Still no excuses

Orphans and vulnerable children and HIV/AIDS

July 2004

Christian Aid
We believe in life before death

This report was written for Christian Aid by Mark Nunn, Dr Rachel Baggaley, Judith Melby and Anna Thomas.

The report was edited by Andy Jacques.

Contact
Judith Melby - 44(0)7720 467 679; 0207 523 2408; jmelby@christian-aid.org
Dr Rachel Baggaley - 0207 523 2172; rbaggaley@christian-aid.org

Christian Aid is a UK-based non-governmental organisation with almost 60 years of development experience. Established in 1945 as an agency of the churches in the UK and Ireland, Christian Aid works wherever the need is greatest, irrespective of religion. Christian Aid works to achieve the eradication of poverty by supporting 574 partners in 56 countries.

Christian Aid has made HIV a corporate priority. We focus on challenging stigma and discrimination; promoting hope and empowerment for people living with and affected by HIV; supporting communication; the learning and sharing of good practice; and continuing to work for the eradication of poverty and inequality, especially gender inequality. Christian Aid currently works with and supports 136 community-based partner organisations working on HIV-programmes in more than 35 countries in sub-Saharan Africa, Asia, Latin America, the Caribbean, Eastern Europe and central Asia.

© Christian Aid 2004

Contents

Introduction 4

Still no excuses 5

Africa 7
- Orphaned teenagers 7
- Community-based care 8
- Child-headed households 8
- Christian Aid partners' community-based programmes 9

Asia 10
- Stigma and discrimination 11
- Post-conflict environments 11

OVC – a lack of policy 13

Economic impact 15
- Poverty and the economic impact of HIV 15
- The consequences of failure 16
- HIV's impact on growth 17

Recommendations 18

Endnotes 19

Introduction

HIV/AIDS is the biggest threat to the developing world. Fairer trade rules and debt relief will be in vain if the HIV epidemic is not dealt with. Its impact on the societies and economies of the developing world, especially in Africa, is already devastating. As the working generation dies, the future for the children left behind is grim. Around 12 million children in sub-Saharan Africa have lost one or both parents to HIV/AIDS. By 2010, there could be 18 million orphans and vulnerable children (OVC) in sub-Saharan Africa. How will Zambia, already hard hit by debt and structural adjustment, cope with the future when already 12 per cent of its children are orphaned by HIV/AIDS?

The state of these children – who are the future of Africa – is worrying. Many are living with grandparents, who are already struggling to survive. They tend to be poorer than children living with their families. They face a higher risk of malnutrition and death – even if they themselves are not HIV-positive. They are less likely to attend school; more likely to suffer violence and sexual abuse; more likely to drift on to the street where they are at higher risk of HIV infection.

The impact of HIV/AIDS is most obvious in the areas where the UN has set its Millennium Development Goals (MDGs). The MDGs involve hitting specific targets for reducing poverty and hunger levels, cutting mortality rates among mothers and children, and increasing access to education, all by 2015. But as A K Amoako, executive secretary of the Economic Commission for Africa, said: 'The chances of any country coming anywhere near to meeting the Millennium Development Goals is very low unless we tackle HIV/AIDS aggressively.'

Christian Aid has been working with OVC for many years. In this report we set out recommendations for the major donor countries, the governments of countries with high numbers of OVC, and faith-based organisations on how to deal with this economic and social time bomb. The responsibility of these parentless children lies with society and, most critically, with governments.

Africa should be a wake-up call for all governments, including those in Asia and eastern Europe, where HIV is now taking hold. All food shortages in Africa are now HIV-related: sick people find it difficult to farm and dead parents cannot pass on farming skills to children. The worst can be avoided in other countries only if there is an urgent investment in orphans and vulnerable children now.

Still no excuses

HIV does not discriminate. It strikes the rich and the poor, the privileged and the marginalised. But the poor and the young are least equipped to deal with it. And children are the ones left behind.

- Across the world, more than 13 million children under 15 have already lost parents to HIV. It is predicted that by 2010 one or both parents of 25 million children worldwide will have died of HIV.[1]
- Every day, 1,600 children die of HIV.[2]
- **Every day, six thousand children are orphaned[3] by HIV/AIDS.[4]**

Most HIV-related child deaths happen because the virus has been passed on to children at birth or through breastfeeding. The world's imagination has been seized by the struggle to provide treatment for people living with HIV. Although in the long term this will prove crucial to reducing the number of orphans and vulnerable children (OVC), in the short term these children are being overlooked.

- Each day, more than 8,000 people worldwide die of AIDS-related illnesses[5]
- Nearly 2,000 under-15s are infected with HIV daily[6]
- Across the globe, under-18s make up more than ten per cent of the 40 million people who are already living with HIV[7]
- Every day, more than 6,000 children are left orphans by HIV/AIDS – that is, they have lost one or both parents to HIV[8]
- **A third of these children are under five years old.[9]**

The young are at the front line of the HIV epidemic. By definition in need of care and by nature a vulnerable group, children are especially exposed to HIV and its effects. Often, they are the least well-equipped to cope.

Three years ago, Christian Aid published *No Excuses*,[10] a pioneering report addressing the problem of OVC and highlighting the failure of the international community to tackle HIV. When the report was written there were already 13 million OVC as a result of HIV. The report was a call to action to rich countries, national governments of countries with high infection rates, donor organisations, and churches. Three years on, action is even more urgently required as the number of those affected by HIV continues to rise.

The current situation will deteriorate further. Across the developing world, adult deaths due to HIV are increasing very fast. This means that the number of children orphaned each day is expanding increasingly rapidly. Despite improvements in access to antiretroviral treatment (ART), which prolongs lives and thus decreases the number of children growing up without parents, the majority of people in high-prevalence countries do not have access to ART now and will not have in the near future. The number of OVC in the world is a long way from peaking.

> 'Orphaned children are the most vexing issue related to care, because there are not enough adults left to do the caregiving, no one to hand down knowledge or experience, or – perhaps most important of all – values – from one generation to another. It's appalling that so many children are growing up without the kind of emotional anchor that leads to a life of stability.'[11]
>
> Stephen Lewis, UN special envoy on HIV/AIDS

Children and young people in HIV-affected households are affected even before a parent or caregiver has died.

- As wage earners sicken, household income falls.
- Schooling is interrupted as children are forced to drop out, either to care for a sick relative or to earn money. Girls tend to be the first to suffer in this way.
- The earning potential of these children consequently decreases, as they lose out on an education.
- Low income and lack of education makes children – especially girls – more vulnerable to HIV themselves. They are abused, enter relationships with more affluent, older men, or are forced into sex work.
- Survival strategies, such as eating less and selling the household's assets, only increase their vulnerability.
- Children in such households are likely to suffer depression and alienation.[12]

Children whose parents die are additionally disadvantaged in numerous ways. They suffer the trauma of witnessing sickness and death within their families. They are likely to be poorer than non-orphans, and less able to afford even such basic rights as schooling and healthcare.

They tend to be less healthy than non-orphans, as they have worse diets, poorer access to immunisation, and greater workloads.[13] They are more likely to suffer damage to their cognitive and emotional development.

Vulnerable and excluded, they are often subjected to child labour, exploitation and abuse. It is worse for female children, who are particularly vulnerable to sexual violence and exploitation.

Churches still have much to do in their response to HIV. They have a vital role in educating people about HIV/AIDS and breaking down the stigma that surrounds it. Stigma and discrimination remain widespread and constitute very significant barriers to prevention and care.

Because of the time lag between a person contracting HIV and dying as a result – normally in the region of ten years – the consequences of the epidemic are slow to make themselves felt. Those carrying HIV often have ten apparently healthy years during which they may be entirely unaware that they are sick and may pass HIV on to others. It is often only at the end of this period, when the bearer falls visibly ill, that they seek medical attention. Much of southern Africa is in this situation now, as societies wake up to the number of people infected and the real impact of HIV becomes apparent. Many countries – such as South Africa, Ethiopia and Nigeria – are struggling with rapidly expanding epidemics. As the pandemic accelerates, it is clear that the full force of its consequences is yet to be felt.

Africa

> 'Now I have two more children to look after. We have four children of our own and already look after seven orphaned children of our relative. My home is an orphanage.'
>
> Andrew Banda at the funeral of his sister-in-law, Ndola, Zambia

It is in Africa that the epidemic's terrible consequences are currently most visible. HIV has already orphaned more than 12 million African children – a number equivalent to twice the population of Switzerland. In addition:

- more than 80 per cent of all HIV orphans are in sub-Saharan Africa[14]
- by 2010 there will be approximately 18 million HIV orphans in Africa[15]
- in Botswana, Lesotho, Swaziland and Zimbabwe, more than one in five children will be orphaned by 2010. More than 80 per cent of those will have lost one or both parents due to HIV[16]
- up to 60 per cent of today's 15-year-olds will not reach their 60th birthday.[17]

It is a commonly held belief that throughout Africa the social safety-net of the extended family will cope with and care for OVC. It is true that extended families are currently caring for 90 per cent of all AIDS orphans. However, it is in precisely those countries where the extended family is bearing the greatest strain that the largest increases in AIDS orphans will take place. In the four countries mentioned above, HIV prevalence is higher than was at one point thought possible, exceeding 30 per cent of adults.[18]

> 'Orphaned children… remain perhaps the most intractable of all issues related to care and support. We've obviously been dealing with legions of orphaned children – sometimes adequately, mostly inadequately – for well over a decade. But something startling is happening: the increased spiral of adult deaths in so many countries means that the numbers of children orphaned each day is expanding exponentially. Africa is staggering under the load.'[19]
>
> Stephen Lewis, UN special envoy on HIV/AIDS

Orphaned teenagers

Teenaged OVC comprise another especially vulnerable sub-group. At a naturally turbulent and crucially formative time in their lives, HIV leaves them without the guiding influence of their parents and exerts hugely increased pressure just as they undergo an essential stage in their emotional development.

- Teenagers are more likely to be 'double orphans' – children who have had to witness the deaths of both parents.
- There is an increased likelihood that such children may even be 'serial orphans' – those who have been cared for by others after the deaths of their parents, only to watch their new carers die, too.
- On top of these incredible pressures, teenagers are at a time in their lives where their emotional vulnerability is already naturally increased.
- Given their age, they are more likely to be subject to the pressures of work and caring for younger siblings and other family members.[20]
- The combination of these factors means that teenaged OVC are themselves more vulnerable to sexual exploitation and abuse. This is especially true for girls, who often find themselves in the desperate situation of swapping sex for food and clothes, simply to ensure their survival and that of their younger siblings.[21] This leaves them correspondingly vulnerable to contracting HIV themselves.[22]

Community-based care

Christian Aid believes in the importance of allowing OVC to be cared for within their communities. Community-based care means communities accepting responsibility – responsibility for feeding OVC, sheltering them, clothing them and protecting them from abuse. Such care must also provide them with the life skills necessary to avoid HIV infection. It is important that such responsibility is not passed on or delegated to those outside the community.

Residential care for OVC is not the best means of relieving pressure on extended families. Community-based care is a key means of protecting them from the stigma that surrounds HIV, and preparing them for their life in the same community. As *Children on the Brink 2002*, a joint report by the UNAIDS and Unicef, pointed out: 'Care provided in institutional settings often fails to meet the developmental and long-term needs of children... children benefit greatly from the care, personal attention, and social connections that families and communities can provide. Particularly in the developing world… the absence of such connections greatly increases long-term vulnerability.'

Orphanages are also relatively expensive, and the OVC problem is at its most severe in some of the world's most cash-starved countries: 'Orphanages are much more expensive to maintain than providing direct assistance to families and communities to care for orphaned children themselves.'[23]

Child-headed households

> 'How to realise rights for children in child-headed households is perhaps the most perplexing and complex aspect of the HIV/AIDS disaster,' says Cati Vawda of the Children's Rights Centre in South Africa. 'I do not think that we have good answers. I have not seen responses that do more than make the most of a bad situation. These children are the testimony to the depth and breadth of our failure to address the HIV/AIDS disaster holistically and effectively.'[24]

As previously mentioned, the HIV epidemic is not just a health issue – it is intimately linked with gender inequality and poverty. As more and more people succumb to HIV, poor and overburdened countries are seeing great increases in the numbers of families headed by women and grandparents, and in many cases by orphaned children themselves. These households – especially those headed by children – tend to be poorer, and are progressively less able to provide adequately for the children in their care. Even in countries where they are available, social funds are much less accessible to child-headed households than they are to other families.

As the economic structure of the worst-affected countries disintegrates, there are fewer and fewer exits from the vicious circle of poverty and disease.

Christian Aid partners' community-based programmes

AMO Congo, a local NGO and Christian Aid partner, is based in five regions of the **Democratic Republic of Congo**. It helps families look after 5,000 orphaned children and provides training and start-up costs for income-generating ventures. AMO also offers emotional support to families and encourages discussions about the disease in order to reduce the stigma and prevent its further spread.

One person who has benefited is **Yumba Kamwanya** in Lubumbashi. Her husband died of an HIV-related illness, and her family abandoned her when they found out the cause of his death. She is HIV-positive and was very sick when she was found, destitute, by an AMO volunteer. She has seven children, six of whom are under 16. Four had left home to fend for themselves on the streets.

AMO Congo paid for Yumba to receive medical care, found her children and brought them home. They gave her and her family food and clothing to get them back on their feet. Staff and volunteers made regular visits, and AMO helped her start a small business. She is now selling flour and oil outside her home, and using the money to buy food for her family and keep the business going. She is finally able to send one of her children to primary school.

Yumba is the first person in Lubumbashi to have talked openly about her HIV status. She has now given her testimony twice on television.

Christian Aid partner **Youth With A Mission (YWAM)** runs an integrated HIV-prevention, care and support programme in Kangulumira, Uganda. YWAM has also found that orphan care in extended families puts traditional family structures under pressure. Recognising the importance of community-based care, YWAM volunteers work with communities to prioritise the needs of families caring for OVC.

Problems with the extended-family model are numerous. Families are put under immense strain trying to use their limited resources to pay for food, clothing, medical bills and schooling for additional children. In some cases the resentment can manifest itself in carers taking advantage of OVC – making them undertake a disproportionate amount of work, forbidding them from going to school, or even abusing them. But YWAM believes that the problems created by leaving orphans without a family environment are potentially much worse. Consequently, it works to find homes for OVC and provides support to care-providers and the extended family, so that orphans are not seen as an extra burden.

Asia

In Asia, the spectre of children orphaned by HIV/AIDS is currently less visible. It is no less frightening. In Asia an estimated 7.4 million people are living with HIV.[25]

While overall reported prevalence rates are relatively low – in India, for example, prevalence, though increasing, is currently around one per cent – the vast population of the region means that even a small percentage rise in prevalence equates to a formidable number of extra people living with HIV/AIDS (PLHA). An increase as small as 0.1 per cent in India's prevalence rate would increase the national total of adults living with HIV by about half a million. Already India has the largest number of people living with HIV outside South Africa – estimated at 4.6 million in 2002.[26]

Countries with lower adult prevalence rates, such as Bangladesh (less than 0.1 per cent), Pakistan (0.1 per cent), and Sri Lanka (more than 0.1 per cent),[27] have nascent epidemics, but the threat of HIV spreading is significant due to the prevalence of high-risk behaviours and high vulnerability.

- This huge region has 3.5 billion people in the most sexually active age range (15-49 years).[28]
- Asia is home to nearly 60 per cent of the entire population of the world.
- Due to its sheer size, the Asian population could have significant influence over the course and overall impact of the HIV pandemic.[29]

In single countries with vast populations, such as China and India, where prevalence rates are lower than in most of Africa and the HIV epidemic is less visibly widespread, other HIV-related issues have taken priority over OVC. Prevention is understandably the first priority, and treatment – bolstered by the momentum of the **WHO's 3 by 5 initiative** – is becoming more important.

Recently, the Indian government announced, to much fanfare, that it would provide free antiretrovirals (ARVs) to 100,000 HIV-positive people in the country's six most affected states. Initiatives such as this are welcome where programmes are comprehensive and effective – but barriers to distribution in India, such as poor infrastructure and crippling stigma, remain significant. OVC have been largely overlooked.

> 'We are starting to see AIDS orphans… I was in a village just yesterday where a friend had asked me to look at an orphaned boy of seven years old. He was living with his old aunt. She lives in extreme poverty. The boy's father had died of AIDS and the mother had been discriminated against and committed suicide, leaving the boy. The village people made me take the boy – who is sitting next to me here now eating a large quantity of rice.'
>
> Arogya Agam, a Christian Aid partner in Tamil Nadu

The issue of OVC has not been a major part of the debate surrounding HIV/AIDS in Asia. Although a direct parallel cannot be drawn between the spread of HIV in southern Africa and the future for Asia – the contexts are different – Asia's children *will* feel the impact of HIV, and the pandemic *will* mean a large and damaging increase in the number of OVC if HIV work in Asia is not scaled up.

Stigma and discrimination

> 'In India, with this new plan to have a 100,000 people on ARVs this year, nothing's been done. Or it's been done, but in places where stigma is so bad no-one's been to visit. So it's not followed through. Care is overlooked. There's no drive for community-based projects. OVC are neglected.'
>
> Ray Hasan, Christian Aid programme manager

Stigma is particularly problematic in Asia. Because the Asian epidemic is still relatively new and is expanding rapidly, stigma is even more pervasive and damaging than in Africa. Discrimination and denial undermine prevention and care efforts; those infected or affected by HIV are subject to abuse and marginalisation. Often, children find themselves excluded from school as a result of HIV in the family, with all the consequent risks that a lack of education entails. Worse still, children orphaned by the disease risk being abandoned by their subsequent carers, plunging them into extreme vulnerability, exploitation, abuse and poor health.

> **In Kerala, India**, the attention of the international press focused in 2003 on two HIV-positive children who had been continually being forced out of community schools.[30] Bency and Benson – at the time seven and five years old – had spent two years being excluded from various schools after complaints from other parents. The two children became symbols of the social discrimination faced by HIV-positive people in India. When they were finally admitted into a state-run school at Kollam in south Kerala, local residents forced them out by threatening to withdraw their children. Eventually the government arranged for them to be taught at home, where they have no one of their own age to talk or play with.

In Asia, HIV is more common in society's poorest and most socially excluded groups. This can often compound an already severe problem. OVC are frequently more neglected in such settings than they would be in Africa, for example, because even before they become associated with HIV they are identified with groups that are marginalised and discriminated against. Such groups might include sex workers and injecting drug users. OVC may be their children; or, as a result of the increased vulnerability that accompanies HIV and its associated stigma, OVC might even already be sex workers or drug users themselves. In addition, mothers identified as HIV-positive during antenatal screening are often abandoned by husbands and families, leaving them without a support network when their child is born.

Post-conflict environments

Cambodia provides a sobering example of a post-conflict environment. Like too many other places – the Democratic Republic of Congo, Angola and Sierra Leone, for instance – it is a setting in which OVC are especially vulnerable. The fighting that devastated Cambodia during the 1970s, 80s and 90s means that today's OVC constitute the second generation of unparented and unnurtured children to grow up in the country – a reality which will severely affect Cambodia's future.

Some aid workers estimate that about 40 per cent of OVC now living on Cambodian streets are orphans as a result of HIV.[31]

The local community often does not have the resources to care for OVC, and extended families and wider communities have frequently been decimated by decades of killing. An insufficient proportion of the older generation has survived to care adequately for increasing numbers of OVC; many of those who were not killed had to permanently leave their homes.

The extended family is not strong enough to cope. Church-funded orphanages are better resourced, with access to external funding, but simply do not have space to contend with demand.

Even aside from HIV/AIDS, Cambodia is a country where children are already highly vulnerable:

- malnutrition is widespread, particularly among children under five years and among expectant and nursing women. The country's malnutrition rates are among the highest in Southeast Asia[32]
- more than 50 per cent of the population is under 15.[33]

Maryknoll, an international NGO and Christian Aid partner working in Cambodia, runs programmes for OVCs and HIV-positive adults. In a context where many people are too poor to own anything more than the basic necessities of survival, the dying can often leave nothing personal for their children. Maryknoll helps HIV-positive parents to make 'memory books' containing pictures and drawings, personal writings and decorations – anything that will evoke a memory. It is hoped the children will relate to these books, even if they are too young when their parents die to remember them directly. At the same time, the process of making the books helps parents prepare themselves for dying.

'We need advocacy for the Rights of the Child and Education for All. Cambodia is a signatory to these conventions but they are far from realised. There is no social safety net and very few "free" essential services.'

Father Jim Noonan of Maryknoll, a Christian Aid partner organisation in Cambodia

OVC – a lack of policy

- By 2010, there will be more than 18 million OVC as a result of HIV in sub-Saharan Africa,[34] and 25 million worldwide.[35]
- If not for HIV, developmental gains would mean that the number of orphans in the region would be decreasing.
- The percentage of all the region's orphans who are OVC because of HIV has grown dramatically, from 3.5 per cent in 1990 to 32 per cent in 2001.[36]
- By 2010, it will be 50 per cent.[37]

Despite these facts, many of the most severely affected countries in Africa have no national policies to address the needs of OVC. The same is true for countries hosting the growing epidemics of Asia.

There can be no long-term, sustainable fight against HIV and poverty in the worst-affected nations unless responses are designed from a local perspective by the governments and people involved. **If there is a generalised HIV epidemic in a country, governments need to implement a national OVC strategy**. A strategic framework already exists in the United Nations Convention on the Rights of the Child, and Unicef has defined four key policy areas. The Unicef framework should form the basis of national responses.

International policies relating to orphans and vulnerable children

UN Convention on the Rights of the Child
It is the most widely signed UN convention – 192 countries are signatories. It is based on the following core values:

- The best interests of the child.
- Non-discrimination.
- The right to survival, well-being and development.
- Respect for the view of the child.

Article 65

The **2001 UN Declaration of Commitment on HIV/AIDS** stated in Paragraph 65 that the international community would:

'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 psychosocial support, ensuring their enrolment in school, and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.'

The UNICEF framework
The 2004 UNICEF framework for the protection, care and support of OVC living in a world with HIV/AIDS demands strong action on the following five fronts:

- Strengthening the capacity of families to protect and care for OVC.
- Mobilising and strengthening community-based responses.
- Ensuring access to essential services for OVC.
- Ensuring that governments protect the most vulnerable children.
- Raising awareness to create a supportive environment for OVC.

Economic impact

Poverty and the economic impact of HIV

HIV is fuelled by poverty. The economic and social effects of HIV are especially pronounced in comparison to other epidemic diseases, because it disproportionately affects adult wage-earners.

Christian Aid's 2001 report, *No Excuses,*[38] was a call to action for donors. The report:

- Called on developed countries to increase their overseas aid to meet the **United Nations target of 0.7 per cent of GDP**.
- Listed a number of steps that governments must implement to halt the spread of HIV and protect children from its effects. These included the provision of free healthcare and voluntary testing and counselling, prevention campaigns, the provision of free primary schooling and community-based care programmes for orphans.
- Highlighted the vital role of the churches, particularly in Africa, in educating people about HIV/AIDS and challenging the stigma and discrimination that surrounds it.

In 2004, the signs are not encouraging. HIV and poverty are often closely linked. Not only are the countries most affected by HIV some of the world's poorest, but as a result of HIV they swiftly become vulnerable to further impoverishment. Disease accompanies poverty. This is a key reason for the HIV epidemic's rapid proliferation. It spreads faster in populations where there is untreated sexually transmitted disease and where there are no effective HIV-prevention programmes. Such circumstances are more likely where there is poverty. In addition, the immune systems of people who are inadequately fed, badly housed and in poor health are weakened. This means that when they do become HIV-positive, they develop symptoms more quickly and die earlier.

One way of accelerating poverty reduction would be for developed countries to fulfil their commitments on aid. The rich world's promise to spend 0.7 per cent of their income on aid was made in 1970 and adopted by the UN General Assembly. Since then, the UK and most other donor countries (not including the US) have committed themselves to reaching the UN target; but more than 30 years later, the UK is still failing to live up to this commitment. Britain has currently pledged to donate 0.4 per cent of GDP to overseas aid by 2006, but several other countries, including France, Belgium and the Republic of Ireland, are now moving faster towards the target.[39] So far, only the countries of Scandinavia have reached it.

'The developed world must commit 0.7 per cent of its wealth to overseas aid by 2008. If this does not happen, quite simply we are consigning the next generation of the world's children to a lifetime of poverty and ill health.'

Daleep Mukarji, director of Christian Aid

Some of this aid money needs to be earmarked specifically for HIV spending. Funding for HIV prevention, care, treatment and orphan support is still inadequate. In 2003, global funding flows did not reach half the level considered necessary by UNAIDS for an effective response to HIV. UNAIDS estimates that this will require US$12 billion annually in aid by 2005, increasing to US$20 billion by 2007. These are minimal estimates – they do not allow for expanding health and education infrastructure. Moreover, costing estimates are currently underway for implementing the Unicef/UNAIDS framework, and preliminary figures suggest this alone may cost US$10 billion annually.

The consequences of failure

Without all rich countries meeting the 0.7 per cent commitment, international goals to halve world poverty and improve education and health by 2015 – the Millennium Development Goals (MDGs) – are in grave jeopardy. Already, progress towards meeting them is poor.

At current rates of improvement, the international community's health target for a two-thirds reduction in child deaths will be met 150 years late. Millions of children will continue to die from preventable diseases such as diarrhoea, pneumonia and HIV/AIDS. And it is already certain that the first MDG – to ensure equal access for girls to education by 2005 – will be missed.

The knock-on effects of the failure to meet education targets are significant. Without education campaigns and programmes designed to prevent high-risk behaviour, the threat of contracting HIV is higher. Young people are not taught what HIV is, what puts them at risk, and how to avoid it.

It is disturbing that girls' access to education is one of the first things to suffer from the failure to meet development goals. HIV is one of the most serious concerns facing women. Never before has a gender issue – the fact that all over the world, millions of women denied education and equality are not empowered to protect themselves – put so many women at direct, immediate risk of losing their lives. Halting the spread of HIV depends on helping women gain control over their own sexual decision-making. **Education is essential to avoiding HIV**. Without it, the deaths continue to rise.

The rich world is coming up short. But the fault lies also with the governments of the worst-affected countries. Across the world, national governments have failed to face up to the problem of OVC, with the result that their numbers are increasing and their prospects are becoming more and more bleak.

HIV may push some households into poverty; where a household is already poor the impact may be devastating. This was demonstrated by a recent Christian Aid case study conducted in the sugar belt of western Kenya,[40] where HIV prevalence is more than 20 per cent.

It is widely understood that extended families will bear the brunt of the OVC crisis. But they are being stretched beyond their ability to cope and caring for OVC is much more difficult in poor areas. The Kenyan study, carried out in a poor, high-prevalence area, showed that traditional community care is becoming impossibly overburdened. Interviewees reported that OVCs are no longer receiving their previous level of care, and child-headed households and street children have increased in number and frequency. These children are especially vulnerable to exploitation, violence and abuse – and therefore to HIV infection.

> 'The children lack proper care and parental guidance, so they make their own choices. They can end up in the wrong company and with the wrong people. People take advantage of them. Because they are poor they will do anything for food. They are at risk.'
> Respondent in CCFMC/Christian Aid study, Kisumu, Kenya

HIV's impact on growth

Not only are the countries most affected by HIV some of the world's poorest, but as a result of HIV they have become correspondingly more vulnerable to further poverty. Recent studies on the HIV epidemic's effects on economic growth predict a greater impact than previously thought. These studies take into account HIV's slow and ominous attrition of the community base of knowledge and skills.

Because HIV affects mainly young adults, it weakens the transmission of knowledge and abilities from one generation to the next, as increasing numbers of children are being left without parents to raise and educate them. The effects of this are only felt, however, after a considerable time lag. Damage is wrought not only to the community coping with HIV, but on its ability to develop for the future.

In 2003, an important World Bank study looked at the long-term economic impact of HIV in South Africa, arguing that the orphan situation is central to the overall economic effect of the epidemic. The study concluded that in the theoretical absence of HIV, modest growth could be predicted for South Africa, with universal education obtained over three generations. With optimal spending on a response to HIV – not currently the case – a slow rate of growth could be maintained. In dramatic contrast, if nothing further is done now to combat the epidemic, 'a complete economic collapse will occur within three generations.'[41]

Some progress has been made since *No Excuses* was published in 2001. In particular, international pressure has led to a decrease in the price of antiretroviral drugs. There are also new, easier-to-follow drug regimes and simpler monitoring. The prevention of mother-to-child HIV transmission has also improved, due to international pressure and commitment. But this means, while fewer children born to HIV-positive women are becoming HIV-positive themselves, they will inevitably become orphans unless their mothers receive treatment. Although the number of people receiving ART has increased, there is still no access to treatment for the vast majority of those who need it, despite the efforts of 3 by 5.

No concerted long-term effort has yet been made to counter the current OVC situation. As numbers continue to rise, the need for a sustainable response is increasingly urgent. The 2001 UN Declaration of Commitment on HIV/AIDS and the 2004 Unicef/UNAIDS Framework for the Protection, Care and Support of OVCs provide guidance for such a response.

The only long-term way to counter HIV in the developing world remains dealing with the poverty that allows it to flourish. This requires a combination of measures, mainly implemented by donor countries, including fairer trade policies, debt cancellation and increased aid. However, shorter-term measures to tackle HIV – and specifically the OVC crisis – are also needed.

National governments must develop policies that face up to the problem of OVC and provide for their safety in the long term. With this must come improved education and healthcare, and effective HIV-prevention programmes.

The barriers created by stigma – which obstruct effective OVC care – must also be tackled, in Asia's young epidemic in particular. Informed discussion and the education of key people such as health workers, religious leaders and teachers, which involves people living with HIV themselves, would go a long way towards challenging discrimination.

Recommendations

Donor countries must:

- ensure that at least US$12 billion is available annually for HIV programmes by 2005, and at least US$20 billion is available annually by 2007. Increases in HIV funding must not reduce funds available for other development work. Further additional funds will be needed if all OVCs are to be reached
- immediately announce timetables to reach 0.7 per cent of GDP in aid by 2008
- include a major OVC component in all HIV development programmes, which supports community work with OVCs, as well as government work
- ensure no international policies act as barriers to free universal primary education, or free healthcare for children.

Governments of countries with severe HIV epidemics must:

- complete national OVC strategies, as part of national programmes to tackle HIV. The strategies must, however, support all OVCs rather than solely those affected by HIV, as most people living or dying with HIV have not been tested
- base their OVC programmes on the following Unicef/UNAIDS framework:
    1. **Support families to care for OVCs**, for example through financial support, psychosocial support, and vocational training for teenage OVCs.
    2. **Support community responses** – with faith-based organisations and NGOs playing a key role – by encouraging more open discussion about HIV, enabling communities to define their own priorities, and supporting activities such as volunteer social-support schemes, childcare schemes, savings-pooling and youth clubs.
    3. **Ensure OVCs can access essential services,** for example by abolishing fees for health and education, and by encouraging parents to register children's births.
    4. **Protect the most vulnerable children** through a legislative framework which, among other things, guards against abuse and neglect, protects the inheritance rights of orphans and widows, and supports child-headed households.
    5. **Raise awareness about HIV to create a supportive environment,** for example by encouraging influential leaders to speak out against stigma and discrimination.
- pay particular attention to the needs of teenage OVCs, including HIV prevention programmes for this very vulnerable group
- continue to expand HIV-prevention work (reducing the numbers of OVCs in the long run) and treatment (enabling parents and children to live longer)
- factor the likely economic impacts of HIV – and of likely numbers of orphans – into policy decisions across government.

Churches and faith-based organisations must:

- make the most of their uniquely powerful position in many societies, taking a lead role in educating people about HIV, the risks of contracting the virus and how to avoid them
- acknowledge their role and responsibility in fostering compassionate responses to HIV among their congregations
- think innovatively, using their resources to implement community-based OVC care
- take a central role in challenging the stigma and discrimination surrounding HIV.

Endnotes

[1] *Children on the Brink 2002 – a Joint Report on Orphan Estimates and Program Strategies.* UNAIDS/UNICEF/USAID, New York, 2002
[2] *AIDS Epidemic update 2003,* UNAIDS and WHO, Geneva, 2003.
[3] An orphan is defined as a child under the age of 18 who has had at least one parent die. A child whose mother has died is known as a maternal orphan; a child whose father has died is a paternal orphan. A child who has lost both parents is a double orphan [UNAIDS 2004 Report on the global AIDS epidemic, Geneva 2004].
[4] *Children on the Brink 2002,* UNAIDS/UNICEF/USAID, New York, 2002.
[5] UNAIDS, 2004 Report on the global AIDS epidemic.
[6] *Children on the Brink 2002,* UNAIDS/UNICEF/USAID, New York, 2002.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] J Melby: *No Excuses – Facing up to the AIDS Orphans Crisis in sub-Saharan Africa.* http://www.christian-aid.org.uk/indepth/0105aids/aidsorph.htm.
[11] Stephen Lewis, UN secretary-general's special envoy for HIV/AIDS in Africa. Speech at the official opening of the 13th international conference on HIV/AIDS and sexually transmitted infections in Africa, 21 September 2003.
[12] RK Verma et al, HIV/AIDS and Children in the Sangli district of Maharashtra, *AIDS, public policy and child well-being*, chapter 8, Ed, Cornia, G A, Unicef, 2000.
[13] Landis, Robin. *Widening the 'Window of Hope' – Using Food Aid to Improve Access to Education for Orphans and other Vulnerable Children in sub-Saharan Africa,* World Food Programme, 2003.
[14] *Children on the Brink 2002* UNAIDS/Unicef/USAID, New York 2002. *AIDS Epidemic Update 2003,* UNAIDS and WHO, Geneva, 2003.
[15] UNAIDS, 2004 Report on the global AIDS epidemic, Geneva 2004.
[16] *Children on the Brink 2002* UNAIDS/Unicef/USAID, New York 2002. *AIDS Epidemic Update 2003,* UNAIDS and WHO, Geneva, 2003.
[17] UNAIDS, 2004 Report on the global AIDS epidemic, Geneva 2004.
[18] *AIDS Epidemic Update 2003,* UNAIDS and WHO, Geneva, 2003.
[19] Speech by Stephen Lewis, 21 September 2003.
[20] Ann Strode consulting & Nonkosi development services: 'The nature and extent of problems facing child-headed households within the Thandanani programme'. March 2003. http://www.thandanani.org.za/Downloads/PMB RESEARCH DOC AUG 03.pdf.
[21] Ibid.
[22] Ibid.
[23] *Children on the Brink 2002*, UNAIDS/UNICEF/USAID, New York 2002. www.usaid.gov/www.unaids.org/www.unicef.org
[24] 'The nature and extent of problems facing child-headed households within the Thandanani programme', 2003.
[25] UNAIDS, 2004 report on the global AIDS epidemic, Geneva 2004.
[26] Ibid.
[27] *AIDS Epidemic update 2003,* UNAIDS and WHO, Geneva, 2003.
[28] WHO, 'HIV/AIDS in Asia and the Pacific Region'. http://w3.whosea.org/hivaids/hiv_aids.htm
[29] Ibid.
[30] http://news.bbc.co.uk/2/hi/south_asia/2910335.stm
[31] Fr Jim Noonan (Maryknoll), letter to Christian Aid, June 2004.
[32] World Food Programme country brief, Cambodia. WFP 2004. http://www.wfp.org/country_brief/index.asp?region=5
[33] WHO/UNAIDS/UNICEF. *Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections – Cambodia, 2002 update*, UN, Geneva 2002.
[34] UNAIDS, 2004 report on the global AIDS epidemic
[35] *Children on the Brink 2002,* UNAIDS/UNICEF/USAID, New York, 2002.
[36] Ibid.
[37] Ibid.
[38] J Melby, *No Excuses – Facing up to the AIDS Orphans Crisis in sub-Saharan Africa.* http://www.christian-aid.org.uk/indepth/0105aids/aidsorph.htm, 2001
[39] http://www.christianaid.org.uk/news/media/pressrel/040331p.htm
[40] This case study was facilitated by Christian Aid partner Correspondence Course Franciscan Missionary Charism (CCFMC). CCFMC is based in Kisumu, western Kenya. Its work includes support for orphans and other children made vulnerable by HIV, and their families.
[41] Bell et al, 'The Long-Run Economic Costs of AIDS: Theory and Application to South Africa', 2003. http://www1.worldbank.org/hiv_aids/docs/BeDeGe_BP_total2.pdf