Please note: this report is EMBARGOED until 26 November 2003, 9am GMT.

AFRICA'S ORPHANED GENERATIONS

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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“In the past, people used to care for the orphans and loved them, but these days they are so many, and many people have died who could have assisted them, and therefore orphanhood is a common phenomenon, not strange. The few who are alive cannot support them.”

A widow in her early fifties, Kenya[1]

Cover photo: UNICEF/HQ96-1377/GIACOMO PIROZZI

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The HIV/AIDS epidemic in sub-Saharan Africa has already orphaned a generation of children – and now seems set to orphan generations more.

Today, over 11 million children under the age of 15 living in sub-Saharan Africa have been robbed of one or both parents by HIV/AIDS. Seven years from now, the number is expected to have grown to 20 million. At that point, anywhere from 15 per cent to over 25 per cent of the children in a dozen sub-Saharan African countries will be orphans – the vast majority of them will have been orphaned by HIV/AIDS.

Africa's Orphaned Generations reports on the life circumstances of today's orphans with new data and fresh analyses. It presents the possibility of change – for those already orphaned and for the generation to come – if certain things are done now.

Tragically, the number of orphans in sub-Saharan Africa will continue to rise in the years ahead, due to the high proportion of sub-Saharan African adults already living with HIV/AIDS and the continuing difficulties in expanding access to life-prolonging antiretroviral treatment. But, it is not inevitable that these children should be left to suffer twice, denied their rights because they are orphaned. *Africa's Orphaned Generations* presents a strategy for ensuring that all of Africa's orphaned children have a safe, healthy and well-educated childhood, establishing the foundation for a productive adult life and for their countries' overall development. It encourages hope in the face of an epic disaster.

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EXECUTIVE SUMMARY

Among the most devastating effects of the HIV/AIDS epidemic in sub-Saharan Africa is that it is orphaning generations of children – jeopardizing their rights and well-being, as well as compromising the overall development prospects of their countries.

- In 1990, fewer than 1 million sub-Saharan African children under the age of 15 had lost one or both parents to HIV/AIDS.
- At the end of 2001, 11 million in this age group were orphans because of HIV/AIDS, nearly 80 per cent of the world total.
- By 2010, 20 million in this age group are likely to be orphans from this single cause, comprising about half the total number of orphans expected in the region.

More catastrophically than elsewhere, the HIV/AIDS epidemic has deepened poverty and exacerbated myriad deprivations in sub-Saharan Africa. The responsibility of caring for orphaned children is a major factor in pushing many extended families beyond their ability to cope. With the number of children that require protection and support soaring – and ever-larger numbers of adults falling sick with HIV/AIDS – many extended family networks have simply been overwhelmed. Many countries are experiencing large increases in the number of families headed by women and grandparents; these households are often progressively unable to adequately provide for children in their care. The number of children living on the street is rising, most likely driven by HIV/AIDS.

Orphaned children are disadvantaged in numerous and often devastating ways. In addition to the trauma of witnessing the sickness and death of one or both parents, they are likely to be poorer and less healthy than non-orphans are. They are more likely to suffer damage to their cognitive and emotional development, less likely to go to school, more likely to be subjected to the worst forms of child labour. Survival strategies, such as eating less and selling assets, intensify the vulnerability of both adults and children.

The implications for generations of orphans in sub-Saharan Africa are extraordinarily grave, but governments, international agencies, non-governmental organizations, schools and other community groups can still alter the course of the crisis. Immediate support will allow families and communities to build the protective environment that orphans both need and have a right to. Eliminating all school fees and providing children with basic education, giving them safe and viable options for earning a living, and providing families with financial and other assistance would mean that many orphans who might otherwise be separated from their families will not be.

Governments – in sub-Saharan Africa and in donor countries – have been slow to respond. But, in June 2001, the United Nations General Assembly Special Session on HIV/AIDS paid special attention to children orphaned and made vulnerable by HIV/AIDS, and set specific goals for the subsequent five years in its Declaration of Commitment. These goals underscore the importance of developing and implementing national strategies to strengthen governmental, family and community capacities to respond to the crisis, ensuring non-discrimination and building international cooperation.

The core of a framework of action, developed by a number of international agencies, including UNICEF, UNAIDS and USAID, highlights the need for strong action on five fronts.

1. Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS. In sub-Saharan Africa, extended family relationships are the first and most vital source of support for households affected by HIV/AIDS, including for orphaned children.

2. Mobilizing and strengthening community-based responses. After families, communities provide the next level of support.

3. Ensuring access to essential services for orphans and vulnerable children. Orphans and other vulnerable children need a number of services to ensure their rights and well-being, including education, birth registration, health care and nutrition, psychosocial support, safe water and sanitation, and strong and independent justice systems.

4. Ensuring that governments protect the most vulnerable children. While the family has primary responsibility for the care and protection of children, national governments have ultimate responsibility for guaranteeing the rights of children.

5. Raising awareness to create a supportive environment for children affected by HIV/AIDS. Action against HIV/AIDS has to be a shared national responsibility.

The orphan crisis in sub-Saharan Africa has implications for stability and human welfare that extend far beyond the region, affecting governments and people worldwide. Wealthy nations must recognize that in the spirit of the Convention on the Rights of the Child and in terms of global interests, they have a vital role to play in accelerating the response to the orphan crisis. They must mobilize substantially increased resources, keep this issue high on the global agenda, provide technical and material support, and ensure that progress towards global goals is monitored and that stakeholders are held accountable. Their commitment and participation is essential, for the children of Africa, orphaned by HIV/AIDS, are the world's responsibility.

1 THE SCALE OF THE ORPHAN CRISIS

Among the most devastating outcomes of the HIV/AIDS epidemic in sub-Saharan Africa is that it is making orphans of generations of children, jeopardizing not just their rights and well-being but also the overall development prospects of their countries.

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SUB-SAHARAN AFRICA HAS BEEN WORST HIT BY HIV/AIDS

Although HIV/AIDS has reached almost every part of the world, no other region has been harder hit than sub-Saharan Africa, home to nearly three quarters of the world's people living with HIV/AIDS. By the end of 2002, over 29 million people in sub-Saharan Africa were living with HIV/AIDS. Of those, 10 million were young people (aged 15-24) and almost 3 million were children under 15. In 2002 alone, about 2 million adults died of HIV/AIDS in the region.[2]

THE EPIDEMIC HAS ORPHANED MILLIONS

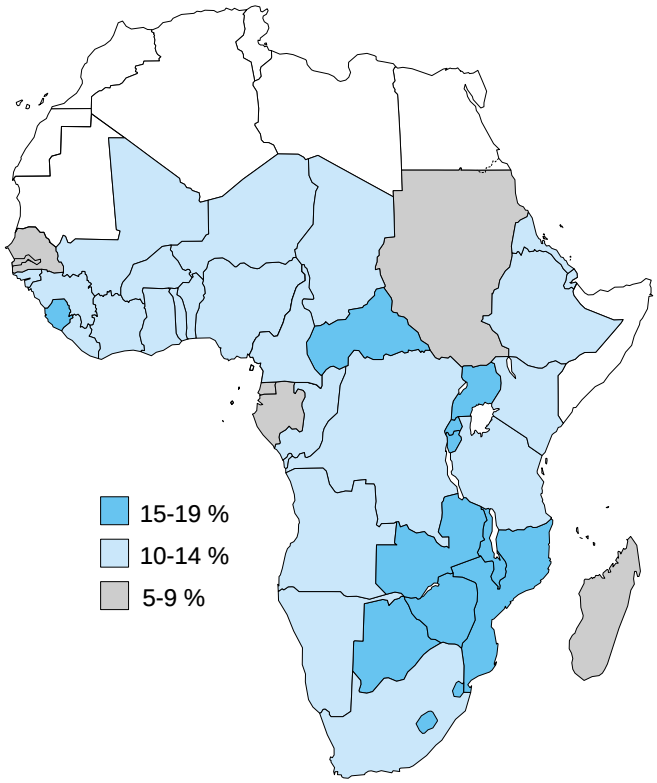
Eight out of every 10 children who have lost parents to HIV/AIDS live in sub-Saharan Africa. Between 1990 and 2001, the proportion of orphans whose parents died from HIV/AIDS rose from 3.5 per cent to 32 per cent. There are more than 34 million orphans in the region today, 11 million of them orphaned by HIV/AIDS.[3] Figure 1-1 shows the most recent estimate of children orphaned by HIV/AIDS published in *Children on the Brink 2002*. (*Children on the Brink* is a biennial report on orphan estimates and strategies published jointly by UNAIDS, UNICEF and USAID. The data is the outcome of a modelling exercise that involved estimating how many people will die from HIV/AIDS and other causes and calculating the number of children who are likely to be orphaned.)

The number of orphans in sub-Saharan Africa would be declining were it not for HIV/AIDS. But because of the disease's spread, the number of orphans is increasing exponentially.

Even without HIV/AIDS, the percentage of children who are orphans would be significantly higher in sub-Saharan Africa than in other regions of the world. In sub-Saharan Africa, 12 per cent of all children are orphans, compared with 6.5 per cent in Asia and 5 per cent in Latin America and the Caribbean. In 10

FIGURE 1-1: 34 MILLION CHILDREN ORPHANED IN SUB-SAHARAN AFRICA

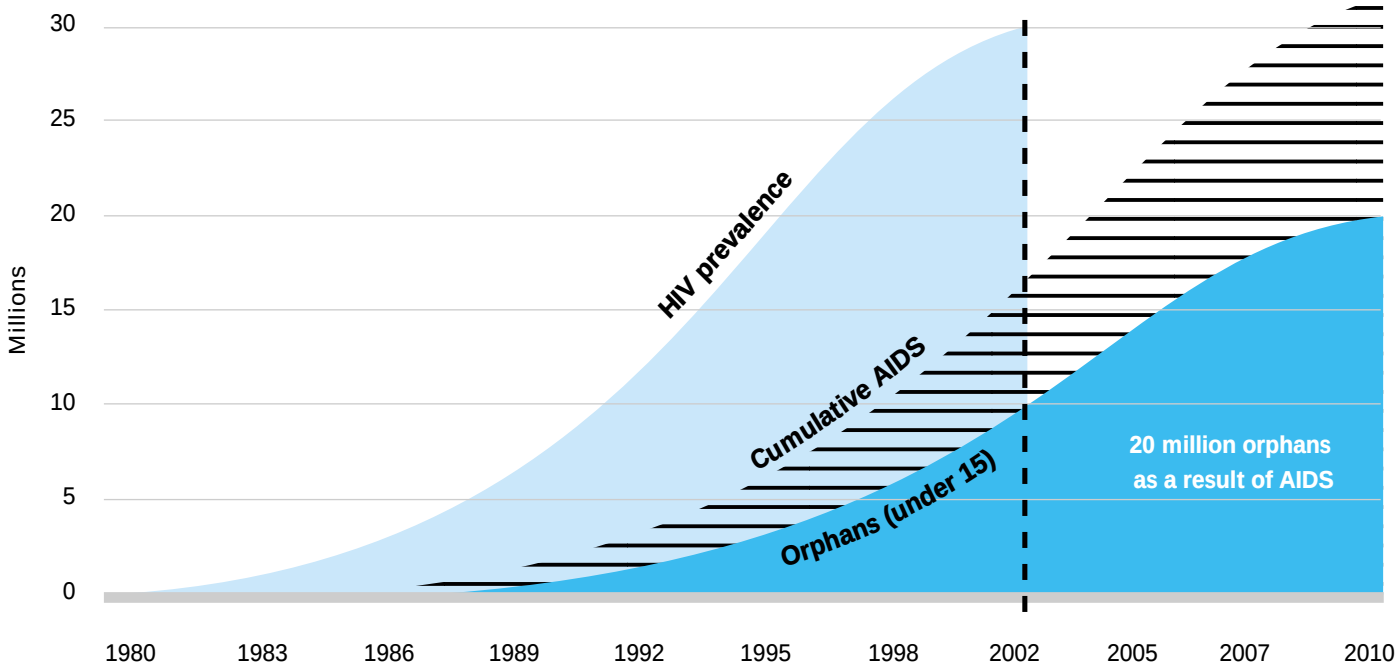
Estimated % of children under 15 orphaned, 2001



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: *Children on the Brink 2002.*

FIGURE 1-2: THE WORST IS YET TO COME: EPIDEMIC CURVES, HIV/AIDS AND ORPHANS



Source: UNAIDS/UNICEF, 2003, adapted from Whiteside, A. and C. Sunter, 2000.

countries in the region, more than one in five 14-year-olds is an orphan. HIV/AIDS (together with ongoing armed conflict) is multiplying the already severe pressures on sub-Saharan African families and communities resulting from the exceptionally high numbers of orphaned children.

THE WORST IS YET TO COME

As staggering as the numbers already are, the orphan crisis in sub-Saharan Africa is just starting to unfold. As today's young adults die in growing numbers, they will leave growing numbers of orphaned children. By 2010, HIV/AIDS will have robbed an estimated 20 million children under the age of 15 of one or both parents, nearly twice the number orphaned in this age group in 2001.

The largest increases will be in countries with the highest HIV rates, such as Botswana, Lesotho and Swaziland, where the national adult HIV prevalence has risen higher than thought possible, exceeding 30 per cent. But even where HIV prevalence has stabilized or declined, the number of orphans will continue to grow or at least remain high for several years, reflecting the long time lag between HIV infection and death (*see Figure 1-2*). For example, HIV prevalence in Uganda peaked in the late 1980s at around 14 per cent and then began to decline dramatically to an estimated 5 per cent in 2001. The number of orphans in the country, however, continued to increase and is only now slowly beginning to decline, from 14.6 per cent of all children in 2001 to a projected 9.6 per cent in 2010.

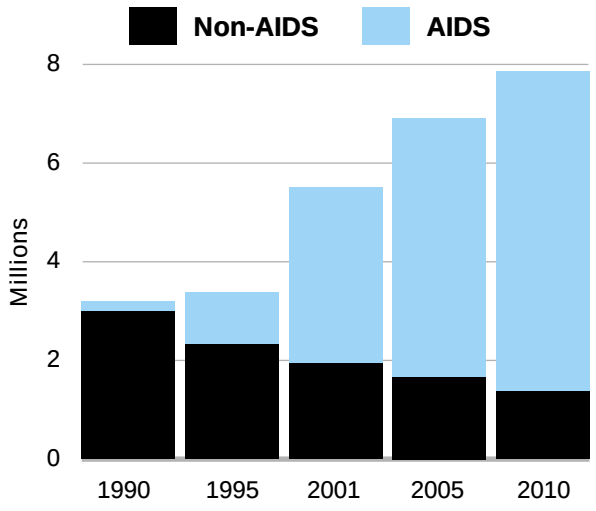
‘DOUBLE’ ORPHANS – HIV/AIDS KILLS BOTH PARENTS

As a cause of orphanhood, HIV/AIDS is exceptional in that if one parent is infected with HIV, the probability that the spouse is also infected is quite high. This means that children face a large risk that both their parents could die within a relatively short period. Without HIV/AIDS, the total number of ‘double’ orphans – the term used to describe children who have lost both parents – would have declined from 1990 to 2010, in line with overall orphan rates in sub-Saharan Africa. HIV/AIDS, however, will nearly triple by 2010 the number of orphans in sub-Saharan Africa who have no living parents (*see Figure 1-3*).

WHERE ORPHANS LIVE

Orphans are concentrated in certain regions and countries in sub-Saharan Africa. The highest percentages of children orphaned are in countries with high HIV-prevalence levels or those that have been recently involved in armed conflict. Given current trends, by 2010, the countries with the highest proportion of children orphaned – more than one in five – will be Botswana, Lesotho, Swaziland and Zimbabwe (*see Figure 1-4*). Over 80 per cent of these children will be orphaned as a result of adults dying from HIV/AIDS, most of whom are already infected today.

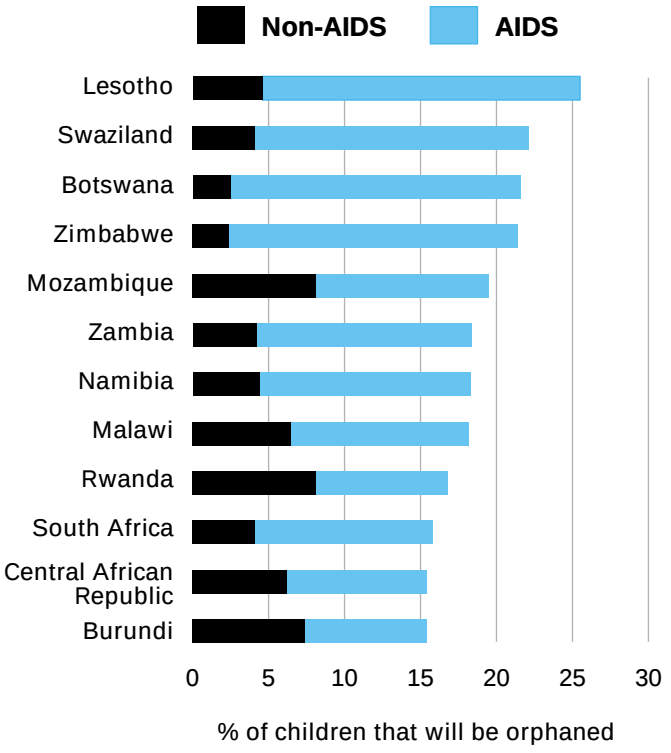
FIGURE 1-3: INCREASE IN DOUBLE ORPHANS IN SUB-SAHARAN AFRICA DUE TO HIV/AIDS



Source: *Children on the Brink 2002.*

FIGURE 1-4: SELECT ORPHAN PROJECTIONS, 2010

By 2010, orphans will account for 15% to over 25% of all children in 12 sub-Saharan countries

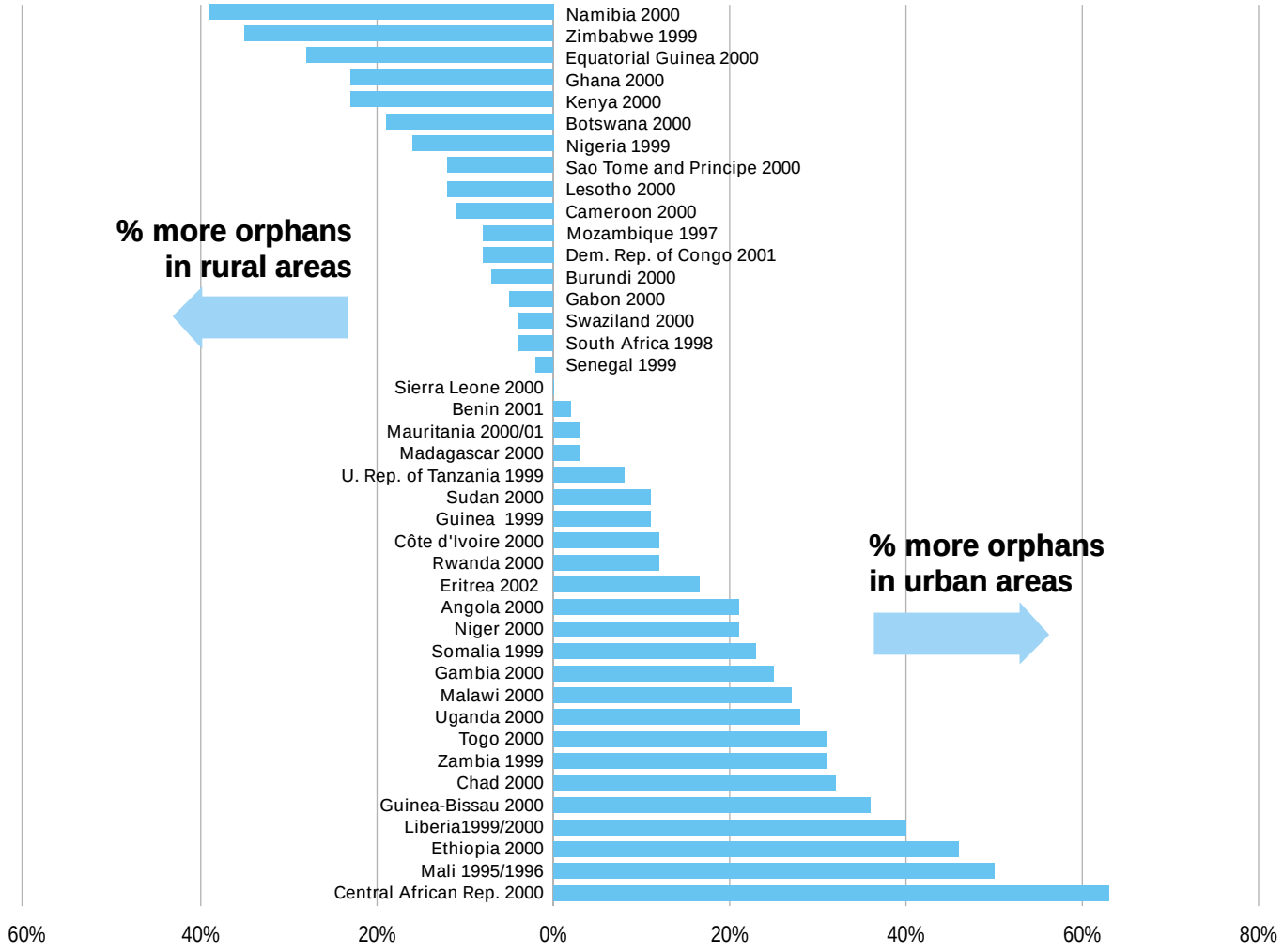


Source: *Children on the Brink 2002.*

BOX 1-1: SUBNATIONAL DIFFERENCES

Orphans are not necessarily equally distributed within countries. Particular areas within countries have higher or lower percentages of orphans, largely depending on the HIV/AIDS-prevalence rate. In many countries, such as Ethiopia and Uganda, prevalence rates are higher in urban areas, which might account for the higher proportion of orphans in these areas, as suggested in Figure 1-5. However, sickness and death from HIV/AIDS or other causes often provokes migration from urban areas back to village homes. Urban parents faced with a terminal illness may choose to die in their home village and may take their family with them – which might account for the greater rural share of orphans in some countries, including Zimbabwe (*see Figure 1-7*). Complicating the picture, there is also migration in the other direction: The death of the male head of household in a rural area could force the mother and children to the city in search of work or other forms of support.

FIGURE 1-5: DISTRIBUTION OF ORPHANS BY RURAL/URBAN AREAS



Sources: UNICEF-MICS, Measure DHS, 1997-2002.

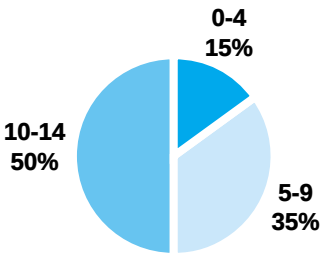
AGE OF ORPHANS

The age distribution of orphans is fairly consistent across countries. Surveys indicate that on average only 2 per cent of children were orphaned before their first birthday. Overall, about 15 per cent of orphans are 0-4 years old, 35 per cent are 5-9 years old, and 50 per cent are 10-14 years old.[4]

OTHER VULNERABLE CHILDREN

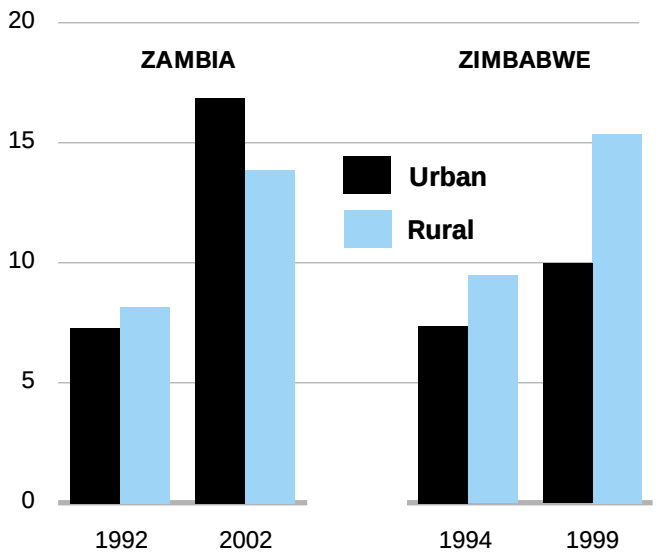
Orphans are part of a much larger health and development crisis engendered by HIV/AIDS in sub-Saharan Africa. Thus, in countries where large proportions of children are orphaned by HIV/AIDS, the odds are high that the epidemic has had a damaging impact on a far larger number of children who are not orphans, eroding their well-being and the opportunities available for fulfilling their rights. These 'other vulnerable children' include those who are living with HIV/AIDS, those whose parents are sick with HIV/AIDS, and, more generally, children who are especially vulnerable because of poverty, discrimination or exclusion, whether as a consequence of HIV/AIDS or not.

FIGURE 1-6: AGE OF ORPHANS



Sources: UNICEF-MICS, Measure DHS, 1997-2002.

FIGURE 1-7: PERCENTAGE OF CHILDREN WHO ARE ORPHANS, BY URBAN/RURAL RESIDENCE



Sources: UNICEF-MICS, Measure DHS, 1992-2002.

2 THE IMPACT OF ORPHANING ON FAMILIES, HOUSEHOLDS AND COMMUNITIES

In sub-Saharan Africa, even more catastrophically than elsewhere, the HIV/AIDS epidemic has deepened poverty and exacerbated myriad deprivations. The responsibility of caring for orphaned children is a major factor in pushing many extended families beyond their ability to cope. With the number of children that require protection and support soaring – and ever-larger numbers of adults falling sick with HIV/AIDS – many extended family networks have simply been overwhelmed. Many countries are experiencing large increases in the number of families headed by women and grandparents; these households are often progressively unable to adequately provide for the children in their care.

THE EXTENDED FAMILY

In nearly every sub-Saharan country, extended families have assumed responsibility for more than 90 per cent of orphaned children (*see Box 2-1*). But this traditional support system is under severe pressure – and in many instances has already been overwhelmed, increasingly impoverished and rendered unable to provide adequate care for children. Most worryingly, it is precisely those countries that will see the largest increase in orphans over the coming years where the extended family is already most stretched by caring for orphans.

Where one parent has died, the majority of orphans stay with the surviving parent. There are, however, important differences between (and within) countries. These are illustrated in Table 2-1, which shows the proportion of 'single' orphans not living with a surviving mother or father. (Single orphans are children who have one surviving parent. Children whose mothers have died are referred to as 'maternal' orphans and those whose fathers have died as 'paternal' orphans.) In South Africa, one third of paternal orphans do not stay with their mother, while in Burundi the proportion is less than one tenth.

TABLE 2-1: DIFFERENT CHILDCARE PRACTICES FOR NON-ORPHANS AND 'SINGLE' ORPHANS

Country	% of non-orphans living with mother	% of paternal orphans living with mother	% of non-orphans living with father	% of maternal orphans living with father
Burundi	96	92	92	76
Nigeria	90	77	87	76
Malawi	87	72	70	27
Ghana	81	67	58	52
Gabon	77	76	53	52
South Africa	73	65	42	28

Sources: UNICEF-MICS; Measure DHS, 1998-2001.

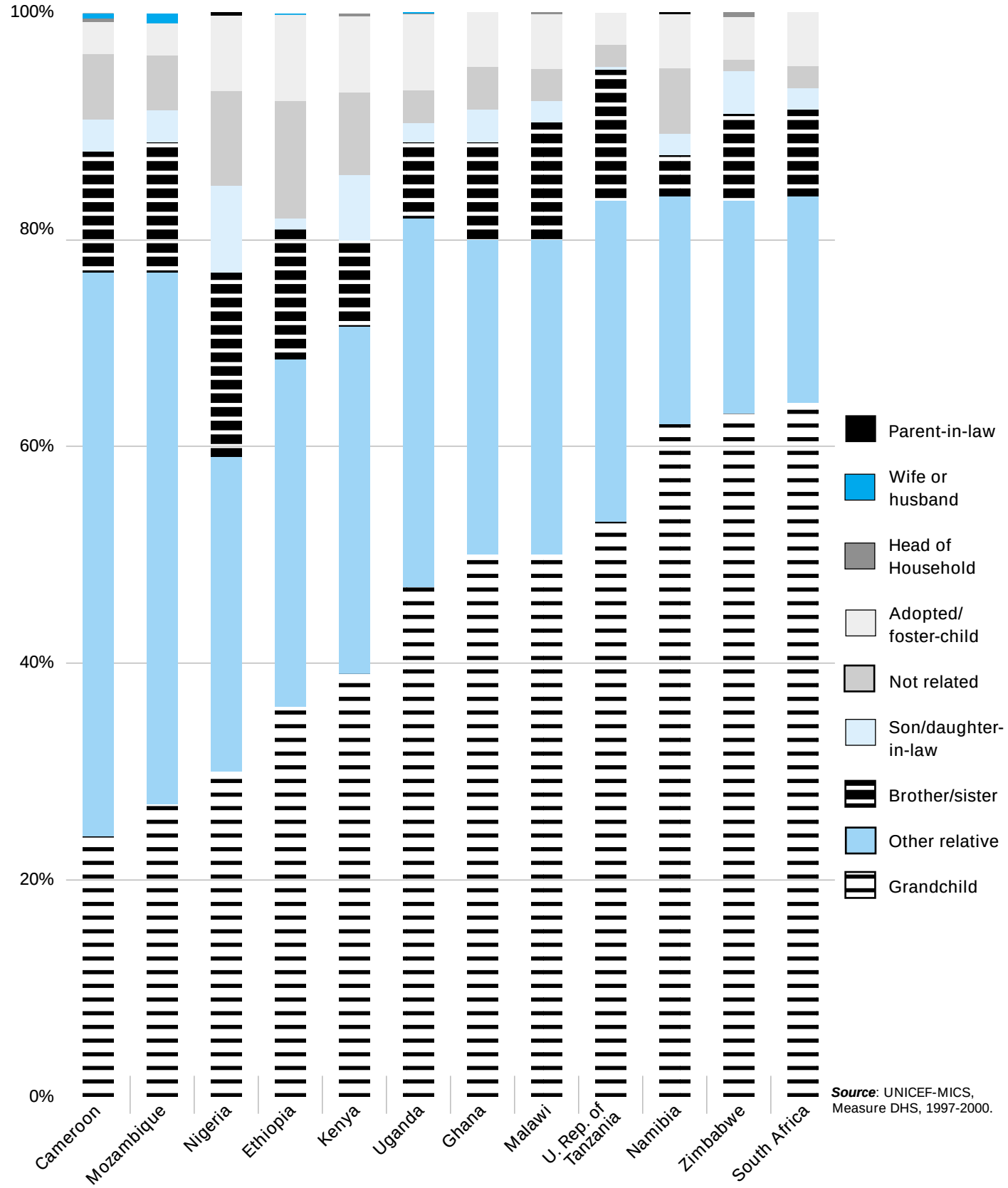
BOX 2-1: EXTENDED FAMILIES AND FOSTER HOUSEHOLDS

The vast majority of orphans in sub-Saharan Africa continue to be taken in by the extended family. Here, the extended family has historically formed an intricate and resilient system of social security that usually responds quickly to the death of a mother or father. It is very common for families to raise children who are not members of the immediate family. For example, it is traditional in many southern African communities for the deceased father's nearest male relative, such as a brother or a nephew, to inherit the deceased man's wife and children. Similarly, if a mother dies, the husband would then marry a close female relative of the deceased, who would then be obliged to regard any of his children as her own.[5]

Another traditional way in which children have moved between households is through fostering. It is common for parents in many sub-Saharan African countries to send their children to be raised away from home, either by relatives or by non-relatives. They may do this because they are unable to take care of the children themselves, to save money, or to provide their children with better economic opportunities. The foster family also gains from this arrangement since it can acquire child workers, particularly for domestic service.[6] In some countries a high proportion of children, 20 per cent or more, may not be living with their parents.

FIGURE 2-1: EXTENDED FAMILIES TRADITIONALLY CARE FOR ORPHANS

Relationship of double orphans and single orphans (not living with surviving parent) to the head of household



Source: UNICEF-MICS, Measure DHS, 1997-2000.

In almost every country in the region, there are notable differences between the responsibilities assumed by fathers and mothers, with mothers more likely to continue to be responsible for their orphaned children than are fathers.[7] (Fathers are also more likely to look after orphaned sons than orphaned daughters.) In Malawi, nearly three out of four paternal orphans continue to live with their mothers, while only a quarter of maternal orphans live with their surviving fathers.

If both parents die, other members of the extended family typically care for the orphaned children (*see Figure 2-1*). But, there are again differences between countries with regard to who within the family will assume primary responsibility. In South Africa, the majority of double orphans (and children not living with a surviving parent) are being raised by their grandparents (64 per cent), while in Cameroon 57 per cent are raised by 'other relatives', generally aunts and uncles.

HIV/AIDS AFFECTS FAMILIES LONG BEFORE PARENTS DIE

Household incomes plummet when adults fall ill from HIV/AIDS and can no longer work full-time or at all. In rural Zambia, households where the head was chronically ill reduced the area of land they cultivated by 53 per cent, compared to households without a chronically ill adult, resulting in reduced crop production and lower food availability.[8]

In Welkom, South Africa, the average monthly per capita income in households where at least one person was known to be HIV-positive was less than half the income of non-affected households (335 rands versus 741 rands).[9]

The costs of treating illnesses caused by HIV/AIDS place a huge economic burden on families. Studies in urban households in Côte d'Ivoire show that when a family member has HIV/AIDS, the household spends four times as much on health care as unaffected households. This extra expenditure is particularly onerous because household income was cut by more than half because of working days lost to illness.[10]

Even after death, funeral expenses contribute to the toll exacted by HIV/AIDS. A study in four provinces in South Africa found that households with a HIV/AIDS-related death in the past year spent an average of one third of their annual income on funerals.[11]

WORSENING POVERTY

Households with orphans are more likely to become poorer (*see Box 2-2*). This is primarily because of the increased 'dependency ratio', meaning that in these households the income of fewer earning adults is sustaining more dependents (*see Table 2-2*). In the worst-affected countries in sub-Saharan Africa, households with orphans have higher dependency ratios than those with children but no orphans (*see Box 2-3*).

TABLE 2-2: DEPENDENCY RATIOS IN UGANDA

Orphan households have more dependants and lower income

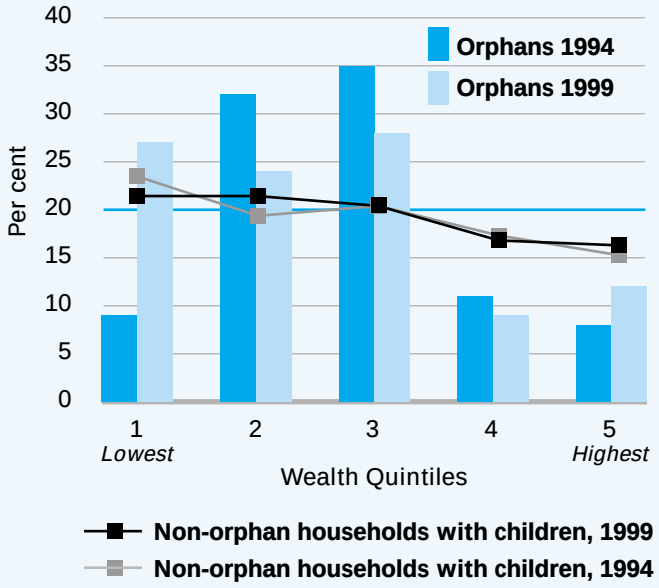
	Orphan households	Non-orphan households
Household size	6.8	4.9
Number of children *(17 years and below)*	4.3	2.7
Dependency ratio	2	1.4
Per capita income *(Uganda shillings)*	352,741	459,315

Source: Wakhweya et al., 2002.[12]

BOX 2-2: THE WEALTH INDEX

The 'wealth index' is a measure of economic status derived from information on ownership of assets and housing characteristics gathered in recent household surveys. The index is constructed according to the following: whether any household member owns a radio, television, refrigerator, bicycle, motorcycle or car; whether electricity is used; the source of drinking water; the type of sanitation; the number of rooms in the home; and the type of materials used in construction. By dividing populations into economic quintiles, it is possible to assess whether orphans are distributed among the different income quintiles in the same manner as other children.

FIGURE 2-2: IMPACT INCREASINGLY FELT BY POOREST HOUSEHOLDS



Source: Bicego, G., S. Rutstein and K. Johnson, 'Dimensions of the emerging orphan crisis in sub-Saharan Africa', *Social Science & Medicine,* vol. 56, no. 6, March 2003, pp. 1235-1247.

The figure illustrates that non-orphans are distributed in households as expected based on fertility patterns, with slightly more children in poorer households. Conversely, the distribution of orphans has an inverted 'U' shape in 1994, with orphans being overrepresented in the second and third quintiles, and underrepresented in the poorest and wealthiest quintiles. By 1999, orphans in Zimbabwe were more concentrated at the lower end of the wealth index. Their representation in the poorest quintile increased by 12 percentage points; their underrepresentation in the wealthiest two quintiles remained approximately the same. If the pattern in 1994 represents pre-HIV/AIDS conditions (i.e. before increases in adult mortality), where the poorest households do not typically absorb orphans because of their relative poverty, the 1999 findings may signal a strain in the way communities deal with orphans as the impact of HIV/AIDS is felt more widely.

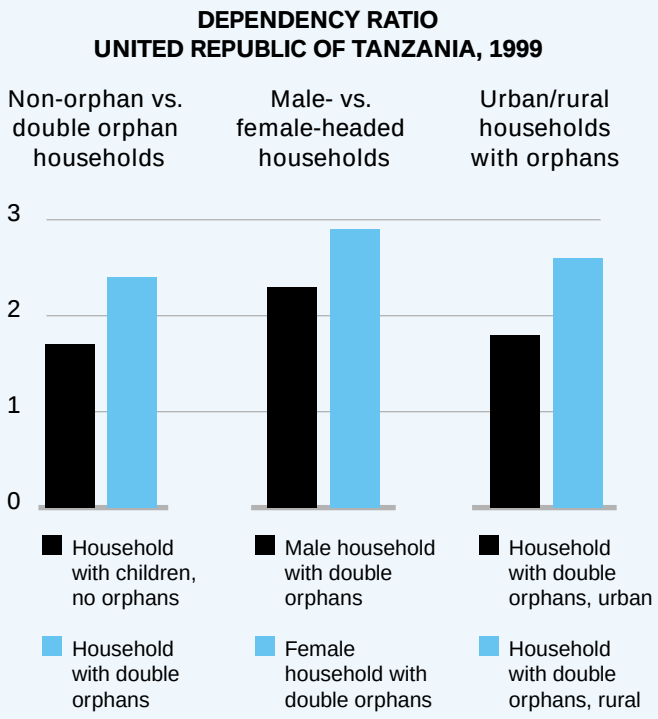
Many households with orphans reduce the area of land they cultivate and grow crops that are less labour intensive but less nutritious. A United Nations Food and Agricultural Organization study in Uganda found that widows were working two to four hours more each day to make up for cuts in labour and income resulting from their husband's death, and that older children were also working longer hours to help their mothers.[14] Other strategies used in the attempt to make ends meet include selling household goods, land or other assets and borrowing from extended family and friends. These strategies, however, are unsustainable.

During 2002, in rural Zimbabwe households with orphans earned on average 31 per cent less than households without orphans.[15] Female-headed households are the most severely affected. In a 2001 study of female-headed households with orphans in Mwanza, United Republic of Tanzania, over two thirds were living on less than $1 per day.[16] A survey in 2002 of four Zambian districts found that the average income of female-headed households with orphans was only around half that of male-headed households with orphans.[17]

BOX 2-3: THE DEPENDENCY RATIO

The mean dependency ratios (ratio of children aged 0-14 and elderly aged 60 and above, to prime-age adults aged 15-59) indicate the number of people in a household who must rely on each adult for food security and livelihoods. A ratio of 1.6 means that for each adult, there are 1.6 people who must be supported. The dependency ratios for households that are taking care of orphans are higher compared to other households with children. Female-headed households with orphans in rural areas have the highest dependency ratios.[13]

FIGURE 2-3: ADULTS IN ORPHAN HOUSEHOLDS HAVE MORE DEPENDENTS



Source: Measure DHS, 1999.

MEETING BASIC NEEDS

Whether households with orphans will be able to meet basic needs depends largely on their circumstances. Some families may still have sufficient income to cope; the extended family or community may support others. But a large and increasing share of families are impoverished to the point where basic needs go unmet.

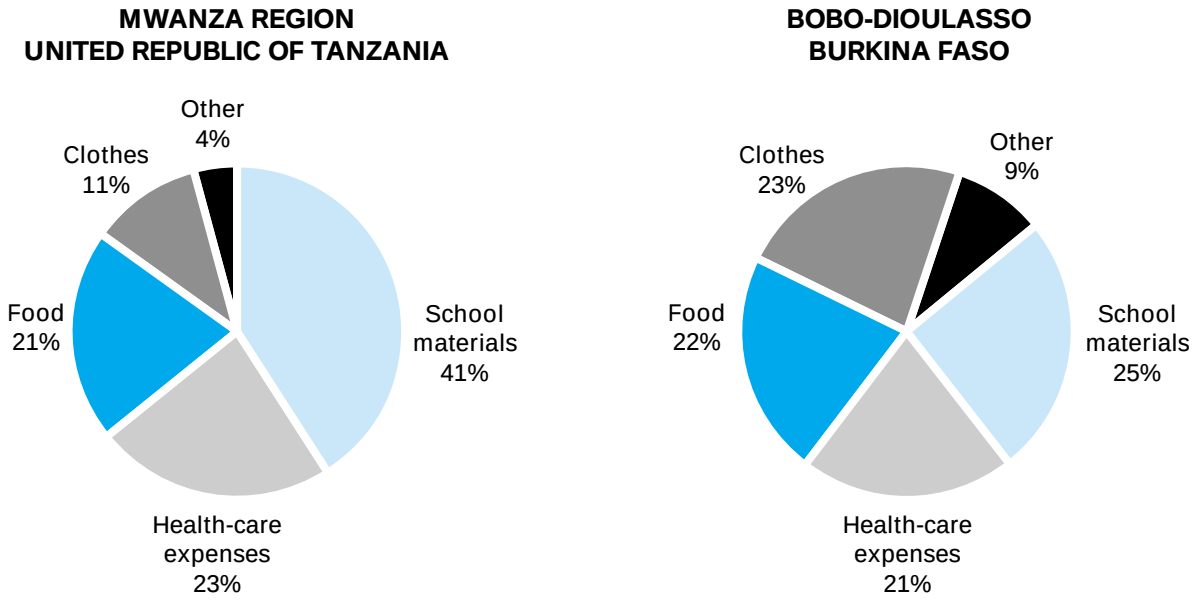
The most common unmet needs are education, food, medical care and clothes (*see Figure 2-4*). A survey of over 400 households with orphans in the Mwanza region of the United Republic of Tanzania reported that almost 40 per cent could not cover even basic expenses. The most common difficulty was to cover school fees, including those for materials and uniforms.[18] Recent surveys in eight other countries report similar findings.

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 grabbed by other family members, or, in some cases, by other members of the community (*see Box 2-4*). In a survey in two districts of Uganda of families affected by HIV/AIDS, half the adults identified property-grabbing as a problem.[19]

Widows are most likely to have their property seized. At least 1 in 4 widows in the Uganda survey said they had lost property when their partner died, compared with 1 in 14 widowers. Even where the inheritance rights of women and children are spelled out in law, such rights are difficult to claim and are poorly enforced.

FIGURE 2-4: MOST IMMEDIATE NEEDS THAT HOUSEHOLDS WITH ORPHANS CANNOT MEET



Source: Whitehouse, A., *A situation analysis of orphans and other vulnerable children in Mwanza Region, Tanzania*, Dar-es-Salaam, Catholic Relief Services, Dar es Salaam, and Kivulini Women's Rights Organisation, Mwanza, Tanzania, 2002; *Needs Assessment of Orphans and Vulnerable Children in AIDS affected areas, in Bobo-Dioulasso, Burkina Faso*, Axios, 2001.

FAMILIES UNDER PRESSURE

The extended family system will continue to be the central social welfare mechanism in most parts of sub-Saharan Africa. Already overstressed and often already overwhelmed, these networks will face ever-greater burdens as the number of orphans spirals over the coming decade.

These intense pressures come at a time when the very nature of the extended family is rapidly evolving. With modernization, the extension of cash economies and labour migration, extended family relationships have been weakened. More people live in nuclear units with weaker ties to other branches of the family. This is particularly true of families in cities.[20, 21]

HIV/AIDS has had a negative impact on the extended family system. The powerful stigma and discrimination related to the disease can result in the isolation of infected family members. In Côte d'Ivoire, extended families find it harder to arrange for foster-parents for children orphaned by HIV/AIDS than for children orphaned by other causes.[22] A survey in Senegal, where HIV prevalence is relatively low, indicates that families with one HIV-positive person are less likely to have other members of the extended family in the household.[23]

The pressures of caring for increasing numbers of orphaned children can affect whole branches of an extended family. Family units have to consider whether they have the capacity to absorb and care for orphans. Rather than automatically accepting extra children, family members may argue that others are better placed to care for them. When all else fails, grandparents typically shoulder the responsibility, often bringing together children from different parts of the extended family.

BOX 2-4: CHALLENGES TO WILL WRITING IN UGANDA

- The widespread belief that making a will and "preparing for death" will cause death.
- Traditionally, property is distributed only posthumously, by clan leaders.
- Traditionally, women and young children do not own or inherit property.
- Poor knowledge and enforcement of laws protecting women and children.
- Low literacy rates.
- Limited experience with legal issues among non-governmental organizations in rural areas.

Source: *Succession planning in Uganda: Early outreach for AIDS-affected children and their families,* Population Council Horizons, Washington, D.C., 2003.

Families that take in children may find themselves more isolated. In the United Republic of Tanzania, caretakers have reported that because poverty is so pervasive they cannot rely on support from the extended family or from friends or neighbours. Increasingly, the common thought is "everyone has to carry their own burden."[24] In Nyanza Province, western Kenya, the high number of orphans has overwhelmed the traditional mechanisms for orphan care, based on patrilineal kinship ties. A study in 2001 found that 28 per cent of orphans were looked after by 'culturally inappropriate' caregivers, such as matrilineal kin or strangers. Furthermore, many of the caretakers were themselves not fully capable, due to ill health or old age.[25]

Finally, there is the danger that caregivers of orphans themselves will succumb to HIV/AIDS, leaving children to be 'orphaned' more than once. Research among guardians of orphans who knew their HIV status in Uganda revealed that one third were themselves HIV-positive.[26] As a result, the number of potential caregivers is steadily contracting.

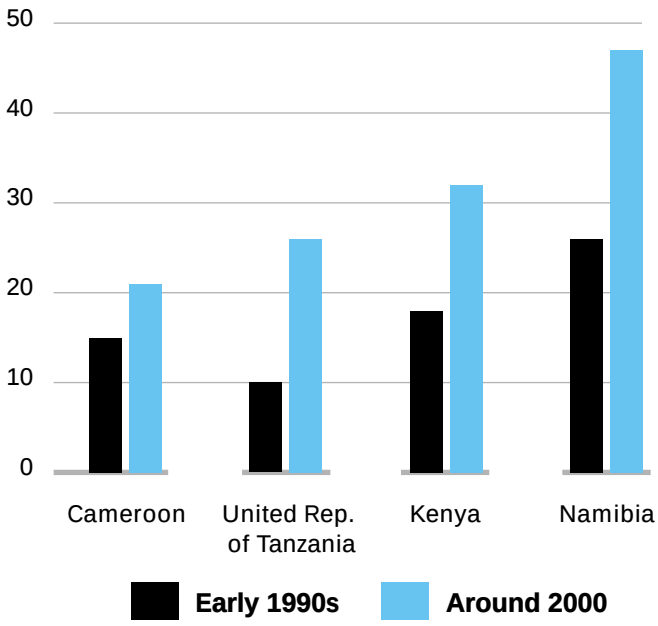
To say that orphanhood through HIV/AIDS has overwhelmed the capacity of extended families, or that it is stretching them to a breaking point, suggests some single cataclysmic event. The picture is more complex. It is clear, for example, that there is no fixed outer limit to the concept of extended family: The sense of responsibility can expand or contract. What appears to be happening under the pressure of the orphan crisis is that relationships are changing. Families are splitting and reforming in different ways in response to more stressful circumstances. Many countries are seeing an increase in certain types of households and living arrangements:[27]

Female-headed households

Households headed by women are more likely to take responsibility for orphans. Not only are women more likely to look after their own children, they are also more prepared to take care of other orphans (*see Figure 2-5*). Female-headed households generally assume care of more orphans than male-headed households[28] (*see Box 2-5*). As a result, female-headed households with orphans have the highest dependency ratios.

FIGURE 2-5: THE BURDEN FALLS ON FEMALE-HEADED HOUSEHOLDS

% of children who lost their mother, living in a female-headed household, 1993-2000



Sources: UNICEF-MICS, Measure DHS, 1992-2000.

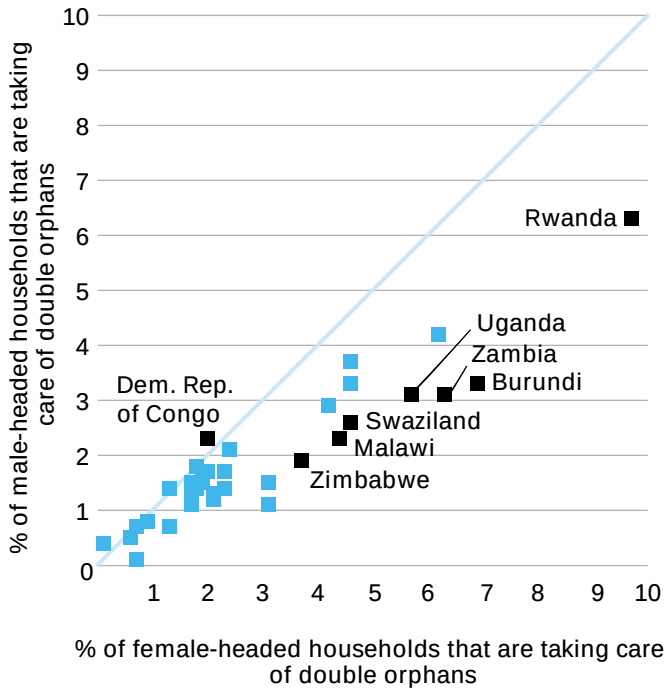
BOX 2-5: INCREASED BURDEN ON FEMALE-HEADED HOUSEHOLDS

Figure 2-6 represents the proportion of female- and male-headed households in each country that are taking care of children who lost both parents. Each square represents one country. If the burden of responsibility for double orphans were divided equally, the points would fall on the diagonal line. However, data from 34 countries show that the households headed by women are much more likely to care for double orphans (right-bottom area of the graph, under the diagonal line). In Zambia, 6 per cent of female-headed households take care of double orphans, in contrast to 3 per cent of male-headed households. The burden on female-headed households is the highest, most so in the countries with the highest proportions of orphans.

Counting only households that actually do assume responsibility for orphans, Figure 2-7 shows the average number of double orphans taken in by female- and male-headed households, per household. If both types of households assumed responsibility for the same number of orphans, the points would fall on the diagonal line. However, the majority of points are in the bottom-right area under the diagonal line, which means that in the majority of countries, female-headed households take in significantly more double orphans than do male-headed households. For example, in South Africa, there are on average two double orphans in each female-headed household, while in male-headed households the average is slightly above one.

FIGURE 2-6: WOMEN ARE MORE LIKELY TO TAKE RESPONSIBILITY FOR ORPHANS

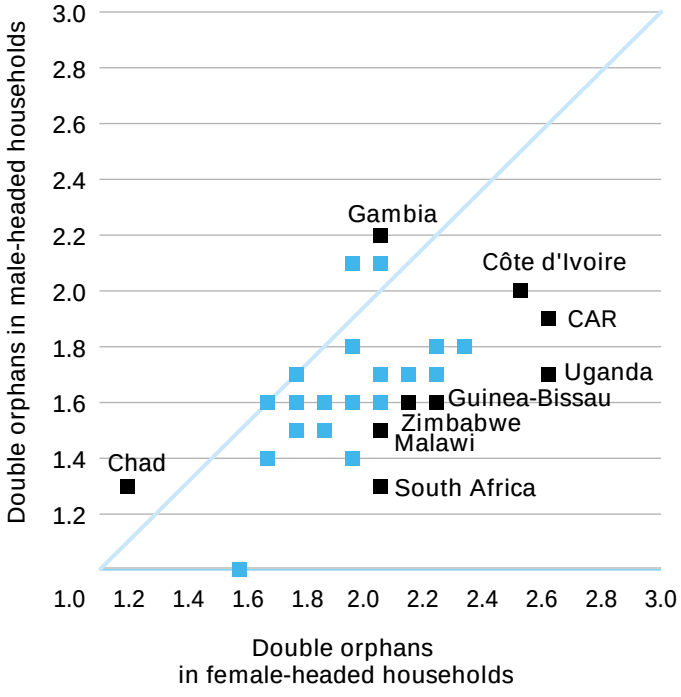
Proportion of female- and male-headed households taking care of double orphan/s



Sources: UNICEF-MICS, Measure DHS, 1997-2002.

FIGURE 2-7: FEMALE-HEADED HOUSEHOLDS TAKE IN MORE ORPHANS THAN MALE-HEADED HOUSEHOLDS

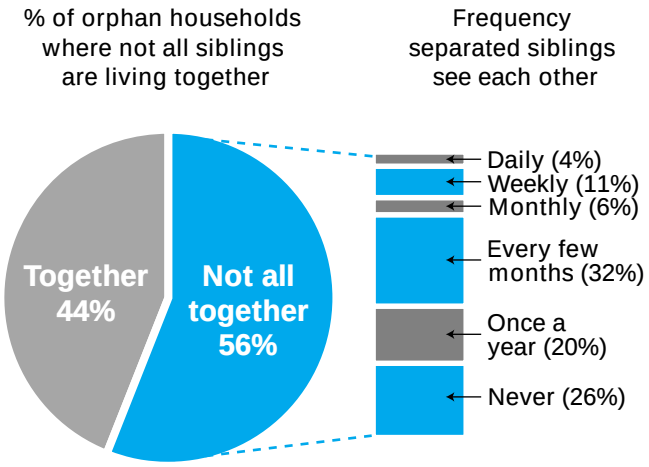
Average number of double orphans cared for by female- and male-headed households



Sources: UNICEF-MICS, Measure DHS, 1997-2002.

FIGURE 2-8: ORPHANS ARE LIKELY TO BE SEPARATED FROM THEIR SIBLINGS

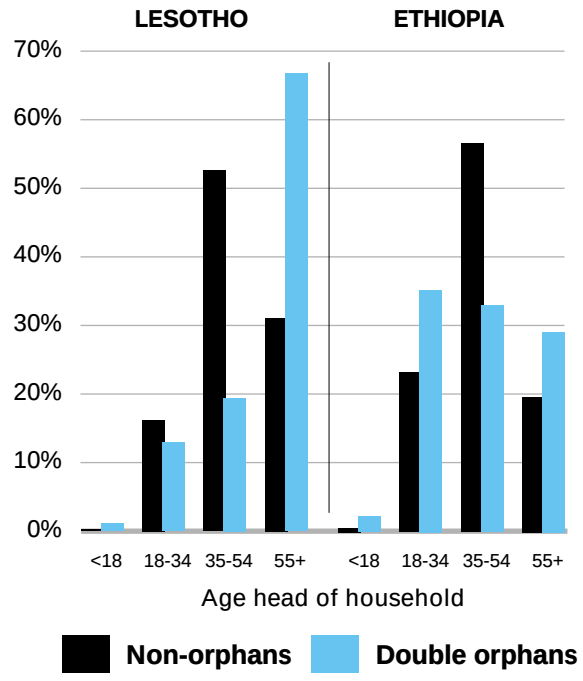
Four districts in Zambia, 2001



Source: *Results of the Orphans and Vulnerable Children Head of Household Baseline Survey in Four Districts in Zambia,* USAID, SCOPE-OVC, Zambia, and Family Health International, draft, 2002.

FIGURE 2-9: OLDER AND YOUNGER FAMILY MEMBERS ARE CARING FOR ORPHANS

Age of head of household, Lesotho and Ethiopia, 2000



Sources: Lesotho-MICS, 2000; Ethiopia Measure DHS, 2000.

Separation of siblings

Orphaned siblings are often placed in different homes as a way of distributing the burden of care.[29] In Zambia, nearly 60 per cent of a sample of orphaned children had been separated; nearly four out of five saw their brothers and sisters less than once a month[30] (*see Figure 2-8*).

Grandparent-headed households

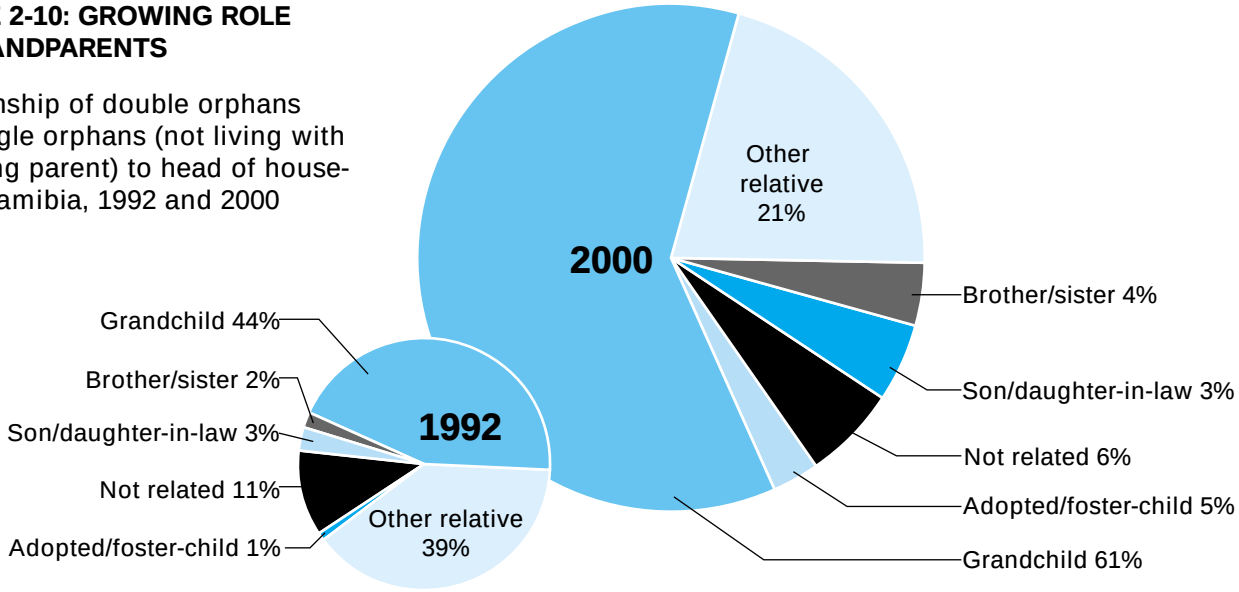
As a result of the increasing number of orphans and the shrinking number of potential caregivers, orphans tend to live in bigger households headed by much older relatives[31] (*see Figure 2-9*). While grandparents already have an important role in the care of orphans, there is a notable increase in their burden. Figure 2-10 illustrates the change in the proportion of orphans looked after by grandparents in Namibia between 1992 and 2000. The difference in the size of the charts corresponds to the increase in the number of orphans, while the divisions show that the proportion being taken care of by grandparents rose from 44 per cent to 61 per cent, probably because many people in the 'other relatives' category are themselves dying or dead from HIV/AIDS.[32]

Youth- and child-headed households

There are still relatively few households – less than 1 per cent in most countries – headed by children under the age of 18.[33] In many more households older siblings (18 years or older) who have been caring for younger brothers and sisters during their parents' illness may carry on as the head of household. Some of these households are only temporary until it is decided which relative should take responsibility for the orphaned children. Even if orphans stay in households headed by an adolescent or young adult for longer periods, they may also be watched over by members of the extended family in the form of clustered foster care.[34]

FIGURE 2-10: GROWING ROLE OF GRANDPARENTS

Relationship of double orphans and single orphans (not living with surviving parent) to head of household, Namibia, 1992 and 2000

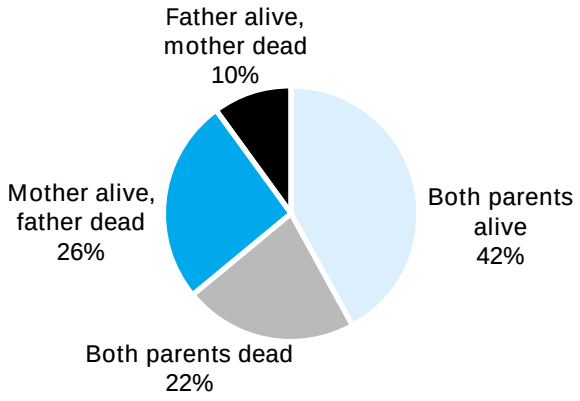


Sources: UNICEF-MICS, Measure DHS, 1992 and 2000.

Children living on the street

A number of children find themselves without family support, either because the initial solution was unsustainable or because they had no options available. Many end up living on the streets. There are no meaningful estimates of the numbers or proportions of children orphaned by HIV/AIDS who live on the street, but there are clear indications that the overall numbers of street children are rising in many sub-Saharan cities, most likely because of the increasing number of children orphaned by HIV/AIDS. In Brazzaville, Congo, almost one half of street children are orphans.[35] In Lusaka, Zambia, the majority of children living on the street are orphans[36] (*see Figure 2-11*).

FIGURE 2-11: MOST CHILDREN LIVING ON THE STREET IN LUSAKA, ZAMBIA ARE ORPHANS



Source: *Rapid Assessment of Street Children in Lusaka,* Concern/UNICEF, March 2002.

3 THE IMPACT OF ORPHANING ON CHILDREN

Children orphaned by HIV/AIDS are disadvantaged in numerous and often devastating ways. In addition to the trauma of witnessing the sickness and death of one or both parents, they are likely to be poorer and less healthy than non-orphans. They are more likely to suffer damage to their cognitive and emotional development, to have less access to education, and to be subjected to the worst forms of child labour. Survival strategies, such as eating less and selling assets, are not lasting solutions but instead intensify the vulnerability of both adults and children.

HIV/AIDS TAKES A TOLL ON CHILDREN LONG BEFORE THE DEATH OF A PARENT

When parents fall sick, particularly in poor families, children come under intense stress that may continue, in different ways, for the rest of their childhood. They often take on a heavy burden of nursing for ailing parents, and may miss or drop out of school. Added to this is the constant worry about their parents' well-being and the family's future.

In a survey in Uganda of older children of people living with HIV/AIDS, 26 per cent said that their attendance at school declined, citing the need to stay at home to care for sick parents, increased household responsibilities and falling household incomes.[37]

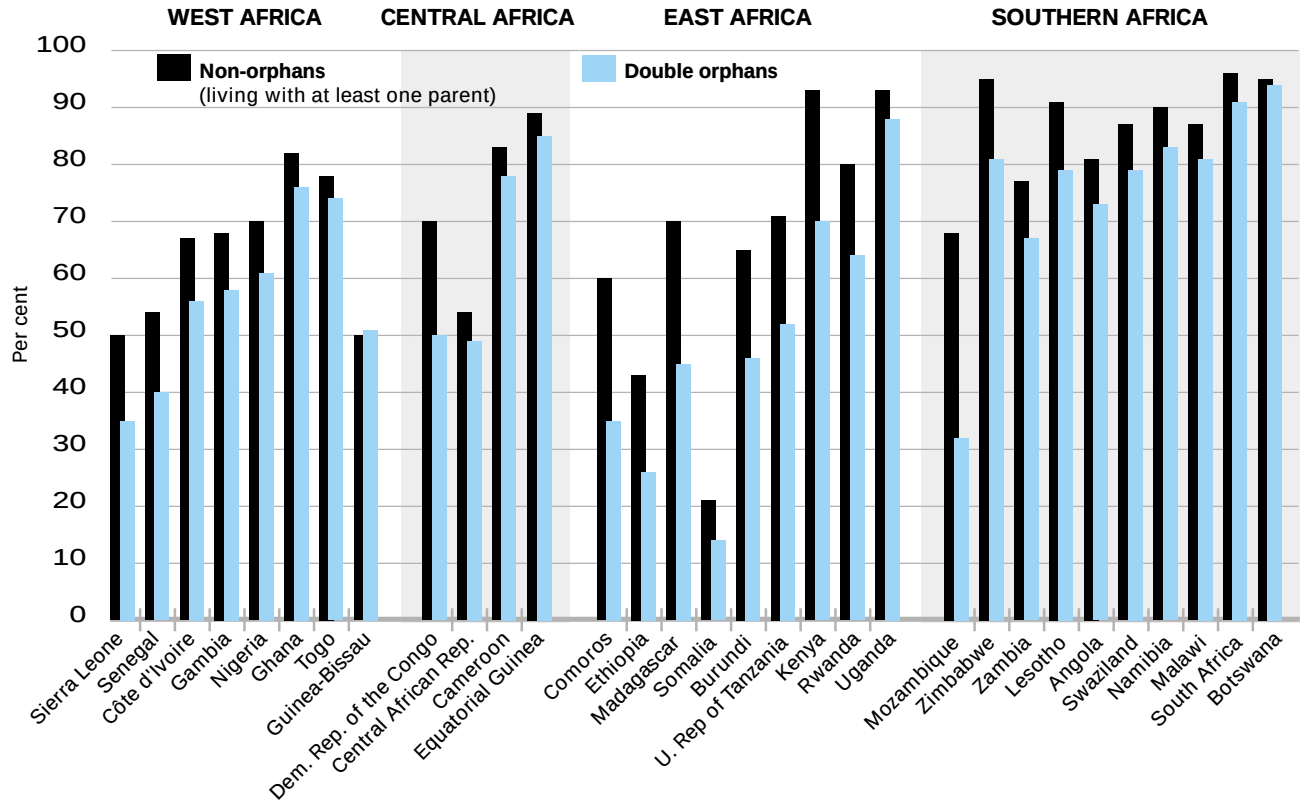
EDUCATION

Orphans are less likely to be in school and more likely to fall behind or drop out, compromising their abilities and prospects.

The hazards are greatest for double orphans. In the United Republic of Tanzania, the school attendance rate for non-orphans who live with at least one parent is 71 per cent but for double orphans it is only 52 per cent. (In data from household surveys, children living outside household or family care settings – children living on the street and in institutions – are not included. The data thus probably underestimates the impact of orphanhood on child well-being. Future data collection efforts need to take this into account.) This is illustrated for a selection of countries in Figure 3-1, which also shows that the contrast between the

FIGURE 3-1: ORPHANS ARE LESS LIKELY TO ATTEND SCHOOL

% of orphans and non-orphans in school



Sources: UNICEF-MICS, Measure DHS, 1997-2001.

attendance of orphans and non-orphans is greatest in countries where attendance is already low.[38]

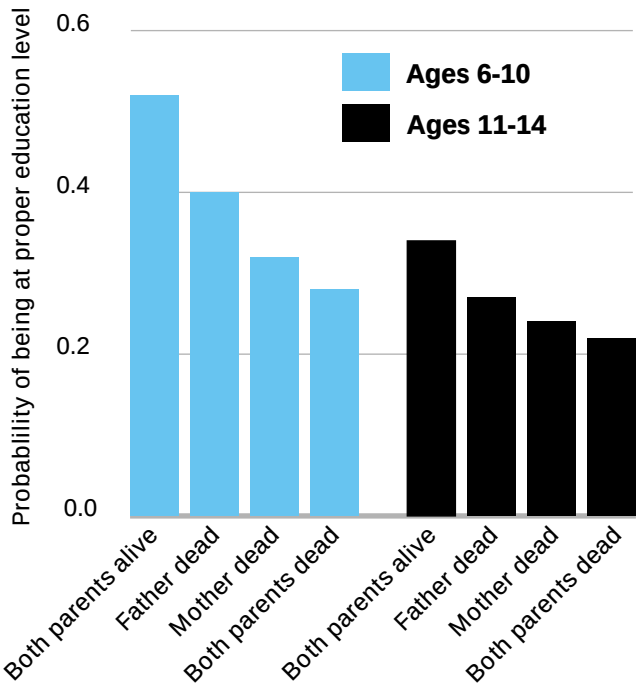
Poverty is not the sole determinant of an orphan's school attendance. Studies show that the critical determinant is the nature of the family relationship between the orphan and the decision-making adult in the family or household; the closer the tie, the greater the chance that the child will go to school. Children living in households headed by non-parental relatives fare worse than those living with parental heads, and those living in households headed by non-relatives fare worse still. Much of the gap between the schooling of orphans and non-orphans is explained by the greater likelihood that orphans will live with more distant relatives or unrelated caregivers.[39]

Orphans are also more likely to have their schooling interrupted. A study in Uganda found that while 14 per cent of primary-school pupils had at some point missed an entire term, 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 orphans missing a term.[40]

The same survey found that that more than a quarter of orphans said that their school performance had deteriorated, partly because of interruptions, and partly because of stress. Figure 3-2 combines survey data for Kenya, the United Republic of Tanzania and Zimbabwe, for age groups that correspond roughly to primary and secondary education.[41] This shows that even for non-orphaned children, the probability of being in the appropriate grade is very low – about half of primary schoolchildren and a third of secondary schoolchildren are at the appropriate grade for their age. However, the odds are even lower for children who have lost one parent, and lowest of all for those who have lost both parents.

FIGURE 3-2: ORPHANS ARE LESS LIKELY TO BE AT THE PROPER EDUCATION LEVEL

Probability of being at the proper education level in Kenya, the United Republic of Tanzania and Zimbabwe, 1999



Source: Bicego, G., S. Rutstein and K. Johnson, 'Dimensions of the emerging orphan crisis in sub-Saharan Africa', *Social Science & Medicine,* vol. 56, no. 6, March 2003, pp. 1235-1247.

The impact of HIV/AIDS on the entire education system – seen primarily in the deterioration of educational services and the deaths of teachers – adversely affects orphans, as it does all children. In Zambia, where 40 per cent of teachers are HIV-positive, they are dying at a faster rate than they can be replaced by new graduates.[42]

THE IMPACT ON NUTRITION AND HEALTH AND SURVIVAL PROSPECTS

In HIV/AIDS-affected households lacking community support, food consumption can drop by more than 40 per cent, putting children at higher risk of malnutrition and stunting.[43]

Children orphaned by HIV/AIDS face a higher risk of malnutrition and stunting, as seen through sub-national studies of the impact of an adult death on child nutrition. (It is difficult to judge from national household surveys the extent to which orphans are becoming malnourished because the sample sizes of orphans under five are quite small.) Research in the United Republic of Tanzania shows that the loss of either parent and the death of other adults in the household will worsen a child's height for age and increase stunting. Both maternal and paternal orphans are much more likely to be short for their age than non-orphans. In non-poor families, the loss of a parent raises stunting to levels found among children in poor families with living parents. In poor families, orphaning raises stunting levels even higher.[44]

A recent study in western Kenya found that orphans appear to be at a disadvantage compared to non-orphans using the weight-for-height measure.[45] The 2003 nutritional survey for Zimbabwe, which weighed and measured nearly 42,000 children, including 1,760 orphans, shows that a higher percentage of orphans are malnourished than non-orphans.[46] The risk is high that these children will never develop to their full physical and intellectual capacity.[47]

An analysis of a cohort study in south-west Uganda, using data from 1989 to 2000, showed that the loss of a mother was associated with an increase in child mortality during the first year after her death, including among orphans who were HIV-negative.[48]

Orphans' nutritional, health and survival prospects are also worsened by the increasingly weakened state of health-care services, which have been overwhelmed by the HIV/AIDS onslaught in many sub-Saharan African countries.

CHILD LABOUR

Sub-Saharan Africa already has a higher proportion of children working than any other region, with 29 per cent of children aged 5 to 14 economically active.[49] As their parents fall progressively sick from HIV/AIDS, children generally must take on an increasing number of responsibilities. Girls take responsibility for more household chores. Boys often take over agricultural tasks or bring in income by working as street vendors.

Household surveys show little difference in the proportions of working non-orphaned and orphaned children. But this is possibly underreporting resulting from the methodology used to interview caretakers. The surveys also do not include children outside of family care.[50]

A different approach to investigating the extent to which orphaned children are working is through surveys of working children. Rapid assessments carried out by the International Labour Organization to investigate the situation of working children found that orphaned children are much more likely than non-orphans to be working in commercial agriculture, domestic service, commercial sex and as street vendors.[51] In most professions, the majority of the children were orphans who had lost their parents to HIV/AIDS. In Zambia, HIV/AIDS was estimated to have increased the child labour force by between 23 per cent and 30 per cent.[52] The assessments indicate strong links between HIV/AIDS, orphanhood and the worst forms of child labour (*see Box 3-1*).

BOX 3-1: ORPHANS AND THE WORST FORMS OF CHILD LABOUR

Domestic workers

In Ethiopia, the working and living conditions of child domestic labourers in Addis Ababa were studied in 2002 using a rapid-assessment method. More than three quarters of the domestic workers were orphans. Eighty per cent of the child domestics interviewed did not have the right to voluntarily quit their jobs. Most children in the study population (65 per cent) were enrolled either in a literacy class or in formal education while the remainder lacked any schooling opportunities. A large number could not study or do their homework at home, and were often late or absent from school. They had no time or means for recreation and leisure as they worked on average more than 11 hours per day, seven days a week. Most were not allowed to play with the children of their employers, watch television or listen to the radio, which curtailed their chances of obtaining vital information on topics such as HIV/AIDS.[53]

Quarrying

Working conditions for children in this occupation are even worse than for adults. Children collect, crush, haul and load stones for construction. In some cases, children participate in actual mining, and are often involved in accidents. A rapid assessment in four mining areas in the United Republic of Tanzania found that the children involved in the mines were between 7 and 17 years old. Among children working part-time, 7 per cent were orphans, while 38 per cent of children working full-time were orphans.[54]

Child prostitution

A rapid assessment in Zambia in 2002 found that the average age of children engaged in prostitution was 15. About half of them (47 per cent) were double orphans and 24 per cent single orphans. The need to earn money was the main reason given for entering into prostitution. Their daily earnings ranged from 3,000 to 33,400 kwachas (about $0.63 to $7); the majority, especially younger ones, rarely made as much as 10,000 kwachas ($2.10). On average, the children slept with three to four clients each day.[55]

PSYCHOSOCIAL IMPACT

Children whose parents are ill because of HIV/AIDS or those who have been orphaned by the disease face stigma and discrimination. They may be rejected by their friends and schoolmates, as well as at health centres. As one 16-year-old South African girl put it: "They treat you badly. You don't feel like walking in the street, they give you names. They whisper when you pass. They take it that when one person in the house is sick, all of you in that house are sick."[56]

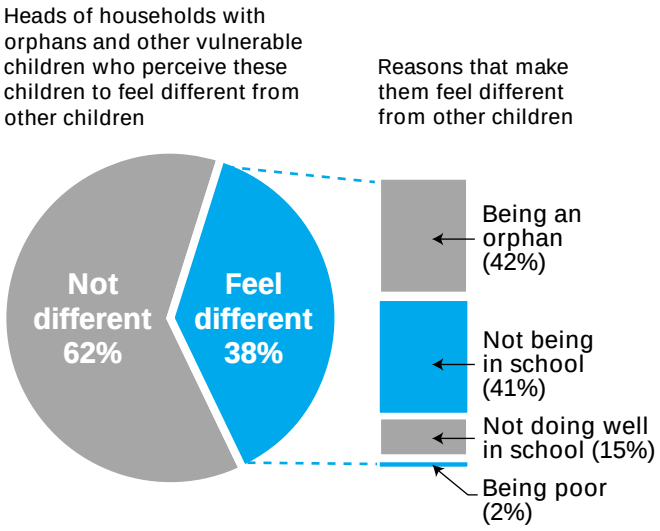
Psychosocial trauma can continue even when orphans move to foster families. They may be treated as second-class family members – discriminated against in the allocation of food, perhaps, or in the distribution of work. Orphans in Zambia have reported a lack of love and a feeling of being excluded, as well as outright discrimination.[57]

Separation from siblings is another source of trauma. Even older children are distressed by separation. Of a group of older orphans in Uganda separated from their siblings, 44 per cent said that they felt sad about it and 17 per cent said it made them feel isolated.[58]

Orphans can feel even more isolated when another of the routines of normal daily life, school attendance, is broken. A survey in four districts of Zambia asked the heads of households with orphans whether they thought the orphans felt different from other children. Over a third answered that orphaned children did feel different, and one of the most important causes was not being in school (*see Figure 3-3*).

FIGURE 3-3: SCHOOL IS CRUCIAL TO THE WELL-BEING OF ORPHANS

Four districts in Zambia, 2001



Source: *Results of the Orphans and Vulnerable Children Head of Household Baseline Survey in Four Districts in Zambia,* USAID, SCOPE-OVC, Zambia, and Family Health International, draft, 2002.

BOX 3-2: DISTRESS SIGNALS

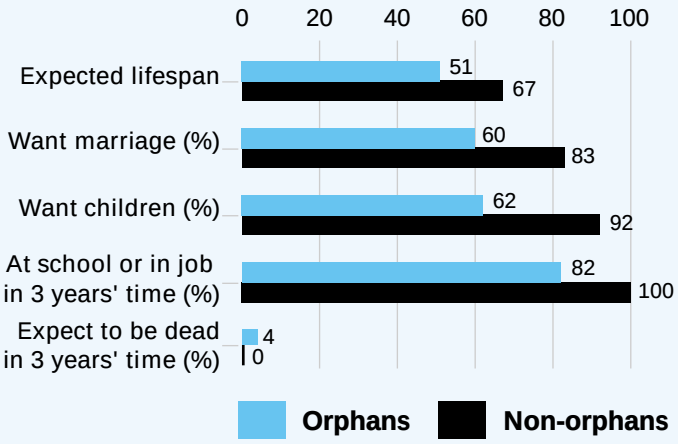
Children react to stress in different ways. Many will find it difficult to talk about their worries. They may internalize their feelings and stress, believing that they are abnormal in some way, and suffer from low self-esteem, depression or anxiety. Or they can become aggressive, abuse drugs and alcohol, or engage in anti-social behaviour.

- A study in Brazzaville, Congo, of 354 children who had lost one or more parents to HIV/AIDS, found that 71 were suffering from some kind of psychosocial problem. Of these, 39 per cent were affected by 'post-traumatic stress'. Another 27 per cent were suffering from problems of 'adaptation', which could take the form of running away from school or home or various types of offensive or hyperkinetic behaviour. The final 34 per cent had 'affective' problems: depression, anxiety, irritability, or feelings of rivalry.[59]

- A study in the suburbs of Dar es Salaam, United Republic of Tanzania, also reported significant problems among 41 children aged 10 to 14 who had been orphaned by HIV/AIDS. In this group, only eight were still living with the surviving parent. The orphans were asked a series of questions that corresponded 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 somewhat more likely to be affected than boys.[60]

FIGURE 3-4: ORPHANS ARE LESS OPTIMISTIC ABOUT THEIR FUTURE

The psychological effect of orphanhood
Rakai, Uganda, 1997



Source: Sengendo, J. and J. Nambi, 'The Psychological Effect of Orphanhood: A study of orphans in Rakai district' [Uganda], in *Health Transition Review*, vol. 7 (suppl.), 1997, pp. 105-124.

- A study in the Rakai District of Uganda looked at the effect of orphanhood on 1,993 children and asked both orphaned and non-orphan children about their expectations for the future.[61] Some of the findings are illustrated in Figure 3-4, indicating that orphaned children are less optimistic about their future: They not only expected to have shorter lives but also were less likely to want to be married or to have children.

“They treat you badly. You don’t feel like walking in the street, they give you names. They whisper when you pass. They take it that when one person in the house is sick, all of you in that house are sick.”

A 16-year-old girl, South Africa[56]

4 SUPPORTING AFRICA'S ORPHANS

The orphan crisis has grave implications for the welfare of both Africa's children and Africa's societies. This report argues that the course of the crisis can be altered by providing immediate support to families and communities to ensure that all of Africa's orphans have a secure and healthy childhood. Offering children free basic education, giving them safe and viable options for earning a living, and providing families with financial and other assistance can mean that many orphans who might otherwise be separated from their families are able to remain with them. The family – whether the head of household is a widowed parent, elderly grandparent, or a young person – represents the single most important factor in building a protective environment for children who have lost their parents to HIV/AIDS or to any other cause.

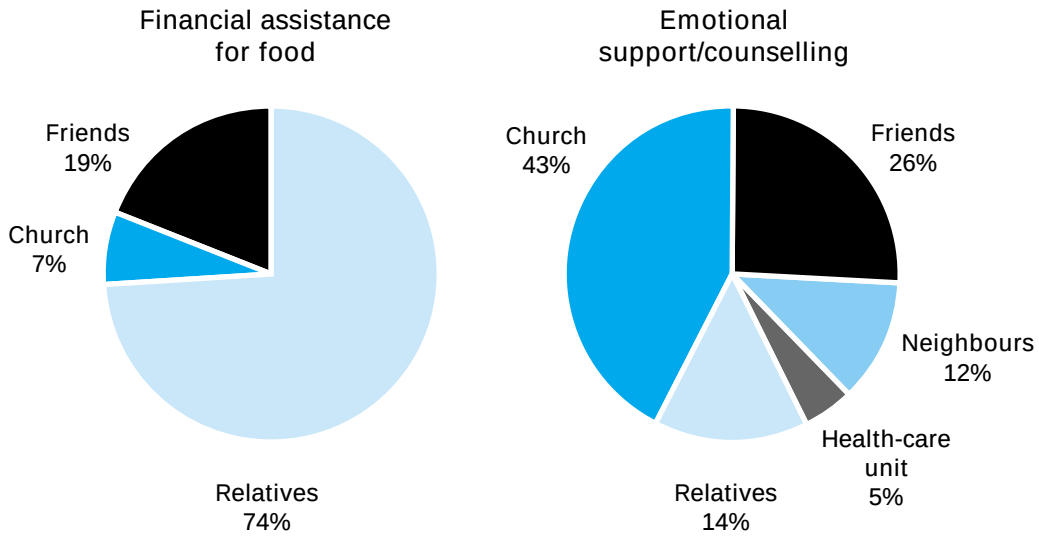
NATIONAL RESPONSES

Governments in sub-Saharan Africa have so far been slow to respond to the orphan crisis, for many reasons. A host of immediate challenges compete for their attention and for scarce public funds. Their reluctance also often reflects a lingering unease about HIV/AIDS itself; many policy makers hesitate to take action against a disease so closely associated with private sexual behaviour. Complicating matters further, the orphan crisis is not especially visible, because these millions of children are dispersed over many families, in communities where the hardships of individual children are lost from sight. Some orphans may be more visible, particularly those who are forced onto the streets to work and live, but even they simply add to the many children, orphaned or not, who struggle to make a living on African city streets.

Finally, and perhaps most significantly, governmental action has been slow to emerge because families and communities have shouldered most of the strain. African traditions of community cooperation have relieved the pressure on governments and national institutions. Surveys in urban areas of Zambia show that only around one third of households with orphans were receiving any kind of support.[62] This included emotional support and counselling and financial assistance for food, most of which came from relatives and friends (*see Figure 4-1*).

FIGURE 4-1: COMMUNITIES ARE AT THE FOREFRONT OF CARING FOR VULNERABLE HOUSEHOLDS

Providers of support to households that received assistance in four districts in Zambia, 2001



Source: *Results of the Orphans and Vulnerable Children Head of Household Baseline Survey in Four Districts in Zambia,* USAID, SCOPE-OVC, Zambia, and Family Health International, draft, 2002.

BOX 4-1: INTERNATIONAL COMMITMENTS

The commitments made at the 2001 United Nations General Assembly Special Session on HIV/AIDS and reiterated at the Special Session on Children in 2002 include:

By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa.

THE INTERNATIONAL RESPONSE

At the international level, the global community, through the United Nations, has emphasized the seriousness of the orphan crisis in sub-Saharan Africa and the urgent need for government action. In June 2001, the United Nations General Assembly Special Session on HIV/AIDS paid special attention to children orphaned and made vulnerable by HIV/AIDS and set specific goals for the subsequent five years in its Declaration of Commitment. These goals – establishing the importance of developing national strategies, ensuring non-discrimination, mobilizing resources, and building international cooperation (*see Box 4-1*) – were reiterated in May 2002 at the United Nations General Assembly Special Session on Children in its outcome document, 'A World Fit for Children'.

At the close of 2003, of the 40 sub-Saharan countries with generalized epidemics (1 per cent or higher HIV in general adult population) only 6 (15 per cent) had a national policy on orphans and other vulnerable children. Eight countries (20 per cent) were in the process of preparing these plans. Another 26 countries (65 per cent) have no national policy in place.

BOX 4-2: GUIDING HUMAN RIGHTS PRINCIPLES

The Convention on the Rights of the Child and other relevant human rights instruments guide all actions in support of children, in the recognition that human development is the realization of a set of universally applicable, inalienable rights. This approach recognizes children as rights holders and not merely as recipients of services or beneficiaries of protective measures. The Convention affirms that governments have the principal responsibility to ensure that children's rights are met and protected. It recognizes the essential role played by parents, family and legal guardians who, as the primary caregivers, ensure the well-being and development of the child. The State is required to provide assistance to parents and legal guardians to enhance their capacity as caregivers. The Convention also specifies the responsibility of States to provide special protection for a child who is deprived of his or her family environment. The underlying values of the Convention, described below, serve as a constant reference for implementing and monitoring all efforts to fulfil and protect children's rights.

The best interests of the child

In each decision affecting the child, the best interests of the child must be a primary consideration. This principle is immediately relevant to orphans and vulnerable children where decisions are being made regarding their caretakers, property and futures, but extends much further to all matters that concern children, including development policies and programmes, military actions and allocation of public resources.

Non-discrimination

All children should be given the opportunity to enjoy the rights recognized by the Convention. States must identify the most vulnerable and disadvantaged children within their borders and take affirmative action to ensure that the rights of these children are met and protected.

The right to survival, well-being and development

This principle is in no way limited to a physical perspective, but rather emphasizes the need to ensure full development of the child, including at the spiritual, moral, psychological and social levels.

Respect for the views of the child

Children have the right to participate in all matters affecting them and their views must be given due weight in accordance with their age and maturity. The Convention recognizes the potential of children to enrich decision-making processes and to participate as citizens and actors of change.

PRIORITY ACTION AREAS

To achieve the global goals agreed to in the Declaration of Commitment on HIV/AIDS, strong action on five fronts is essential:

1. Strengthening the **capacity of families** to protect and care for orphans and other children made vulnerable by HIV/AIDS.
2. Mobilizing and strengthening **community-based responses**.
3. Ensuring access to **essential services** for orphans and vulnerable children.
4. Ensuring that **governments protect** the most vulnerable children.
5. Raising awareness to create a **supportive environment** for children affected by HIV/AIDS.

These efforts must work in tandem with broader efforts to prevent the further spread of HIV/AIDS and so reduce the number of future orphans.

1. Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS.

In sub-Saharan Africa, extended family relationships are the first and most vital source of support for households affected by HIV/AIDS, including those with orphaned children. Hence, strengthening the capacity of extended families to care for and protect their children must be at the core of any strategy to respond to the orphan crisis. (While building more orphanages may seem a possible response to the growing number of orphans, it is not a viable solution. Care provided in an institutional setting often fails to meet the developmental needs of children. Countries with long-term experience of institutional care for children have seen the major problems that emerge as institutionalized children grow into young adults and have difficulty reintegrating into society. Institutional care would also be beyond the means of the vast majority of developing countries. Research by the World Bank in the United Republic of Tanzania found that institutional care was about six times more expensive than foster care; other studies report even higher ratios of 20 times more expensive, and as high as 100 times more expensive.)

In Kenya, Malawi and Uganda, the Trickle Up Program provides extended families with additional income to support children orphaned by HIV/AIDS, helping them to preserve or build assets while also paying for medical care and school fees.[63] Even households that are close to destitution can rebuild their capacity using small grants.

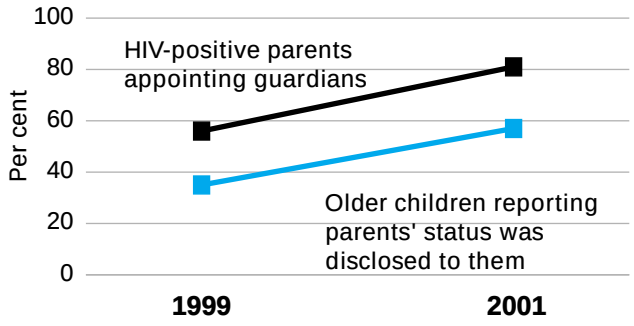
In Uganda, the international non-governmental organization Plan has supported programmes of succession planning, which include counselling for parents on the disclosure of their HIV status, training for standby guardians, and the creation of 'memory books' – journals of facts and memories that enable children and parents to create lasting records of their life together (*see Figure 4-2*).[64]

The following major areas of intervention are vital to strengthening the coping capacity of families.

- Improving the health and prolonging the lives of parents through clinic and home-based care, treatment for opportunistic infections, nutritional support and antiretroviral therapy.
- Improving the economic capacity of households through seed funding for small businesses, micro-finance projects, methods to improve agricultural efficiency, apprentice training for young people and labour-saving innovations.
- Providing psychosocial counselling and support to children and their caregivers.

FIGURE 4-2: SUCCESSION PLANNING WORKS

Results from a succession planning programme reaching HIV-positive parents, Luwero and Tororo Districts of Uganda, 2001



Source: *Succession Planning in Uganda: Early outreach for AIDS-affected children and their families*, Population Council/Horizons, Washington, D.C., 2003.

- Strengthening childcare skills and capacity of caregivers, especially in terms of early child development.
- Strengthening young people's life and survival skills to better equip them for newly acquired responsibilities and to protect them from HIV infection.
- Supporting succession planning by empowering parents to prepare wills, identify caretakers and provide psychological support to their children.

2. Mobilizing and strengthening community-based responses

When families cannot adequately provide for the basic needs of their children, the community is the next safety net for essential support.

In Malawi, the Community-Based Options for Protection and Empowerment programme of Save the Children (United States) has demonstrated a systematic approach to mobilizing community-based responses.[65] Through the programme, non-governmental organizations, religious bodies, the private sector and government establish district AIDS committees that in turn help mobilize and support village AIDS committees. The village committees undertake a range of activities, including regular visits to households with the most vulnerable children, development of community gardens and distribution of improved crop varieties. They also work to ensure that children continue to go to school by convincing foster-parents of the importance of continued schooling, and encouraging schools to waive fees for orphans and other vulnerable children.

Similarly in the United Republic of Tanzania, villagers have set up 'Most Vulnerable Children Committees' that mobilize and distribute villagers' donations of food and funds and also organize income-generation activities and other forms of support. And in Swaziland, local people have established Orphans and Vulnerable Children Committees to pool resources and organize community support. One has used the money raised from community donations to establish a shop at the local primary school, the income from which pays the school fees of several children. Another has established Neighbourhood Care Points, managed by local volunteers to provide day care.[66]

The many community efforts in support of orphans and vulnerable children show that community initiatives can be nurtured and taken to scale through:

- Engaging local leaders, including traditional and religious leaders, administrators, prominent citizens, journalists, teachers and others, by sensitizing them to the impact of HIV/AIDS and the circumstances of orphans and other vulnerable children. This is a vital step towards strengthening community response. The key aim is to mobilize leaders and their communities to organize support for orphans and vulnerable children, to monitor their well-being and to reduce the risks of abuse and exploitation.

- Opening a community dialogue on HIV/AIDS in order to dispel myths, raise awareness and engender compassion. Misinformation, ignorance and prejudice about HIV/AIDS limit the willingness of a community to provide for the needs of those who are affected by the disease. Children and young people can be important participants in opening a community dialogue. Youth clubs, religious groups, schools and other community structures are possible venues for sharing information and for dialogue.

- Organizing cooperative support activities such as community monitoring and home-visit programmes that provide much-needed psychosocial support, communal gardens, community day-care programmes, relief labour and respite childcare. Pooling of funds provides material assistance to vulnerable households, community protectors and youth clubs and recreation programmes.

- Promoting and supporting community care for children without any family support. This will be increasingly critical to an effective response as the orphan crisis worsens. Some orphans, at least temporarily, will not have family-based care within their own community. Fostering, adoption and other types of care must be expanded for them. Small family-type group homes integrated within children's communities are one option. Greatly increasing the availability of foster or adoptive care in children's communities is one of the challenges that must be met.

3. Ensuring access to essential services for orphans and vulnerable children

A critical component of the response to the orphan crisis is to increase access to essential services and to ensure parity for orphans and other vulnerable children. Comprehensive local action plans are essential to meet the needs of orphans and vulnerable children. Increasing access will depend on building district-level capacity for effective decentralization and targeting of services as well as multisectoral coordination among service providers.

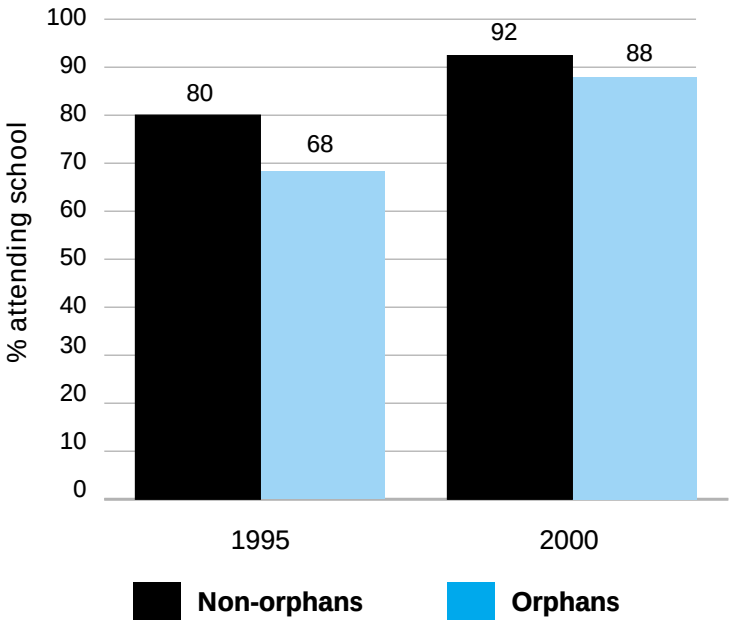
Education is a critical part of this. Everything possible should be done to ensure that all children are enrolled and stay in school. Governments can do many things to help. One is to change policies on school fees and uniform requirements.

In 1996, for example, the Ugandan Government introduced a Universal Primary Education policy, offering free primary education to up to four children in every family. In 1995, orphaned children in Uganda were less likely to go to school than other children; by 2000, as a result of this policy, this disadvantage had largely disappeared[67] (*see Figure 4-3*). In 2003, Kenya abolished school fees for primary school children – and as a result school enrolment increased substantially (*see Box 4-3*). Other opportunities include providing school meals and making education more relevant and accessible to children by allowing local groups to start community schools.

FIGURE 4-3: DISADVANTAGE DISAPPEARS UNDER A UNIVERSAL PRIMARY EDUCATION POLICY

Percentage of children attending school (orphans/non-orphans), Uganda, 1995-2000

Orphan school attendance ratio improves from 0.85 to 0.96



Sources: UNICEF-MICS, Measure DHS, 1995 and 2000.

BOX 4-3: ABOLISHING SCHOOL FEES: THE KENYA EXPERIENCE

When primary schools across Kenya reopened for winter term in January 2003, 5.9 million children re-enrolled and an additional 1.3 million children sought admission for the first time. Under Kenya's newly passed Free Primary Education policy, none of these children will pay tuition fees.

The free basic education policy throws open an urgently needed window of opportunity for millions of disadvantaged and marginalized children, many of whom had never enrolled or had dropped out because they simply could not afford the school fees.

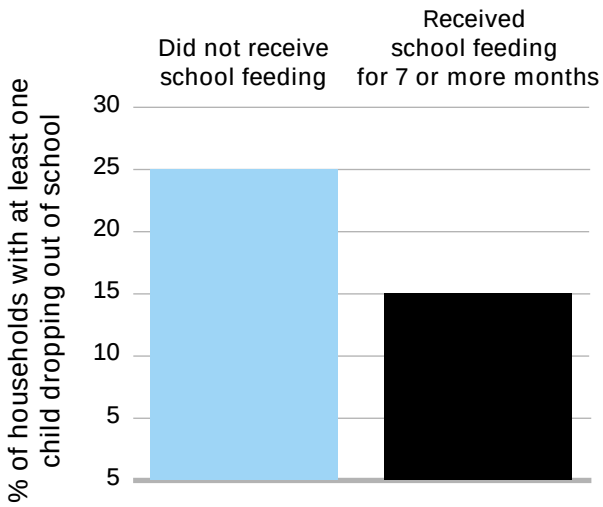
This is particularly true for some 890,000 Kenyan children under 15 who have lost one or both parents to HIV/AIDS. For many of these children, free schooling represents the best and perhaps only real chance of breaking out of a vicious cycle of poverty. Schooling offers children the chance to obtain the knowledge, skills and confidence that open up real opportunities for work. Schools are the best delivery mechanism thus far for information and discussion about HIV/AIDS and other threats to children's well-being. They give students a chance to develop life skills, the negotiation, communication and decision-making approaches necessary for healthy living.

For the entire country, the free education policy experience so far has been euphoric – and chaotic. Classrooms that held 40 students the previous year now cram in 70. Administrators were forced to defer admission at some schools for lack of standing space. Materials are scarce; trained teachers even more so. And education is still not entirely free. Families must cover costs for uniforms, transportation, and, in some cases, a range of school maintenance fees.

International support for the initiative, which will cost the Government an estimated $97 million each year, was prompt. UNICEF immediately provided a $2.5 million contribution for teaching and learning materials, recreational equipment, training for 5,000 teachers in child-centred interactive methods, and the establishment of basic water and sanitation facilities. The World Bank has promised $50 million in grants to support the education initiative over three years. The British and Swedish Governments have also pledged support.

FIGURE 4-4: SCHOOL FEEDING PROGRAMMES KEEP VULNERABLE CHILDREN IN SCHOOL

Proportion of children from households with serious food deficits dropping out of school, related to receipt of school feeding during preceding school year, Zimbabwe, 2003



Source: *Zimbabwe Emergency Food Security and Vulnerability Assessment – Report No. 3,* Zimbabwe National Vulnerability Assessment Committee and SADC FANR Vulnerability Assessment Committee, April 2003.

The Regional Psychosocial Support Initiative is another important effort to forge stronger partnerships for psychosocial programming in eastern and southern Africa. This technical resource network, which brings together over 30 organizations in the region, aims to offer psychosocial support to over 250,000 children over the next five years.[68]

Children need protection from violence and abuse, whether it occurs inside or outside the home. Children living or working on the streets are at particular risk of violence and sexual abuse. Many non-governmental organizations organize effective programmes for these children, such as the Undugu Society in Kenya, which offers training programmes and apprenticeships. But it is also vitally important to improve societal attitudes towards children living and working on the streets. In Ethiopia, police officer training includes information on them; child protection units have been formed, composed of police officers and social workers. As a result, police attitudes towards children living or working on the streets have improved significantly.

Orphans and vulnerable children need a number of services to ensure their rights and well-being, notably:

- Education is vital for children's futures and is important for their psychosocial development. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. Interventions to enhance enrolment and retention include reducing or eliminating school fees and hidden costs; improving the quality of schools; introducing life skills development into curricula; implementing school feeding programmes; and engaging schools as community resources for information, psychosocial support, day care, HIV prevention, and other support functions.

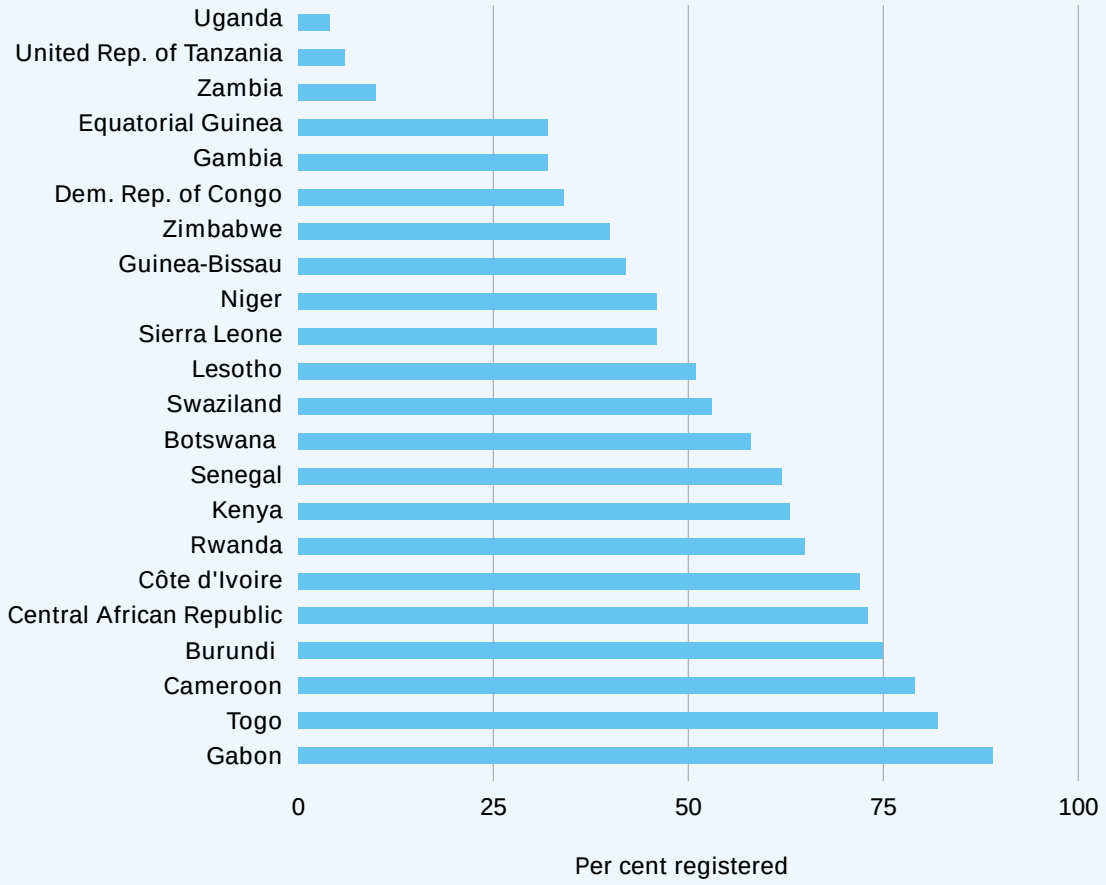
- Birth registration is critical for all children, including orphans, both in terms of identification as well as to ensure access to public services and welfare (*see Box 4-4*).

BOX 4-4: BIRTH REGISTRATION

Children whose births are not registered risk being denied many of their rights. In sub-Saharan Africa in 2000, more than two out of three births went unregistered. A number of countries badly affected by HIV/AIDS have especially low levels of birth registration: 10 per cent in Zambia, 6 per cent in the United Republic of Tanzania, and only 4 per cent in Uganda. Weaknesses in registration systems can also result in deaths not being registered.

FIGURE 4-5: MANY CHILDREN ARE NOT REGISTERED

Percentage of births registered in the five years preceding the survey (1999-2001)



Sources: UNICEF-MICS, Measure DHS, 1999-2001.

- Essential health care and nutrition services include immunization, vitamin A supplementation, de-worming, growth monitoring, infant feeding and the integrated management of childhood illnesses for young children. As children grow older, HIV prevention and youth-friendly health services are critical to their continued well-being. Treatment for HIV-positive youth is also an emerging necessity.

- Psychosocial support is an essential but often over-looked service for orphans and vulnerable children. The loss of a parent is both traumatic and stressful. Early intervention is vital. Caregivers also need psychosocial support to assist them in providing the best possible care.

- Safe water and sanitation are vital for orphans and vulnerable children and their families, as they are for all. Extended pipelines, boreholes and other locally appropriate means for increasing access are warranted. Caregivers must be provided information about proper hygiene and food handling.

- Justice systems that are strong and independent can help protect orphans and vulnerable children from abuse, discrimination and property grabbing. Educating traditional and modern judges about the issues that face orphans and about existing standards for their protection has helped. So too have multi-media campaigns encouraging communities to alert authorities to cases of exploitation and abuse.

4. Ensuring that governments protect the most vulnerable children

While the family has primary responsibility for the care and protection of children, national governments have the ultimate responsibility for protecting children and ensuring their well-being. To meet this obligation, countries must undertake and be supported in a broad range of actions, including adopting national policies, strategies and action plans; allocating and mobilizing increased resources for children; and establishing mechanisms to ensure the coordination of efforts.

Most countries have several policy instruments and pieces of legislation that relate to the rights, protection, care and support of children. Existing laws must be reviewed and revised to reflect current international standards and to address the challenges posed by HIV/AIDS. Areas to be addressed include discrimination, foster care, inheritance rights, abuse and child labour. Most importantly, effective structures are needed to implement and enforce legislation.

5. Raising awareness to create a supportive environment for children affected by HIV/AIDS

From the beginning, the HIV/AIDS epidemic has been accompanied by fear, ignorance and denial, leading to silence and inaction by governments and to stigma, discrimination and abuse against people with HIV/AIDS and their families. Children orphaned and otherwise affected by HIV/AIDS have paid a harsh price for this failure to act.

Action against HIV/AIDS has to be a shared national responsibility. No single stakeholder has the capacity to respond unilaterally to a crisis of this complexity and magnitude. It is vital therefore to ensure that information about the dangers of HIV/AIDS and the steps needed to tackle the crisis is available to every-one – policy makers, community leaders, organizations and the public. Everyone needs to collaborate by collecting and disseminating information and experience at both local and national levels. Zambia has held a series of national workshops, the latest of which in 2002 brought together 350 people from government departments, non-governmental organizations, community organizations, the media and the private sector, at which the participants agreed to build new partnerships, coalitions and networks.

Presidents, prime ministers, youth leaders, entertainers, sports figures, religious leaders and other influential people must have the courage to talk openly about HIV/AIDS. In countries where strong political leadership has fostered openness and wide-ranging responses, such as Brazil, Senegal, Thailand and Uganda, clear successes are being achieved. A comprehensive advocacy strategy includes multiple interventions and channels, including parliamentary debates, multimedia campaigns targeting specific issues such as 'positive living' or access to education, and activities designed to mobilize resources.

Programming guidance:

- Focus on the most vulnerable children and communities, not only those orphaned by HIV/AIDS.
- Define community-specific problems and vulnerabilities at the outset and pursue locally determined intervention strategies.
- Include children and young people as active participants in the response.
- Give particular attention to the roles of boys and girls, men and women, and address gender discrimination.
- Strengthen partners and partnerships at all levels and build coalitions among key stakeholders.
- Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS, and support for orphans and other vulnerable children.
- Use external support to strengthen community initiative and motivation.

INCREASING INTERNATIONAL SOLIDARITY AND SUPPORT

The orphan crisis in sub-Saharan Africa has implications for stability and human welfare that extend far beyond the region, affecting governments and people worldwide. Wealthy nations must recognize that in the spirit of the Convention on the Rights of the Child and in terms of global interests, they have a vital role to play in accelerating the response to the orphan crisis. The commitment and participation of international partners is essential. They must mobilize substantially increased resources, keep this issue high on the global agenda, provide technical and material support, and ensure that progress towards global goals is monitored and that stakeholders are held accountable.

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STATISTICAL TABLES

GENERAL NOTE ON THE DATA

The main sources of information for the statistical tables are UNICEF, USAID and UNAIDS estimates of the number of orphaned children and data from national representative household surveys.

The estimates of numbers of children orphaned (Table 2) are based on methods developed by the UNAIDS Reference Group on Estimates, Modelling and Projections[1] and have been previously published in *Children on the Brink 2002*. A more detailed description of the methodology is reported by Grassly, et al.[2] An orphan is defined as 'a child who has lost at least one parent' and a double orphan 'a child whose mother and father have both died'. 'Maternal orphans' are children whose mothers, and perhaps fathers, have died; and 'paternal orphans' those whose fathers, and perhaps mothers, have died.

The data on care practices (Table 3) and school attendance and birth registration (Table 4) are from nationally representative household surveys. To allow comparisons across countries and over time, surveys were only included if they used internationally standardized data collection methodologies. Therefore, the data are mainly from two major international survey programmes: UNICEF's Multiple Indicator Cluster Surveys (MICS) and the Demographic and Health Surveys (DHS), sponsored primarily by USAID. Both support governments in the implementation of standardized nationally representative population-based household surveys. Secondary analysis of the available data sets was performed.[3]

In order to make meaningful conclusions on care practices, slightly different definitions of orphans are used. 'Maternal orphans' are children whose mother has died but whose father is alive. Similarly, 'paternal orphans' are those whose father is dead but whose mother is alive.

While the two methodologies – modelling exercises and household surveys – give broadly similar results for the overall number of orphans, there are some significant country-specific differences. These differences spring from limitations with both methodologies. The estimates based on household surveys do not include children outside of family care (i.e. children living on the streets and children in institutions) and therefore probably underestimate the numbers of orphans. Respondents may also misreport the survival status of the biological parent.

The modelling exercise involves estimating how many people have been living with HIV/AIDS and will die from HIV/AIDS and other causes. Moreover, the modelling estimates of the number of orphans will only be as accurate as the demographic and epidemiological data on which they are based, and not every country has reliable and comprehensive data. Finally, the national household surveys were conducted in a number of years (ranging from 1997 to 2002), while the modelled estimates are all for the end of 2001. In this report, the joint UNICEF, USAID and UNAIDS modelled estimates are used to indicate the number of orphans per country over time.

Data on orphaned children should include all orphans up to age 18, but neither the estimates nor the household surveys include orphans aged 15 to 17. About 20 per cent of all orphans fall within this age group. Future data-collection tools must cover this age group. The UNAIDS Reference Group on Estimates, Modelling and Projections, responsible for the estimates, is currently improving the modelling exercise to ensure that the new estimates will cover orphans aged 0-17.

The data in these tables include detailed information on living arrangements and child well-being using traditional indicators. However, several important concerns are not covered, including protection, psychosocial well-being, food security and social welfare. Finally, most of the available data is on orphaned children, with very limited information available on other children made vulnerable by HIV/AIDS. UNICEF and its partners are currently in the process of developing a comprehensive set of tools and indicators, which can be used to effectively monitor national efforts for orphans and children made vulnerable by HIV/AIDS. A report including draft indicators is available at http://www.childinfo.org.[4]

All estimates are given in rounded numbers. However, numbers were not rounded in the calculation of rates and regional tables, so there may be small discrepancies in some of the summary tables. Some overall numbers for the sub-Saharan African region might be different from UNICEF's *The State of the World's Children* report, as Djibouti and Sudan are not included in that report.

In order to make subregional comparisons, the countries in the tables are presented by subregion (West, Central, East and Southern Africa).

[1] UNAIDS Reference Group on Estimates, Modelling and Projections (2002), 'Improved Methods of Assumptions for Estimation of the HIV/AIDS Epidemic and Its Impact: Recommendations of the UNAIDS Reference Group on Estimates, Modelling and Projections', *AIDS,* vol.16, no.9, pp. W1-W14.

[2] Grassly, N., et al. 'Comparison of Survey Estimates with UNAIDS/WHO Projections of Mortality and Orphan Numbers in sub-Saharan Africa', Paper presented at a scientific meeting on 'Empirical Evidence for the Demographic and Socio-economic Impact of AIDS, Durban, South Africa, 26-28 March 2003.

[3] Monasch, R. and J.T. Boerma, 'Orphanhood and Childcare Patterns in sub-Saharn Africa: An analysis of national surveys from 40 countries', in *AIDS* (forthcoming).

[4] Report on the Tehnical Consulation on Indicators Development for Children Orphaned and Made Vulnerable by HIV/AIDS, Gaborone, Botswana, 2-4 April 2003, UNICEF, UNAIDS.

TABLE 1: BASIC INDICATORS

Countries	Population and demography			Economy	Health	Estimated number of people living with HIV/AIDS, end-2001			Demographic impact		
	Total population (thousands) 2002	Number of children 0-14 (thousands) 2001	% of population urbanized 2002	GNI per capita (US$) 2002	Under-5 mortality rate 2002	Adult prevalence rate (%) (15-49 years)	Adults (15-49 years)	Children (0-14 years)	Life expectancy at birth (years) 2000-2005	Reduction in life expectancy due to AIDS (years) 2000-2005	AIDS deaths 2001
Benin	6,558	2,966	44	380	156	3.6	110,000	12,000	51	3	8,100
Burkina Faso	12,624	5,769	17	220	207	6.5	380,000	61,000	46	8	44,000
Cape Verde	454	181	65	1,290	38	...	...	...	70	...	...
Côte d'Ivoire	16,365	6,806	45	610	176	9.7	690,000	84,000	41	12	75,000
Gambia	1,388	537	32	280	126	1.6	7,900	460	54	2	400
Ghana	20,471	7,985	37	270	100	3.0	330,000	34,000	58	5	28,000
Guinea	8,359	3,632	28	410	169	...	...	...	49	2	...
Guinea-Bissau	1,449	535	33	150	211	2.8	16,000	1,500	45	2	1,200
Liberia	3,239	1,321	46	150	235	...	...	...	41	5	...
Mali	12,623	5,391	32	240	222	1.7	100,000	13,000	49	2	11,000
Mauritania	2,807	1,144	61	410	183	...	...	...	52	...	...
Niger	11,544	5,606	22	170	265	...	...	...	46	...	...
Nigeria	120,911	52,459	46	290	183	5.8	3,200,000	270,000	52	6	170,000
Senegal	9,855	4,262	49	470	138	0.5	24,000	2,900	53	...	2,500
Sierra Leone	4,764	2,037	38	140	284	7.0	150,000	16,000	34	4	11,000
Togo	4,801	2,054	35	270	141	6.0	130,000	15,000	50	7	12,000
West Africa	**238,214**	**101,358**	**41**	**309**	**186**	**5.2**	**5,100,000**	**510,000**	**50**	**...**	**360,000**
Cameroon	15,729	6,506	51	560	166	11.8	860,000	69,000	46	10	53,000
Central African Republic	3,819	1,626	42	260	180	12.9	220,000	25,000	40	14	22,000
Chad	8,348	3,787	25	220	200	3.6	130,000	18,000	45	4	14,000
Congo	3,633	1,443	67	700	108	7.2	99,000	15,000	48	10	11,000
Congo, Democratic Republic of the	51,201	25,698	31	90	205	4.9	1,100,000	170,000	42	6	120,000
Equatorial Guinea	481	206	51	700	152	3.4	5,500	420	49	3	370
Gabon	1,306	510	83	3,120	91	...	...	...	57	6	...
Sao Tome and Principe	157	61	48	290	118	...	...	...	70	...	...
Sudan	32,878	12,701	38	350	94	2.6	410,000	30,000	56	2	23,000
Central Africa	**117,552**	**52,477**	**37**	**296**	**171**	**5.4**	**2,800,000**	**330,000**	**46**	**...**	**240,000**
Burundi	6,602	3,064	10	100	190	8.3	330,000	55,000	41	11	40,000
Comoros	747	303	35	390	79	...	...	...	61	...	...
Djibouti	693	277	84	900	143	...	...	...	46	7	...
Eritrea	3,991	1,671	20	160	89	2.8	49,000	4,000	53	3	350
Ethiopia	68,961	29,141	16	100	171	6.4	1,900,000	230,000	46	7	160,000
Kenya	31,540	13,428	35	360	122	15.0	2,300,000	220,000	45	17	190,000
Madagascar	16,916	7,344	31	240	136	0.3	21,000	1,000	53	...	...
Rwanda	8,272	3,503	6	230	183	8.9	430,000	65,000	39	11	49,000
Somalia	9,480	4,166	29	130	225	1.0	43,000	...	48	...	...
Tanzania, United Republic of	36,276	16,094	34	280	165	7.8	1,300,000	170,000	43	9	140,000
Uganda	25,004	11,852	15	250	141	5.0	510,000	110,000	46	9	84,000
East Africa	**208,482**	**86,376**	**23**	**211**	**159**	**7.3**	**6,900,000**	**860,000**	**46**	**...**	**660,000**
Angola	13,184	6,526	36	660	260	5.5	320,000	37,000	40	4	24,000
Botswana	1,770	650	50	2,980	110	38.8	300,000	28,000	40	28	26,000
Lesotho	1,800	805	30	470	87	31.0	330,000	27,000	35	24	25,000
Malawi	11,871	5,350	16	160	183	15.0	780,000	65,000	38	18	80,000
Mozambique	18,537	8,196	35	210	197	13.0	1,000,000	80,000	38	10	60,000
Namibia	1,961	780	32	1,780	67	22.5	200,000	30,000	44	21	13,000
South Africa	44,759	14,773	58	2,600	65	20.1	4,700,000	250,000	48	19	360,000
Swaziland	1,069	388	27	1,180	149	33.4	150,000	14,000	34	28	12,000
Zambia	10,698	4,961	40	330	192	21.5	1,000,000	150,000	32	21	120,000
Zimbabwe	12,835	5,779	37	470	123	33.7	2,000,000	240,000	33	34	200,000
Southern Africa	**118,485**	**48,208**	**43**	**1,277**	**160**	**19.2**	**11,000,000**	**920,000**	**40**	**...**	**920,000**
Sub-Saharan Africa	**682,733**	**288,418**	**35**	**445**	**171**	**9.0**	**26,000,000**	**2,600,000**	**46**	**...**	**2,200,000**

For definitions of the indicators, see page 52.

TABLE 2: ESTIMATED NUMBER OF ORPHANS BY COUNTRY, YEAR, TYPE, AGE AND CAUSE

Countries	Total orphans 2001				Orphans by type 2001			Orphans by age 2001			Total orphans 2010		
	Orphans as % of all children	Total number of orphans	Number of orphans due to AIDS	Children orphaned by AIDS as % of total orphans	Total maternal orphans (thousands)	Total paternal orphans (thousands)	Total double orphans (thousands)	Total orphans, 0-4 years (thousands)	Total orphans, 5-9 years (thousands)	Total orphans, 10-14 years (thousands)	Total orphans as % of all children	Total number of orphans (thousands)	Children orphaned by AIDS as % of total orphans
Benin	10	286,000	34,000	12	121	197	31	40	110	140	10	348	33
Burkina Faso	13	769,000	268,000	35	392	538	161	110	280	380	12	935	44
Cape Verde	...	...	...	...	...	...	...	...	...	...	...	...	...
Côte d'Ivoire	13	905,000	420,000	46	454	644	192	150	310	440	12	931	58
Gambia	9	47,000	5,000	11	20	33	6	7	17	23	8	49	17
Ghana	10	759,000	204,000	27	326	509	75	110	280	370	8	734	36
Guinea	10	377,000	29,000	8	182	268	73	53	140	180	10	417	14
Guinea-Bissau	11	60,000	4,000	7	27	41	9	8	22	29	10	70	18
Liberia	12	165,000	39,000	24	69	113	18	23	56	86	11	249	49
Mali	11	602,000	70,000	12	278	400	76	84	220	290	10	705	17
Mauritania	...	...	...	...	...	...	...	...	...	...	...	...	...
Niger	10	565,000	33,000	6	264	367	66	78	220	270	9	739	17
Nigeria	10	5,421,000	995,000	18	2,441	3,587	607	730	2,300	2,400	11	6,686	39
Senegal	9	402,000	15,000	4	167	278	42	51	140	210	8	395	6
Sierra Leone	15	299,000	42,000	14	134	216	52	45	130	120	13	385	31
Togo	11	224,000	63,000	28	98	153	27	24	81	120	11	275	46
West Africa	**11**	**10,900,000**	**2,200,000**	**20**	**5,000**	**7,300**	**1,400**	**1,500**	**4,300**	**5,100**	**10**	**12,900**	**36**
Cameroon	11	708,000	210,000	30	308	485	85	88	250	370	14	1,075	63
Central African Republic	15	245,000	107,000	44	118	175	48	30	90	120	15	280	59
Chad	11	417,000	72,000	17	186	291	60	64	170	180	10	503	26
Congo	12	180,000	78,000	43	85	126	31	32	60	88	11	214	52
Congo, Democratic Republic of the	11	2,733,000	927,000	34	1,262	1,785	313	480	910	1,300	9	3,268	42
Equatorial Guinea	9	19,000	100	0	9	13	3	4	6	9	7	20	5
Gabon	9	47,000	9,000	20	19	34	6	8	16	23	8	50	29
Sao Tome and Principe	...	...	...	...	...	...	...	...	...	...	...	...	...
Sudan	9	1,190,000	62,000	5	491	801	102	190	410	580	10	1,396	27
Central Africa	**11**	**5,500,000**	**1,500,000**	**26**	**2,500**	**3,700**	**650**	**900**	**1,900**	**2,700**	**10**	**6,800**	**42**
Burundi	17	508,000	237,000	47	286	362	139	72	200	240	15	577	51
Comoros	...	...	...	...	...	...	...	...	...	...	...	...	...
Djibouti	11	30,000	6,000	21	13	21	4	4	11	15	13	38	39
Eritrea	12	199,000	24,000	12	83	130	14	28	72	100	10	221	25
Ethiopia	13	3,839,000	989,000	26	1,706	2,588	455	530	1,400	1,900	14	5,029	43
Kenya	12	1,659,000	892,000	54	847	1,103	291	240	570	850	14	2,099	73
Madagascar	9	644,000	6,000	1	268	412	36	130	220	290	7	664	3
Rwanda	17	613,000	264,000	43	329	429	145	81	220	310	17	687	52
Somalia	...	...	...	...	...	...	...	...	...	...	...	...	...
Tanzania, United Republic of	12	1,928,000	815,000	42	917	1,299	288	210	730	990	12	2,152	54
Uganda	15	1,731,000	884,000	51	902	1,144	315	210	610	910	10	1,554	39
East Africa	**13**	**11,200,000**	**4,100,000**	**37**	**5,400**	**7,500**	**1,700**	**1,500**	**4,000**	**5,600**	**12**	**13,000**	**48**
Angola	11	701,000	104,000	15	309	491	99	130	250	320	11	967	34
Botswana	15	98,000	69,000	71	69	91	62	15	36	46	22	136	88
Lesotho	17	137,000	73,000	53	66	108	37	23	40	73	26	206	82
Malawi	18	937,000	468,000	50	506	624	194	110	340	490	18	1,150	64
Mozambique	16	1,274,000	418,000	33	562	896	184	190	450	640	19	1,820	58
Namibia	12	97,000	47,000	49	47	68	18	12	36	49	18	156	76
South Africa	10	1,528,000	662,000	43	622	1,173	267	220	540	760	16	2,303	74
Swaziland	15	59,000	35,000	59	32	46	19	11	20	28	22	87	82
Zambia	18	874,000	572,000	65	547	643	316	120	340	420	18	1,083	77
Zimbabwe	18	1,018,000	782,000	77	733	828	543	130	350	540	21	1,341	89
Southern Africa	**14**	**6,700,000**	**3,200,000**	**48**	**3,500**	**5,000**	**1,700**	**960**	**2,400**	**3,400**	**17**	**9,200**	**69**
Sub-Saharan Africa	**12**	**34,300,000**	**11,000,000**	**32**	**16,300**	**24,000**	**5,500**	**4,900**	**12,700**	**16,700**	**12**	**42,000**	**48**

For definitions of the indicators, see page 52.

TABLE 3: CARE PRACTICES

Countries	Orphan households	Average number of orphans per household			Female-headed households			Residence patterns for non-orphans and orphans				Dependency ratio			
	% households with children taking care of orphan(s)	Average no. of orphans per household	Average no. of orphans per male-headed household	Average no. of orphans per female-headed household	% households with orphans that are female-headed	% all households with children 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	Non-orphan households with children	Orphan households	Male-headed households with orphans	Female-headed households with orphans
Benin	14	...	...	...	39	19	29	82	65	76	57	1.6	1.9	1.9	2.0
Burkina Faso	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Cape Verde	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Côte d'Ivoire	16	1.8	1.7	1.9	34	18	31	84	68	71	56	1.4	1.6	1.5	1.7
Gambia	18	1.7	1.6	2.0	26	17	27	91	56	83	46	1.5	1.6	1.6	1.6
Ghana	9	1.6	1.5	1.6	58	40	13	81	67	58	52	1.6	2.1	1.8	2.4
Guinea	17	...	...	...	22	13	30	84	67	78	67	1.6	1.8	1.7	1.8
Guinea-Bissau	16	1.7	1.6	2.1	31	14	34	87	69	80	53	1.4	1.6	1.6	1.5
Liberia	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Mali	10	...	...	...	27	10	26	91	74	88	71	1.6	1.9	1.9	1.8
Mauritania	13	...	...	...	44	30	20	86	81	64	50	1.6	1.7	1.6	1.7
Niger	9	1.7	1.7	1.8	22	7	26	91	60	89	61	1.6	1.8	1.8	1.9
Nigeria	10	1.7	1.6	1.9	36	13	28	90	77	87	76	1.5	1.8	1.8	1.8
Senegal	15	1.7	1.6	2.0	28	17	25	90	76	74	55	1.4	1.5	1.6	1.3
Sierra Leone	22	1.7	1.6	1.9	29	16	41	82	67	78	56	1.2	1.6	1.5	1.7
Togo	16	1.8	1.7	1.9	42	22	30	86	74	78	61	1.5	1.7	1.7	1.9
West Africa (median)	**15**	**1.7**	**1.6**	**1.9**	**30**	**18**	**29**	**86**	**68**	**78**	**56**	**1.5**	**1.7**	**1.7**	**1.8**
Cameroon	16	1.8	1.6	2.0	42	20	33	87	71	78	62	1.5	1.7	1.7	1.6
Central African Republic	21	1.9	1.8	2.2	32	14	47	88	69	82	50	1.6	1.8	1.7	1.9
Chad	11	1.8	1.8	1.8	42	16	29	93	73	86	56	1.8	1.9	1.9	1.9
Congo	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Congo, Democratic Republic of the	18	1.8	1.7	2.2	29	13	39	90	72	80	56	1.5	1.7	1.7	1.7
Equatorial Guinea	16	1.9	1.7	2.2	35	25	22	81	78	56	40	1.6	1.8	1.7	1.9
Gabon	...	...	...	...	...	...	...	77	76	53	52	...	...	...	...
Sao Tome and Principe	7	1.5	1.4	1.7	46	31	11	88	84	59	43	1.5	1.9	1.9	1.9
Sudan	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Central Africa (median)	**16**	**1.8**	**1.7**	**2.1**	**38**	**18**	**31**	**88**	**73**	**78**	**52**	**1.6**	**1.8**	**1.7**	**1.9**
Burundi	26	2.2	1.8	2.5	55	19	74	96	92	92	76	1.5	2.0	1.8	2.3
Comoros	8	1.9	1.7	2.4	32	20	13	94	87	80	80	1.6	1.7	1.7	1.9
Djibouti	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Eritrea	...	...	...	...	...	...	...	96	90	86	56	...	...	...	...
Ethiopia	18	1.6	1.5	1.8	42	21	35	90	80	82	68	1.5	1.6	1.6	1.7
Kenya	12	1.9	1.6	2.1	65	33	28	89	84	69	54	1.4	2.0	1.8	2.1
Madagascar	10	1.7	1.6	1.9	44	19	24	91	78	82	53	1.4	1.7	1.6	1.7
Rwanda	37	2.1	1.6	2.3	64	33	71	94	87	83	62	1.5	1.9	1.8	2.0
Somalia	11	2.1	1.9	2.3	53	18	32	95	90	89	64	...	...	...	...
Tanzania, United Republic of	16	1.6	1.5	1.8	43	21	32	85	64	74	43	1.5	1.8	1.8	1.9
Uganda	22	1.9	1.6	2.2	48	27	38	84	65	74	49	1.7	2.3	2.2	2.4
East Africa (median)	**16**	**1.9**	**1.6**	**2.2**	**48**	**21**	**32**	**93**	**86**	**82**	**59**	**1.5**	**1.9**	**1.8**	**2.0**
Angola	18	1.8	1.6	2.0	49	25	35	91	79	78	48	1.5	1.9	1.8	2.0
Botswana	21	1.8	1.6	1.9	64	52	25	73	71	35	14	1.4	1.7	1.7	1.7
Lesotho	20	1.9	1.6	2.0	66	32	41	86	78	70	56	1.3	1.7	1.7	1.7
Malawi	20	1.7	1.5	1.9	49	26	37	87	72	70	27	1.5	2.0	1.8	2.4
Mozambique	20	1.7	1.5	1.9	39	25	32	86	78	74	59	1.4	1.8	1.7	2.1
Namibia	21	1.6	1.4	1.6	60	47	27	65	51	35	17	1.4	2.2	2.1	2.3
South Africa	15	1.7	1.5	1.8	71	46	23	73	65	42	28	1.4	1.7	1.6	1.8
Swaziland	21	1.9	1.7	2.1	50	34	31	80	66	49	41	1.6	1.9	1.9	2.0
Zambia	25	1.8	1.7	2.0	44	20	50	87	68	77	37	1.4	1.6	1.5	1.6
Zimbabwe	20	1.9	1.7	2.0	61	37	33	80	63	60	46	1.4	2.2	1.9	2.4
Southern Africa (median)	**20**	**1.8**	**1.6**	**1.9**	**55**	**33**	**32**	**83**	**70**	**65**	**39**	**1.4**	**1.9**	**1.8**	**2.0**
Sub-Saharan Africa (median)	**16**	**1.8**	**1.6**	**2.0**	**43**	**21**	**30**	**87**	**73**	**78**	**55**	**1.5**	**1.8**	**1.7**	**1.9**

For definitions of the indicators, see page 52.

TABLE 4: IMPACT AND RESPONSE

Countries	School attendance (10-14 years)				Government response				Birth registration 1999-2001		
	% non-orphans (living with at least one parent)	% orphans (one or both parents dead)	% double orphans	Orphan/ non-orphan school attendance ratio	National Situation Analysis complete	National OVC policy	National Coordination Mechanism	Adequate legislation to protect orphans (i.e. property)	% birth registration total	% birth registration urban	% birth registration rural
Benin	...	...	...	...	I.P.	I.P.	N	...	62	71	58
Burkina Faso	...	...	...	...	Y	N	N	...	...	...	...
Cape Verde	...	...	...	...	I.P.	N	N	...	...	...	...
Côte d'Ivoire	67	58	56	0.83	Y	N	Y	...	72	88	60
Gambia	68	65	58	0.85	N	I.P.	N	...	32	37	29
Ghana	82	72	76	0.93	Y	N	Y	...	...	...	...
Guinea	...	...	...	...	I.P.	N	Y	...	...	...	...
Guinea-Bissau	50	55	51	1.03	N	N	N	...	42	32	47
Liberia	...	...	...	...	N	N	N	...	...	...	...
Mali	...	...	...	...	I.P.	N	Y	...	...	...	...
Mauritania	...	...	...	...	I.P.	N	N	...	55	72	42
Niger	45	38	...	...	I.P.	Y	Y	...	46	85	40
Nigeria	70	70	61	0.87	Y	N	Y	...	...	...	...
Senegal	54	50	40	0.74	N	N	N	...	62	82	51
Sierra Leone	50	42	35	0.71	N	N	N	...	46	66	40
Togo	78	72	74	0.96	Y	Y	N	...	82	93	78
West Africa				**0.85**	**5 /16**	**2 /16**	**6 /16**	...	...	...	...
Cameroon	83	78	78	0.94	I.P.	N	N	...	79	94	72
Central African Republic	54	52	49	0.91	Y	I.P.	N	...	73	88	63
Chad	61	59	...	...	Y	N	I.P.	...	25	53	18
Congo	...	...	...	...	Y	Y	N	...	...	...	...
Congo, Democratic Republic of the	70	58	50	0.72	N	N	N	...	34	30	37
Equatorial Guinea	89	87	85	0.95	N	N	N	...	32	43	24
Gabon	...	...	...	...	I.P.	N	N	...	89	90	87
Sao Tome and Principe	81	80	...	...	N	N	Y	...	70	73	67
Sudan	...	...	...	...	Partial	I.P.	Y	Y	...	...	...
Central Africa				**0.92**	**3 / 9**	**1 / 9**	**2 / 9**	**1 / 1**	...	...	...
Burundi	65	54	46	0.70	Y	N	N	Y	75	71	75
Comoros	60	37	...	...	n.a.	n.a.	n.a.	n.a.	83	87	83
Djibouti	...	...	...	...	N	N	N	...	...	...	...
Eritrea	...	...	...	...	Y	I.P.	Y	I.P.	...	...	...
Ethiopia	43	34	26	0.60	N	N	Y	I.P.	...	...	...
Kenya	93	85	70	0.74	N	N	N	I.P.	63	82	56
Madagascar	70	54	45	0.65	N	N	N	N	75	88	72
Rwanda	80	73	64	0.80	Y	Y	N	I.P.	65	61	66
Somalia	21	18	14	0.65	N	N	N	N	...	...	...
Tanzania, United Republic of	71	68	52	0.74	N	N	Y	N	6	22	3
Uganda	93	88	88	0.95	Y	I.P.	N	Y	4	11	3
East Africa				**0.72**	**4 / 11**	**1 / 11**	**3 / 11**	**2 / 10**	...	...	...
Angola	81	76	73	0.90	N	N	N	N	29	34	19
Botswana	95	94	94	0.99	Y	N	N	N	58	66	52
Lesotho	91	87	79	0.87	Y	N	N	I.P.	51	41	53
Malawi	87	80	81	0.93	Y	Y	Y	N	...	...	...
Mozambique	68	61	32	0.47	N	N	Y	N	...	...	...
Namibia	90	92	83	0.92	Y	I.P.	Y	I.P.	...	...	...
South Africa	96	94	91	0.95	Y	N	Y	I.P.	...	...	...
Swaziland	87	81	79	0.91	Y	N	Y	N	53	72	50
Zambia	77	69	67	0.87	Y	I.P.	Y	I.P.	10	16	6
Zimbabwe	95	89	81	0.85	Y	Y	N	Y	40	54	33
Southern Africa				**0.90**	**8 / 10**	**2 / 10**	**6 / 10**	**1 / 10**	...	...	...
Sub-Saharan Africa				**0.87**	**20 / 46**	**6 / 46**	**17 / 46**	**4 / 21**	...	...	**...**

For definitions of the indicators, see page 52.

DEFINITIONS OF THE INDICATORS

TABLE 1: BASIC INDICATORS

POPULATION AND DEMOGRAPHY

Total population (thousands) 2002: Total population in 2002.

Number of children 0-14 (thousands) 2001: Population aged 0-14 in 2001.

% of population urbanized 2002: % of total population living in urban areas according to the national definition used in the most recent population census.

Source: United Nations Population Division.

ECONOMY

GNI per capita (US$) 2002: Gross national income (GNI) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output, plus net receipts of primary income (compensation of employees and property income) from abroad. GNI per capita is gross national income divided by mid-year population. GNI per capita in US dollars is converted using the World Bank Atlas method.

Source: World Bank.

HEALTH STATUS

Under-5 mortality rate 2002: Probability of dying between birth and exactly five years of age expressed per 1,000 live births.

Source: UNICEF.

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV/AIDS, END-2001

Adult prevalence rate (%) (15–49 years) end-2001: The estimated number of adults aged 15-49 living with HIV/AIDS at end-2001, divided by the 2001 adult population.

Adults (15-49 years): Estimated number of adults living with HIV/AIDS at end-2001.

Children (0-14 years): Estimated number of children living with HIV/AIDS at end-2001.

Source: UNAIDS.

DEMOGRAPHIC IMPACT

Life expectancy at birth (years) 2000-2005: The number of years newborn children would live if subject to the mortality risks prevailing for the cross-section of population at the time of birth.

Reduction in life expectancy due to AIDS (years) 2000-2005: Difference in life expectancy at birth in years lost due to AIDS.

Source: United Nations Population Division.

AIDS deaths, 2001: Estimated number of adults and children who died of AIDS during 2001.

Source: UNAIDS.

TABLE 2: ESTIMATED NUMBER OF ORPHANS BY COUNTRY, YEAR, TYPE, AGE AND CAUSE

TOTAL ORPHANS 2001

Total orphans as % of all children 2001: Estimated % of children (0-14 years) at end-2001 who have lost one or both parents.

Total number of orphans 2001: Estimated number of children (0-14 years) at end-2001, who have lost one or both parents.

Number of orphans due to AIDS 2001: Estimated number of children (0-14 years) at end-2001, who have lost one or both parents to AIDS.

Children orphaned by AIDS as % of total orphans 2001: Orphans due to AIDS as a % of all orphans.

TOTAL ORPHANS BY TYPE 2001

Total maternal orphans (thousands) 2001: Estimated number of children (0-14 years) at end-2001, whose mother has died, where the survival status of the father is unknown (alive, dead from AIDS, or dead from other causes).

Total paternal orphans (thousands) 2001: Estimated number of children (0-14 years) at end-2001, whose father has died, where the survival status of the mother is unknown (alive, dead from AIDS, or dead from other causes).

Total double orphans (thousands) 2001: Estimated number of children (0-14 years) at end-2001, whose mother and father have both died.

ORPHANS BY AGE 2001: Estimates by age are calculated by multiplying the total estimated number of orphans (0-14 years) by the proportion of orphans that are in that five-year age group based on latest household survey data available.

Total orphans, 0-4 years (thousands) 2001: Estimated number of children (0-4 years) as of end-2001, who have lost one or both parents.

Total orphans, 5-9 years (thousands) 2001: Estimated number of children (5-9 years) as of end-2001, who have lost one or both parents.

Total orphans, 10-14 years (thousands) 2001: Estimated number of children (10-14 years) as of end-2001, who have lost one or both parents.

TOTAL ORPHANS 2010

Total orphans as % of all children 2010: Projected % of children (0-14 years) as of end-2001, who have lost one or both parents.

Total number of orphans (thousands) 2010: Projected number of children (0-14 years), as of end-2010, who have lost one or both parents.

Children orphaned by AIDS as % of total orphans 2010: Orphans from AIDS as a % of all orphans.

Sources: UNICEF, USAID, UNAIDS.

TABLE 3: CARE PRACTICES

ORPHAN HOUSEHOLDS

% households with children taking care of orphan(s): % of households with children that are taking care of one or more orphans.

Sources: Multiple Indicator Cluster Surveys (MICS), UNICEF; Demographic and Health Surveys (DHS), Macro International, 1997-2002.

AVERAGE NUMBER OF ORPHANS PER HOUSEHOLD: Average number of orphans in households taking care of orphans.

Average no. of orphans per household: Average number of orphans per household.

Average no. of orphans per male-headed households: Average number of orphans per male-headed household.

Average no. of orphans per female-headed household: Average number of orphans per female-headed household.

Sources: UNICEF MICS, DHS, Macro International, 1997-2002.

FEMALE-HEADED HOUSEHOLDS

% households with orphans that are female-headed: % of all households with orphans that are headed by a woman.

% all households with children that are female-headed: % of all households with children that are headed by a woman.

% households with children that are female-headed taking care of orphan(s): % of households with children headed by women that are taking care of one or more orphans.

Sources: UNICEF MICS, DHS, Macro International, 1997-2002.

RESIDENCE PATTERNS FOR NON-ORPHANS AND ORPHANS

% non-orphans living with mother: % of non-orphaned children who live with their mother.

% paternal orphans living with mother: % of children whose father has died and live with their mother.

% non-orphans living with father: % of non-orphaned children who live with their father.

% maternal orphans living with father: % of children whose mother has died who live with their father.

Sources: UNICEF MICS, DHS, Macro International, 1997-2002.

DEPENDENCY RATIO: Dependency ratio is the sum of children under 18 and persons 60 years or older divided by the number aged 18-59 years.

Non-orphan households with children: Dependency ratio for households with children who are not taking care of orphans.

Orphan households: Dependency ratio for households with orphans of any type.

Male-headed households with orphans: Dependency ratio for households with orphans headed by a man.

Female-headed households with orphans: Dependency ratio for households with orphans headed by a woman.

Sources: UNICEF MICS, DHS, Macro International, 1997-2002.

TABLE 4: IMPACT AND RESPONSE

SCHOOL ATTENDANCE (10-14 YEARS)

% non-orphans (living with at least one parent): Percentage of non-orphaned children age 10-14 who live with at least one parent and attend school.

% orphans (one or both parents dead): Percentage of orphaned children age 10-14 who are attending school.

% double orphans: Percentage of children age 10-14 who lost both natural parents who are attending school.

Orphan/non-orphan school attendance ratio: Percentage of children age 10-14 in a household survey who lost both natural parents and who are currently attending school as a % of non-orphaned children of the same age who live with at least one parent and who are attending school (Millennium Development Goal indicator).

Sources: UNICEF MICS, DHS, Macro International, 1997-2002.

GOVERNMENT RESPONSE

National Situation Analysis complete: National government has completed a national analysis of the situation of orphans and other children made vulnerable by HIV/AIDS.

National OVC policy: Country has a national policy for the protection of orphans and other vulnerable children.

National Coordination Mechanism: National government has established a collaborative coordinating mechanism for responding to the situation of orphans and other children made vulnerable by HIV/AIDS.

Adequate legislation to protect orphans (i.e. property): National government has policy instruments and legislation that relate to the rights, protection, care and support of children and address the challenges posed by HIV/AIDS.

Y -- indicates 'Yes' N -- indicates 'No' I.P. -- indicates 'In progress'

Sources: UNICEF Regional Offices and 2003 National Reports on the follow-up to the Declaration of Commitment made at UN General Assembly Special Session on HIV/AIDS, 2001.

BIRTH REGISTRATION 1999-2001: % of children under five who were registered at the time of the survey. Figure includes children whose birth certificate was seen by the interviewer or whose mother or caretaker says the birth has been registered.

% birth registration 1999-2001, total

% birth registration 1999-2001, urban

% birth registration 1999-2001, rural

Sources: UNICEF MICS, DHS, Macro International, 1999-2001.

Joint United Nations Programme on HIV/AIDS

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