 10 | 120,000 | 16 | 320,000 | 470,000 | 79,000 | 82,000 | 4 | 10 | 17 | 790,000 | 9 |
| Cape Verde | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Côte d'Ivoire | 1,400,000 | 15 | 450,000 | 33 | 790,000 | 940,000 | 350,000 | 150,000 | 6 | 16 | 24 | 1,500,000 | 15 |
| Gambia | 64,000 | 9 | 4,000 | 6 | 26,000 | 43,000 | 6,000 | 7,000 | 3 | 9 | 16 | 65,000 | 8 |
| Ghana | 1,000,000 | 9 | 170,000 | 17 | 490,000 | 640,000 | 110,000 | 110,000 | 3 | 10 | 16 | 1,000,000 | 9 |
| Guinea | 370,000 | 8 | 28,000 | 7 | 160,000 | 250,000 | 38,000 | 39,000 | 3 | 8 | 15 | 380,000 | 7 |
| Guinea-Bissau | 100,000 | 12 | 11,000 | 10 | 48,000 | 72,000 | 16,000 | 12,000 | 5 | 13 | 21 | 120,000 | 12 |
| Liberia | 250,000 | 14 | - | - | 130,000 | 170,000 | 60,000 | 27,000 | 6 | 15 | 28 | 280,000 | 14 |
| Mali | 710,000 | 10 | 94,000 | 13 | 320,000 | 470,000 | 85,000 | 78,000 | 4 | 11 | 19 | 770,000 | 10 |
| Mauritania | 170,000 | 11 | 7,000 | 4 | 75,000 | 120,000 | 17,000 | 19,000 | 4 | 12 | 20 | 190,000 | 10 |
| Niger | 800,000 | 11 | 46,000 | 6 | 370,000 | 520,000 | 87,000 | 92,000 | 4 | 12 | 21 | 890,000 | 10 |
| Nigeria | 8,600,000 | 13 | 930,000 | 11 | 4,400,000 | 5,800,000 | 1,500,000 | 1,000,000 | 5 | 14 | 21 | 9,600,000 | 13 |
| Senegal | 560,000 | 9 | 25,000 | 4 | 250,000 | 370,000 | 67,000 | 61,000 | 4 | 10 | 17 | 570,000 | 9 |
| Sierra Leone | 340,000 | 13 | 31,000 | 9 | 150,000 | 240,000 | 52,000 | 38,000 | 5 | 14 | 23 | 370,000 | 12 |
| Togo | 280,000 | 9 | 88,000 | 31 | 130,000 | 190,000 | 38,000 | 36,000 | 3 | 10 | 16 | 320,000 | 9 |
| Central Africa | | | | | | | | | | | | | |
| Cameroon | 1,000,000 | 13 | 240,000 | 24 | 540,000 | 660,000 | 180,000 | 120,000 | 6 | 14 | 21 | 1,100,000 | 14 |
| Central African Republic | 330,000 | 16 | 140,000 | 41 | 180,000 | 220,000 | 76,000 | 38,000 | 7 | 18 | 26 | 360,000 | 17 |
| Chad | 600,000 | 12 | 57,000 | 10 | 280,000 | 410,000 | 84,000 | 76,000 | 5 | 13 | 21 | 730,000 | 12 |
| Congo | 270,000 | 12 | 110,000 | 39 | 140,000 | 180,000 | 48,000 | 30,000 | 5 | 14 | 22 | 300,000 | 12 |
| Congo, Democratic Republic of the | 4,200,000 | 14 | 680,000 | 16 | 2,100,000 | 2,800,000 | 800,000 | 450,000 | 6 | 16 | 24 | 4,600,000 | 13 |
| Equatorial Guinea | 29,000 | 12 | 5,000 | 16 | 14,000 | 20,000 | 5,000 | 3,000 | 5 | 13 | 21 | 32,000 | 11 |
| Gabon | 65,000 | 11 | 20,000 | 31 | 32,000 | 41,000 | 8,000 | 9,000 | 4 | 11 | 17 | 75,000 | 12 |
| Sao Tome and Principe | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Sudan | 1,700,000 | 9 | 140,000 | 8 | 740,000 | 1,100,000 | 180,000 | 180,000 | 3 | 9 | 15 | 1,800,000 | 8 |
| East Africa | | | | | | | | | | | | | |
| Burundi | 600,000 | 13 | 120,000 | 21 | 310,000 | 400,000 | 110,000 | 61,000 | 5 | 15 | 24 | 650,000 | 12 |
| Comoros | 33,000 | 8 | - | - | 14,000 | 22,000 | 3,000 | 3,000 | 2 | 8 | 15 | 31,000 | 7 |
| Djibouti | 48,000 | 11 | 6,000 | 12 | 22,000 | 32,000 | 6,000 | 5,000 | 4 | 12 | 18 | 51,000 | 11 |
| Eritrea | 280,000 | 11 | 36,000 | 13 | 120,000 | 190,000 | 34,000 | 29,000 | 4 | 12 | 23 | 290,000 | 10 |
| Ethiopia | 4,800,000 | 11 | - | - | 2,300,000 | 3,200,000 | 660,000 | 510,000 | 4 | 12 | 20 | 5,100,000 | 11 |
| Kenya | 2,300,000 | 13 | 1,100,000 | 46 | 1,400,000 | 1,300,000 | 410,000 | 270,000 | 5 | 15 | 21 | 2,500,000 | 13 |
| Madagascar | 900,000 | 9 | 13,000 | 1 | 370,000 | 590,000 | 65,000 | 95,000 | 4 | 10 | 17 | 940,000 | 9 |
| Rwanda | 820,000 | 16 | 210,000 | 26 | 490,000 | 620,000 | 290,000 | 72,000 | 6 | 17 | 33 | 810,000 | 14 |
| Somalia | 630,000 | 13 | 23,000 | 4 | 310,000 | 440,000 | 110,000 | 66,000 | 5 | 15 | 27 | 680,000 | 12 |
| Tanzania, United Republic of | 2,400,000 | 12 | 1,100,000 | 44 | 1,300,000 | 1,500,000 | 410,000 | 270,000 | 5 | 14 | 21 | 2,500,000 | 12 |
| Uganda | 2,300,000 | 14 | 1,000,000 | 45 | 1,300,000 | 1,500,000 | 540,000 | 230,000 | 5 | 16 | 25 | 2,500,000 | 13 |
| Southern Africa | | | | | | | | | | | | | |
| Angola | 1,200,000 | 14 | 160,000 | 13 | 590,000 | 820,000 | 230,000 | 130,000 | 6 | 16 | 24 | 1,300,000 | 14 |
| Botswana | 150,000 | 19 | 120,000 | 76 | 110,000 | 100,000 | 56,000 | 17,000 | 8 | 22 | 27 | 170,000 | 20 |
| Lesotho | 150,000 | 17 | 97,000 | 64 | 100,000 | 95,000 | 47,000 | 20,000 | 8 | 20 | 25 | 170,000 | 20 |
| Malawi | 950,000 | 15 | 550,000 | 57 | 540,000 | 650,000 | 240,000 | 120,000 | 6 | 17 | 24 | 1,100,000 | 15 |
| Mauritius | 23,000 | 6 | - | - | 5,000 | 19,000 | 900 | 3,000 | 2 | 6 | 11 | 23,000 | 6 |
| Mozambique | 1,500,000 | 15 | 510,000 | 34 | 860,000 | 980,000 | 310,000 | 210,000 | 7 | 16 | 24 | 1,900,000 | 17 |
| Namibia | 140,000 | 14 | 85,000 | 62 | 86,000 | 83,000 | 31,000 | 20,000 | 6 | 15 | 19 | 170,000 | 16 |
| South Africa | 2,500,000 | 13 | 1,200,000 | 49 | 1,300,000 | 1,600,000 | 450,000 | 370,000 | 6 | 14 | 19 | 3,200,000 | 17 |
| Swaziland | 95,000 | 17 | 63,000 | 66 | 67,000 | 56,000 | 28,000 | 15,000 | 9 | 20 | 24 | 120,000 | 22 |
| Zambia | 1,200,000 | 20 | 710,000 | 57 | 860,000 | 800,000 | 420,000 | 130,000 | 9 | 23 | 30 | 1,300,000 | 20 |
| Zimbabwe | 1,400,000 | 21 | 1,100,000 | 77 | 1,100,000 | 920,000 | 700,000 | 130,000 | 9 | 24 | 30 | 1,300,000 | 20 |
| Sub-Saharan Africa | 48,300,000 | 12 | 12,000,000 | 25 | 25,500,000 | 31,900,000 | 9,100,000 | 5,500,000 | 5 | 14 | 21 | 53,100,000 | 12 |

Source: UNAIDS and UNICEF 2006.

Note: Numbers may not add up due to rounding.

^a Children are defined as maternal or paternal orphans regardless of the survival status of the other parent. Thus the estimates of maternal and paternal orphans include double orphans. The total number of orphans = maternal orphans + paternal orphans - double orphans.

TABLE 3
AIDS AND OTHER RELEVANT INDICATORS, SUB-SAHARAN AFRICA

| | Population and demographics | | | Economy | Health | Estimated number of people living with HIV/AIDS, year-end 2005 | | | Demographic impact | | |
|-----------------------------------|-----------------------------|------------------------------|---------------------------------|---------|--------|--|-----------------------------|---|--------------------|-----------------------|--|
| | Total population 2005 | Number of children 0–14 2005 | % of population 0–14 years 2005 | | | GNI per capita (US\$) 2004 | Under-5 mortality rate 2004 | Adult prevalence rate (%) (15–49 years) | Adults (15+ years) | Children (0–14 years) | Life expectancy at birth (years) 2000–2005 |
| West Africa | | | | | | | | | | | |
| Benin | 8,400,000 | 3,700,000 | 44 | 450 | 152 | 1.8 | 77,000 | 9,800 | 54 | 3 | 9,600 |
| Burkina Faso | 13,200,000 | 6,200,000 | 47 | 350 | 192 | 2.0 | 140,000 | 17,000 | 48 | 8 | 12,000 |
| Cape Verde | 510,000 | 200,000 | 40 | 1,720 | 36 | - | - | - | 71 | - | - |
| Côte d'Ivoire | 18,200,000 | 7,600,000 | 42 | 760 | 194 | 7.1 | 680,000 | 74,000 | 46 | 8 | 65,000 |
| Gambia | 1,500,000 | 610,000 | 40 | 280 | 122 | 2.4 | 19,000 | 1,200 | 56 | 1 | 1,300 |
| Ghana | 22,100,000 | 8,600,000 | 39 | 380 | 112 | 2.3 | 300,000 | 25,000 | 57 | 4 | 29,000 |
| Guinea | 9,400,000 | 4,100,000 | 44 | 410 | 155 | 1.5 | 78,000 | 7,000 | 54 | 3 | 7,100 |
| Guinea-Bissau | 1,600,000 | 750,000 | 48 | 160 | 203 | 3.8 | 29,000 | 3,200 | 45 | 3 | 2,700 |
| Liberia | 3,300,000 | 1,500,000 | 47 | 120 | 235 | - | - | - | 42 | 5 | - |
| Mali | 13,500,000 | 6,500,000 | 48 | 330 | 219 | 1.7 | 110,000 | 16,000 | 48 | 2 | 11,000 |
| Mauritania | 3,100,000 | 1,300,000 | 43 | 530 | 125 | 0.7 | 11,000 | 1,100 | 53 | - | 1,000 |
| Niger | 14,000,000 | 6,800,000 | 49 | 210 | 259 | 1.1 | 71,000 | 8,900 | 45 | 0 | 7,600 |
| Nigeria | 131,500,000 | 58,200,000 | 44 | 430 | 197 | 3.9 | 2,600,000 | 240,000 | 43 | 6 | 220,000 |
| Senegal | 11,700,000 | 5,000,000 | 43 | 630 | 137 | 0.9 | 56,000 | 5,000 | 56 | - | 5,200 |
| Sierra Leone | 5,500,000 | 2,400,000 | 43 | 210 | 283 | 1.6 | 43,000 | 5,200 | 41 | 2 | 4,600 |
| Togo | 6,100,000 | 2,700,000 | 43 | 310 | 140 | 3.2 | 100,000 | 9,700 | 55 | 6 | 9,100 |
| Central Africa | | | | | | | | | | | |
| Cameroon | 16,300,000 | 6,700,000 | 41 | 810 | 149 | 5.4 | 470,000 | 43,000 | 46 | 8 | 46,000 |
| Central African Republic | 4,000,000 | 1,700,000 | 43 | 310 | 193 | 10.7 | 230,000 | 24,000 | 39 | 14 | 24,000 |
| Chad | 9,700,000 | 4,600,000 | 47 | 250 | 200 | 3.5 | 160,000 | 16,000 | 44 | 5 | 11,000 |
| Congo | 4,000,000 | 1,900,000 | 47 | 760 | 108 | 5.3 | 100,000 | 15,000 | 52 | 8 | 11,000 |
| Congo, Democratic Republic of the | 57,500,000 | 27,200,000 | 47 | 110 | 205 | 3.2 | 890,000 | 120,000 | 44 | 4 | 90,000 |
| Equatorial Guinea | 500,000 | 220,000 | 44 | - | 204 | 3.2 | 8,000 | 1,000 | 43 | 9 | 1,000 |
| Gabon | 1,400,000 | 550,000 | 40 | 4,080 | 91 | 7.9 | 56,000 | 3,900 | 54 | 9 | 4,700 |
| Sao Tome and Principe | 160,000 | 62,000 | 39 | 390 | 118 | - | - | - | 63 | - | - |
| Sudan | 36,200,000 | 14,200,000 | 39 | 530 | 91 | 1.6 | 320,000 | 30,000 | 57 | 2 | 34,000 |
| East Africa | | | | | | | | | | | |
| Burundi | 7,500,000 | 3,400,000 | 45 | 90 | 190 | 3.3 | 130,000 | 20,000 | 44 | 7 | 13,000 |
| Comoros | 800,000 | 330,000 | 42 | 560 | 70 | <0.1 | <500 | <100 | 64 | - | <100 |
| Djibouti | 790,000 | 330,000 | 41 | 950 | 126 | 3.1 | 14,000 | 1,200 | 53 | 3 | 1,200 |
| Eritrea | 4,400,000 | 2,000,000 | 45 | 190 | 82 | 2.4 | 53,000 | 6,600 | 54 | 4 | 5,600 |
| Ethiopia | 77,400,000 | 34,500,000 | 45 | 110 | 166 | - | - | - | 48 | 4 | - |
| Kenya | 34,300,000 | 14,700,000 | 43 | 480 | 120 | 6.1 | 1,200,000 | 150,000 | 48 | 13 | 140,000 |
| Madagascar | 18,600,000 | 8,200,000 | 44 | 290 | 123 | 0.5 | 47,000 | 1,600 | 56 | 1 | 2,900 |
| Rwanda | 9,000,000 | 3,900,000 | 43 | 210 | 203 | 3.1 | 160,000 | 27,000 | 44 | 5 | 21,000 |
| Somalia | 8,200,000 | 3,600,000 | 44 | - | 225 | 0.9 | 40,000 | 4,500 | 47 | - | 4,100 |
| Tanzania, United Republic of | 38,300,000 | 16,300,000 | 43 | 320 | 126 | 6.5 | 1,300,000 | 110,000 | 46 | 12 | 140,000 |
| Uganda | 28,800,000 | 14,500,000 | 50 | 250 | 138 | 6.7 | 900,000 | 110,000 | 48 | 9 | 91,000 |
| Southern Africa | | | | | | | | | | | |
| Angola | 15,900,000 | 7,400,000 | 46 | 1,030 | 260 | 3.7 | 280,000 | 35,000 | 41 | 3 | 30,000 |
| Botswana | 1,800,000 | 660,000 | 38 | 4,340 | 116 | 24.1 | 260,000 | 14,000 | 35 | 34 | 18,000 |
| Lesotho | 1,800,000 | 690,000 | 39 | 740 | 82 | 23.2 | 250,000 | 18,000 | 35 | 29 | 23,000 |
| Malawi | 12,900,000 | 6,100,000 | 47 | 170 | 175 | 14.1 | 850,000 | 91,000 | 40 | 17 | 78,000 |
| Mauritius | 1,200,000 | 310,000 | 25 | 4,640 | 15 | 0.6 | 4,100 | - | 72 | - | <100 |
| Mozambique | 19,800,000 | 8,700,000 | 44 | 250 | 152 | 16.1 | 1,600,000 | 140,000 | 42 | 11 | 140,000 |
| Namibia | 2,000,000 | 840,000 | 42 | 2,370 | 63 | 19.6 | 210,000 | 17,000 | 47 | 21 | 17,000 |
| South Africa | 47,400,000 | 15,500,000 | 33 | 3,630 | 67 | 18.8 | 5,300,000 | 240,000 | 47 | 20 | 320,000 |
| Swaziland | 1,000,000 | 420,000 | 41 | 1,660 | 156 | 33.4 | 210,000 | 15,000 | 31 | 33 | 16,000 |
| Zambia | 11,700,000 | 5,300,000 | 46 | 450 | 182 | 17.0 | 1,000,000 | 130,000 | 38 | 16 | 98,000 |
| Zimbabwe | 13,000,000 | 5,200,000 | 40 | 480 | 129 | 20.1 | 1,500,000 | 160,000 | 37 | 27 | 180,000 |

Source: Population and demographics: UN Population Division, World Population Prospects 2004; Economy: World Bank, World Development Indicators 2005; Health: UNICEF, *State of the World's Children 2006*; HIV: UNAIDS, *2006 Report on the global AIDS epidemic*; Demographic impact: UN Population Division, *World Population Prospects 2004*.

Note: Percentages are calculated based on numbers that have not yet been rounded.

TABLE 4
SITUATION OF CHILDREN, SUB-SAHARAN AFRICA

| Regions/Countries | School attendance (10–14 years old) | | | Female-headed households | | | Residence patterns for non-orphans and orphans | | | |
|--------------------------------------|---|--|--|--|---|---|---|--|--|--|
| | % non-orphans living with at least one par- ent) attending school | % double orphans attending school | Double Orphan/ non- orphan school attendance ratio | % all house- holds with children that are female- headed | % households with orphans that are female- headed | % households with children that are female-headed taking care of orphan(s) | % non- orphans living with mother | % paternal orphans living with mother | % non- orphans living with father | % maternal orphans living with father |
| West Africa | | | | | | | | | | |
| Benin | - | - | - | 39 | 19 | 29 | 82 | 65 | 76 | 57 |
| Burkina Faso | 32 | 35 | 1.09 | 21 | 8 | 35 | 90 | 61 | 88 | 52 |
| Cape Verde | - | - | - | - | - | - | - | - | - | - |
| Côte d'Ivoire | 67 | 56 | 0.83 | 34 | 18 | 31 | 84 | 68 | 71 | 56 |
| Gambia | 68 | 58 | 0.85 | 26 | 17 | 27 | 91 | 56 | 83 | 46 |
| Ghana | 81 | 65 | 0.79* | 53 | 35 | 17 | 82 | 69 | 62 | 46 |
| Guinea | 33 | 38 | 1.13 | 22 | 13 | 30 | 84 | 67 | 78 | 67 |
| Guinea-Bissau | 50 | 51 | 1.03 | 31 | 14 | 34 | 87 | 69 | 80 | 53 |
| Liberia | - | - | - | - | - | - | - | - | - | - |
| Mali | 37 | 39 | 1.04 | 27 | 10 | 26 | 91 | 74 | 88 | 71 |
| Mauritania | - | - | - | 44 | 30 | 20 | 86 | 81 | 64 | 50 |
| Niger | - | - | - | 22 | 7 | 26 | 91 | 60 | 89 | 61 |
| Nigeria | 77 | 55 | 0.64* | 41 | 14 | 32 | 90 | 69 | 83 | 65 |
| Senegal | 54 | 40 | 0.74* | 28 | 17 | 25 | 90 | 76 | 74 | 55 |
| Sierra Leone | 50 | 35 | 0.71 | 29 | 16 | 41 | 82 | 67 | 78 | 56 |
| Togo | 78 | 74 | 0.96 | 42 | 22 | 30 | 86 | 74 | 78 | 61 |
| Central Africa | | | | | | | | | | |
| Cameroon | 85 | 83 | 0.99 | 46 | 23 | 31 | 81 | 72 | 73 | 51 |
| Central African Republic | 54 | 49 | 0.91 | 32 | 14 | 47 | 88 | 69 | 82 | 50 |
| Chad | 61 | 59 | 0.96* | 38 | 18 | 33 | 89 | 68 | 81 | 52 |
| Congo | - | - | - | - | - | - | - | - | - | - |
| Congo, Democratic Republic of the | 70 | 50 | 0.72 | 29 | 13 | 39 | 90 | 72 | 80 | 56 |
| Equatorial Guinea | 89 | 85 | 0.95 | 35 | 25 | 22 | 81 | 78 | 56 | 40 |
| Gabon | - | - | - | - | - | - | 77 | 76 | 53 | 52 |
| Sao Tome and Principe | - | - | - | 46 | 31 | 11 | 88 | 84 | 59 | 43 |
| Sudan | 70 | 67 | 0.96 | - | - | - | - | - | - | - |
| East Africa | | | | | | | | | | |
| Burundi | 65 | 46 | 0.70 | 55 | 19 | 74 | 96 | 92 | 92 | 76 |
| Comoros | 60 | 37 | 0.59* | 32 | 20 | 13 | 94 | 87 | 80 | 80 |
| Djibouti | - | - | - | - | - | - | - | - | - | - |
| Eritrea | - | - | 0.83 | - | - | - | 96 | 90 | 86 | 56 |
| Ethiopia | 43 | 26 | 0.60 | 42 | 21 | 35 | 90 | 80 | 82 | 68 |
| Kenya | 92 | 88 | 0.95 | 61 | 33 | 28 | 90 | 81 | 70 | 63 |
| Madagascar | 80 | 61 | 0.76 | 44 | 19 | 24 | 91 | 78 | 82 | 53 |
| Rwanda | 80 | 64 | 0.80 | 64 | 33 | 71 | 94 | 87 | 83 | 62 |
| Somalia | 21 | 14 | 0.65 | 53 | 18 | 32 | 95 | 90 | 89 | 64 |
| Tanzania, United Republic of | 90 | 73 | 0.82 | 43 | 23 | 33 | 85 | 69 | 72 | 47 |
| Uganda | 93 | 88 | 0.95 | 48 | 27 | 38 | 84 | 65 | 74 | 49 |
| Southern Africa | | | | | | | | | | |
| Angola | 81 | 73 | 0.90 | 49 | 25 | 35 | 91 | 79 | 78 | 48 |
| Botswana | 92 | 93 | 0.99 | 64 | 52 | 25 | 73 | 71 | 35 | 14 |
| Lesotho | 91 | 79 | 0.87 | 66 | 32 | 41 | 86 | 78 | 70 | 56 |
| Malawi | 90 | 87 | 0.97 | 49 | 26 | 37 | 87 | 72 | 70 | 27 |
| Mauritius | - | - | - | - | - | - | - | - | - | - |
| Mozambique | 78 | 63 | 0.80 | 41 | 24 | 34 | 85 | 68 | 70 | 39 |
| Namibia | 90 | 83 | 0.92 | 60 | 47 | 27 | 65 | 51 | 35 | 17 |
| South Africa | 96 | 91 | 0.95 | 71 | 46 | 23 | 73 | 65 | 42 | 28 |
| Swaziland | 87 | 79 | 0.91 | 50 | 34 | 31 | 80 | 66 | 49 | 41 |
| Zambia | 73 | 78 | 0.92 | 44 | 20 | 50 | 87 | 68 | 77 | 37 |
| Zimbabwe | 90 | 92 | 0.98 | 61 | 37 | 33 | 80 | 63 | 60 | 46 |

Source: Multiple Indicator Cluster Surveys and Demographic and Health Surveys, 1998–2005.

* Signifies that the proportion of double orphans attending school was based on less than 50 children.

TABLE 5
GOVERNMENT RESPONSE TO ORPHANED AND VULNERABLE CHILDREN, SUB-SAHARAN AFRICA

| | OVC programme effort index (out of 100) 1999–2004 | | | | | | | | | Birth registration (%) | | |
|-----------------------------------|--|-------------------------------|------------------------|----------------------|--------|--------------------|---------------------------|-----------|-----------------------|------------------------|-----------------|-----------------|
| | National situation | Analysis consultative process | Coordinating mechanism | National action plan | Policy | Legislative review | Monitoring and evaluation | Resources | Total OVC index score | Total | Urban | Rural |
| West Africa | | | | | | | | | | | | |
| Benin | 55 | 73 | 0 | 46 | 13 | 20 | 7 | 68 | 35 | 70 | 78 | 66 |
| Burkina Faso | 86 | 66 | 69 | 49 | 34 | 20 | 49 | 45 | 52 | - | - | - |
| Cape Verde | 0 | 55 | 0 | 46 | 8 | 0 | 7 | 58 | 22 | - | - | - |
| Côte d'Ivoire | 90 | 100 | 100 | 100 | 13 | 68 | 14 | 60 | 68 | 72 | 88 | 60 |
| Gambia | 86 | 80 | 84 | 49 | 90 | 78 | 78 | 70 | 77 | 32 | 37 | 29 |
| Ghana | 86 | 100 | 100 | 49 | 13 | 78 | 93 | 58 | 72 | 21 | - | - |
| Guinea | 82 | 86 | 80 | 49 | 53 | 40 | 51 | 68 | 63 | 67 | 88 | 56 |
| Guinea-Bissau | 20 | 55 | 10 | 23 | 33 | 0 | 2 | 68 | 26 | 42 | 32 | 47 |
| Liberia | 49 | 78 | 90 | 48 | 80 | 57 | 54 | 58 | 64 | - | - | - |
| Mali | 33 | 68 | 20 | 26 | 4 | 24 | 5 | 45 | 28 | 48 | 71 | 41 |
| Mauritania | 53 | 53 | 20 | 46 | 43 | 10 | 12 | 65 | 38 | 55 | 72 | 42 |
| Niger | 17 | 63 | 69 | 84 | 13 | 0 | 12 | 55 | 39 | 46 | 85 | 40 |
| Nigeria | 14 | 86 | 79 | 66 | 0 | 47 | 7 | 68 | 46 | 30 | 53 | 20 |
| Senegal | 28 | 0 | 59 | 42 | 28 | 10 | 25 | 10 | 25 | 62 | 82 | 51 |
| Sierra Leone | 0 | 38 | 0 | 33 | 38 | 30 | 40 | 65 | 31 | 46 | 66 | 40 |
| Togo | 70 | 90 | 54 | 49 | 13 | 32 | 2 | 10 | 40 | 82 | 93 | 78 |
| Central Africa | | | | | | | | | | | | |
| Cameroon | 33 | 28 | 60 | 36 | 8 | 18 | 5 | 25 | 27 | 79 | 94 | 73 |
| Central African Republic | 8 | 68 | 20 | 97 | 68 | 30 | 14 | 70 | 47 | 73 | 88 | 63 |
| Chad | 86 | 28 | 0 | 26 | 24 | 0 | 0 | 48 | 26 | 25 | 53 | 18 |
| Congo | 13 | 51 | 84 | 65 | 73 | 0 | 17 | 48 | 44 | - | - | - |
| Congo, Democratic Republic of the | 59 | 72 | 20 | 59 | 58 | 20 | 46 | 48 | 48 | 34 | 30 | 36 |
| Equatorial Guinea | 8 | 0 | 0 | 10 | 24 | 10 | 7 | 53 | 14 | 32 | 43 | 24 |
| Gabon | 82 | 78 | 30 | 81 | 13 | 0 | 24 | 55 | 45 | 89 | 90 | 87 |
| Sao Tome and Principe | - | - | - | - | - | - | - | - | - | 70 | 73 | 67 |
| Sudan | - | - | - | - | - | - | - | - | - | 64 | 82 | 46 |
| East Africa | | | | | | | | | | | | |
| Burundi | 38 | 48 | 69 | 75 | 34 | 68 | 59 | 78 | 59 | 75 | 71 | 75 |
| Comoros | - | - | - | - | - | - | - | - | - | 83 | 87 | 83 |
| Djibouti | - | - | - | - | - | - | - | - | - | - | - | - |
| Eritrea | - | - | - | - | - | - | - | - | - | - | - | - |
| Ethiopia | 59 | 72 | 59 | 72 | 30 | 61 | 12 | 90 | 57 | - | - | - |
| Kenya | - | - | - | - | - | - | - | - | - | 48 ^a | 64 ^a | 44 ^a |
| Madagascar | - | - | - | - | - | - | - | - | - | 75 | 87 | 72 |
| Rwanda | 46 | 96 | 73 | 97 | 86 | 85 | 93 | 60 | 79 | 65 | 61 | 66 |
| Somalia | - | - | - | - | - | - | - | - | - | - | - | - |
| Tanzania, United Rep. of | 82 | 63 | 69 | 69 | 43 | 30 | 40 | 45 | 55 | 7 | 20 | 4 |
| Uganda | 90 | 90 | 73 | 90 | 78 | 30 | 37 | 35 | 65 | 4 | 11 | 3 |
| Southern Africa | | | | | | | | | | | | |
| Angola | - | - | - | - | - | - | - | - | - | 29 | 34 | 19 |
| Botswana | - | - | - | - | - | - | - | - | - | 58 | 66 | 52 |
| Lesotho | 73 | 72 | 38 | 46 | 4 | 20 | 10 | 45 | 38 | 26 | 39 | 24 |
| Malawi | 8 | 59 | 73 | 26 | 73 | 30 | 66 | 55 | 49 | - | - | - |
| Mauritius | - | - | - | - | - | - | - | - | - | - | - | - |
| Mozambique | 53 | 49 | 64 | 59 | 4 | 10 | 43 | 48 | 41 | - | - | - |
| Namibia | 76 | 90 | 84 | 91 | 82 | 65 | 42 | 55 | 73 | 71 | 82 | 64 |
| South Africa | 72 | 80 | 59 | 94 | 38 | 71 | 61 | 80 | 69 | - | - | - |
| Swaziland | 90 | 90 | 73 | 90 | 43 | 45 | 78 | 65 | 72 | 53 | 72 | 50 |
| Zambia | 17 | 0 | 64 | 36 | 13 | 24 | 19 | 60 | 29 | 10 | 16 | 6 |
| Zimbabwe | 70 | 59 | 63 | 80 | 66 | 47 | 49 | 70 | 63 | 42 | 56 | 35 |

Source: UNICEF, UNAIDS and the Futures Group, National Responses to Orphans and Other Vulnerable Children in sub-Saharan Africa - the OVC Programme Effort Index 2004, September 2004; and Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and the Ghana Department of Birth and Death Registration.

Note: The OVC programme effort index measures the policy and programme response to the crisis facing orphans and vulnerable children. It consists of 120 simple questions that were asked of task forces on orphaned and vulnerable children OVC in 36 countries. An example of the index can be found in *A guide to the monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS* (UNICEF et al., 2005). Based on self-reported responses.

- Indicates no data available.

Methods to estimate and project the impact of HIV/AIDS on the number of orphaned children

AIDS has an impact on adult mortality, fertility and child survival, the main factors in determining the numbers of orphans. The UNAIDS Reference Group on Estimates, Modelling and Projections has developed and refined a model to produce these estimates. An important part of these estimates are the new 2005 estimates on HIV prevalence prepared by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance and adult mortality levels provided by the United Nations Population Division. The 2005 orphan estimates are different than the 2003 estimates because of these new levels of HIV prevalence and new census data altering the life tables used to estimate child and adult mortality.

Methods of estimating orphans due to AIDS and other causes in countries with generalized epidemics, derived by Grassly and Timæus, were originally adopted by the Reference Group in 2002 and subsequently used to produce the estimates in this report. The methods are reported in detail elsewhere (Grassly and Timæus, 2005; UNAIDS Reference Group, 2002).

The estimates of orphans exclude estimates of orphans due to AIDS in countries with low levels of HIV prevalence. In countries where a large percentage of people living with HIV are from populations such as injecting drug users or men who have sex with men, the fertility rates of those infected are unknown. Insufficient information is available to estimate children

orphaned due to AIDS in these countries. Also, as adult prevalence is lower in these countries, it is unlikely that AIDS can have a large impact at the national level on the number of children who are orphaned.

This report uses the definition of an orphan due to AIDS that was agreed upon by the UNAIDS Reference Group as “a child who has at least one parent dead from AIDS,” and the definition of a double orphan due to AIDS as “a child whose mother and father have both died, at least one due to AIDS.”

MATERNAL ORPHANS

Maternal orphans are those children whose mother has died regardless of the survival status of the father.

Maternal orphans due to AIDS are estimated using a similar method to that previously described (Gregson et al., 1994). The number of children born to women who have died from AIDS over the preceding 17 years is estimated using country- and age-specific fertility rates, and the number of these children who are still alive and under 18 years old is calculated using a country-specific life table.

These calculations take account of the impact of HIV infection on fertility, as well as the probability of the virus being transmitted from mother to child, resulting in a reduction in survival of the child. The HIV status of the mother in the years prior to death from AIDS must be back-calculated, using estimates of the rate of disease progression. The calculations also

account for the impact of maternal death on child survival in the year before and after the mother's death, which occurs irrespective of the HIV status of the child (Crampin et al., 2003; Nakiyingi et al., 2003; Ng'weshemi et al., 2003).

Maternal orphans due to causes other than AIDS are estimated in a similar way. However, it is assumed that HIV prevalence (and hence vertical transmission) among women dying from causes other than AIDS is zero, since the majority tend to be women over the age of 35, where HIV prevalence is low. This assumption is necessary because of the absence of data on prevalence among these women, as opposed to women attending antenatal clinics (ANC). At worst, it may overestimate maternal orphans due to causes other than AIDS by 5 per cent (Grassly and Timæus, 2005).

PATERNAL ORPHANS

Similar to maternal orphans, paternal orphans are children whose father has died regardless of the survival status of their mother. The population projections based on female fertility schedules imply a total fertility rate for men that, together with standard male fertility schedules, can be used to estimate age-specific fertility for men. Male fertility can then be used to estimate the number of children whose father died from AIDS in the preceding 17 years in the same way as for estimates of maternal orphans due to AIDS. To account for the impact of HIV on the fertility of a man's partner, and the impact of mother-to-child transmission of HIV

on child survival, additional information on concordance of parents' HIV status is required. This is based on data on the prevalence of HIV among the partners of HIV-positive men from 23 studies. Logistic regression of concordance of HIV positivity on HIV prevalence in the adult population (from ANC data) reveals a significant positive correlation, both because of the increased probability of pre-existing infection in the female partner and because high HIV prevalence is a marker for risk factors for transmission, such as high prevalence of bacterial sexually transmitted infections or low condom use.

Paternal orphans due to causes other than AIDS are estimated in a similar way, with the assumption that female partners of men dying from AIDS have a prevalence of HIV equivalent to that for women attending antenatal clinics.

DOUBLE ORPHANS

Numbers of double orphans due to AIDS as defined can be estimated by calculating the total number of children whose parents have both died from any cause and subtracting those children where both deaths were not due to AIDS. Deaths of parents are not independent due to shared risk factors, such as socio-economic status and environment, and also due to the transmission of disease. The number of double orphans is therefore higher than would be expected if deaths were independent. This excess risk of being a double orphan was estimated by fitting a multilevel Poisson regression model to data on

maternal, paternal and double orphan numbers from Demographic and Health Surveys (DHS) carried out in 31 countries. These analyses reveal that the excess risk, and hence the ratio of double to maternal and paternal orphan numbers, is dependent on a child's age, HIV prevalence five years before the survey and marriage patterns in the population (proportion of 15- to 19-year-old women unmarried and prevalence of polygamy). If maternal and paternal orphan numbers are known precisely, this regression predicts orphan numbers within 5 per cent for the DHS data fitted. Care should be taken in applying these regression results for projections of double orphan numbers into the future, where projected HIV prevalence (lagged by five years) may be higher than the range fitted in the DHS (0–15 per cent, with only Zimbabwe, 1999, having a higher lagged prevalence of 23.6 per cent).

The estimates of maternal and paternal orphans include double orphans because children are defined as maternal and paternal orphans regardless of the survival status of the other parent. Thus, summing maternal, paternal and double orphans will not produce the total number of orphans.

VALIDATION

Previous estimates of orphan numbers published in *Children on the Brink 2002*, based on the methods described above, were compared to estimates of orphans in countries in sub-Saharan Africa that were derived from household surveys (Grassly et al., 2004). Estimates of total orphans

ages 0–14 from the DHS and MICS were found to be in fairly close agreement with estimates derived from the demographic models (comparing to estimates for age 0–14), after accounting for an overestimate of adult mortality due to causes other than AIDS.

Of course, estimates of orphan numbers will only be as accurate as the demographic and epidemiological data on which they are based. Differences in demographic and epidemiological assumptions in the past have led to differing estimates of numbers of orphans due to AIDS by

different organizations (Hunter and Williamson 2000; UNAIDS 2000). As the data and assumptions improve, and consensus is reached on appropriate methods, global estimates of orphan numbers and the impact of HIV/AIDS will likewise improve.

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