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Southern Africa's orphans

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Harare, Zimbabwe
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Dear Peter:

In northern Zimbabwe, near the border with Mozambique, there's a "village of waiting." The village is not waiting for development. It's waiting for death as well as for a new generation to grow up. The people there really have no other choice. Old people care for their sons and daughters dying of AIDS and then the orphans they eventually leave behind.

Thoughts about what will happen to her children when she's dead torment Grace more than her disease. Before she contracted AIDS, Grace was an independent woman who marketed vegetables in the village. As the sole breadwinner for her six children, Grace was proud that her eldest boy was in secondary school and three others were in primary school. But last year she grew weak and had to stay in a hospital for three months. "My parents are old and sick and couldn't help my children," Grace said. "The thought of my children, how they would survive, made me worse ill." Grace is now selling again but she can barely do the job. Her income is scarcely enough to buy food; too little to pay for school fees.

Her neighbor, a divorced farmer, is also dying of AIDS. Makorokoto, whose name means "congratulations," will leave three grade-school-age children for his mother to raise. "There is (the reason) why I fear for my children," Makorokoto said. "My mother is very old and she can't look after them. And I can't wash or cook or clothe or educate them because I have pain all the time. I can't even go to my fields because I'm weak."

A short distance away at Samson's place, an elderly woman is raising 18 children. Not all of the toddlers have lost both their parents to AIDS. Some of the mothers migrated to towns in search of work after their husbands died. Chances are, however, that these women are also infected with AIDS. They may not make it back alive to reclaim their children. "Only to look after AIDS orphans and not the others (with absent mothers), it's not nice," the weary grandmother said. "But there's no help coming from the children. We live hand-to-mouth."

There are many "villages of waiting" emerging across

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Since 1925 the Institute of Current World Affairs (the Crane-Rogers Foundation) has provided long-term fellowships to enable outstanding young adults to live outside the United States and write about international areas and issues. Endowed by the late Charles R. Crane, the Institute is also supported by contributions from like-minded individuals and foundations.

southern Africa and their numbers will continue to grow as AIDS infections spread. Zimbabwe, with a population of 10.4 million, is among the top five African nations hardest hit by the disease. An official count of 10,551 AIDS cases has been documented since 1987, but Zimbabwe's National AIDS Control Programme estimates that the true total tops 55,000. By the end of this year, the number of children orphaned by AIDS is projected to be 67,771. With more than 800,000 Zimbabweans (almost 8 percent of the total population) now infected with the virus, the number of orphans is expected to rise to 623,247 by the year 2000.

The statistics associated with the global AIDS pandemic can become incomprehensibly large. Some 2.5 million AIDS fatalities -- 70 percent on the African continent -- have been recorded in the last 12 years, according to the World Health Organization. These are deaths caused by infections contracted five to 10 years ago. By the end of the decade, another six million people will die of AIDS and 30 to 40 million others will be infected, WHO predicts. In Sub-Saharan Africa, as many as one-third of pregnant women attending urban health clinics are infected with the virus, and they have a 30 percent chance of passing it on to their unborn babies, according to the United Nations Children's Emergency Fund (UNICEF). As a result, infant mortality rates may rise to 50 percent by the end of the century, killing four to eight million children, one UNICEF study states. An additional 10 to 15 million children under 10 years of age will be orphaned.

"The situation is just about to be unmanageable," said Claudius Kasere, the deputy director of Zimbabwe's Department of Social Welfare. "The day is fast coming when families will be unable to cope and that worries us, the people and the government. For as long as there's no cure, no vaccine, we have to create coping mechanisms if we are to survive as a nation. We have to capture our old past, the old morals where virginity is respected. If we do that, then the future is brighter for the next generations. If we fail, then all is blackness and death."

Throughout southern Africa, children orphaned by AIDS have been absorbed into extended family networks. As the numbers grow ever larger, however, traditional ways of caring for orphans may not stand up under this human tidal wave. At the same time, the existing public and private institutions are almost filled to capacity and building new orphanages is too costly for cash-strapped African countries. Even if foreign donors could fund inexpensive barracks-style accommodation for parentless children, most southern Africans see institutional care for orphans as the worst of all alternatives. Lacking solutions, governments shift the blame and burden of AIDS onto individuals, their families and their communities. They already or may soon lack the resources to adequately cope. In the end, social disaster will be averted only with a massive commitment of public funds to enable the region's communities to assimilate the children orphaned by AIDS.

"The grandmother's disease"

In southern Africa, the problem of orphans is less visible than in many Central and East African countries because the extended family remains mostly intact here. A recent survey in a one district in western Uganda found 25,000 orphans out of a population of 350,000. There, the term "child-headed household" has become common because the extended family is so disrupted. By contrast, AIDS in this region has been called "the grandmother's disease." Although a grandmother typically does not contract AIDS, it is becoming common to find a grandmother nursing her terminally ill child at a time when she is traditionally supposed to be supported by her family. And when the ill son or daughter dies, the grandmother loses the economic support her grown child once provided and suddenly becomes mother to her grandchildren, an expensive job. She must rely upon her own feeble efforts to cultivate land for food or upon the generosity of her other relatives, which usually is not forthcoming. Poverty compounds her burden, which in some cases can be caring for more than four grandchildren.

More and more elderly must share their meager resources with orphaned grandchildren.

The findings of one Botswana study are representative of how the extended family works throughout this region. The researchers studying the social impact of AIDS surveyed 67 orphaned children in a traditional area southeast of the capital city of Gaborone. About half (34) of the children had been orphaned by AIDS, but all of them had been absorbed into extended families. The orphans' caretakers --- elderly grandmothers and sometimes aunts --- had an average age of 56 years. More than three-quarters of the caretakers said they regarded the orphans as a burden and two out of three said they needed outside help to cope. Some asked to be relieved of their new hardship. Few received assistance from government social welfare services or non-governmental organizations (NGOs). Yet all those interviewed agreed that the extended family was the best place to raise an orphan because traditionally it is there that the child can get more love than any other place.

"One orphan is attending school. He has a handicapped hand and bad sight. He does not manage well in school. He misses his mother. His poor vision could be helped by a pair of glasses but they can not afford a pair. He also needs a school uniform. The one he has on is worn out and is too small. He has never had a pair of shoes although he is almost 15 years old. The children look under-nourished, but the family does not have enough food. Porridge is served mornings and afternoons, only seldom with vegetables or meat."

From: "The Social Consequences of AIDS: A Study of the Impact on Children," conducted in 1992 by the AIDS/STD Unit, Ministry of Health, Gaborone, Botswana.

Today, there are less than 1,000 children in Botswana who have been orphaned by AIDS, but that number will dramatically rise if present trends continue. In 1993, a sample of pregnant women attending clinics in the nation's two largest cities were tested for the AIDS virus. In Francistown, one out of every three expectant mothers tested HIV positive; in Gaborone, one out of five. In rural areas, that number declined to one out of 10. Based on a wider testing, government researchers estimate that 92,000 persons are now infected out of a population of 1,325,000 -- about 7 percent of all citizens or 15 percent of the sexually active population. The researchers project that there will be 205,000 additional infections and 39,000 deaths from AIDS-related illnesses in five years' time. Within seven years, they believe the number of orphans left behind will exceed 30,000.

Using the standard definition in this region, an "orphan" is a child who has lost his or her mother or both parents. Often losing the mother destroys the family. One remarkable finding of the Botswana study is that fathers played little or no role in

supporting their children once the mother died. Of 54 living, biological fathers of orphans, only two helped in the upkeep of their sons or daughters. It's a pattern in both Botswana and the region that women shoulder a disproportionate amount of family responsibility, and grandmothers are no exception in these cases.

In Zimbabwe, the AIDS pandemic creates a similar ordeal for grandmothers. Most cases begin with young men migrating from rural homes into the towns to find employment and start a family. These men settle in an urban area and almost forget about the extended family left behind in the countryside. But when AIDS attacks the man, he finds it hard to maintain his family in an urban setting. Unable to pay rent or utilities, even a prominent man will go back to his rural roots. He returns with his wife, who's already infected, and five or six children. This is when the grandmother starts the drudgery and unpleasantness of caring for her ill son and daughter-in-law as well as their children.

Lack of resources

One reason the responsibility of caring for family members with AIDS falls upon elderly women is the lack of adequate government health care in Zimbabwe. Current economic austerity measures have curtailed state funding for hospitals and clinics, which already faced an acute shortage of doctors and nurses, beds, drugs and even minor equipment like rubber gloves. It's become more and more common that Zimbabweans with AIDS receive hospital treatment only for the acute phases of illness. The rest of the time, people with AIDS are usually sent home, often to a communal area, to be cared for by the family.

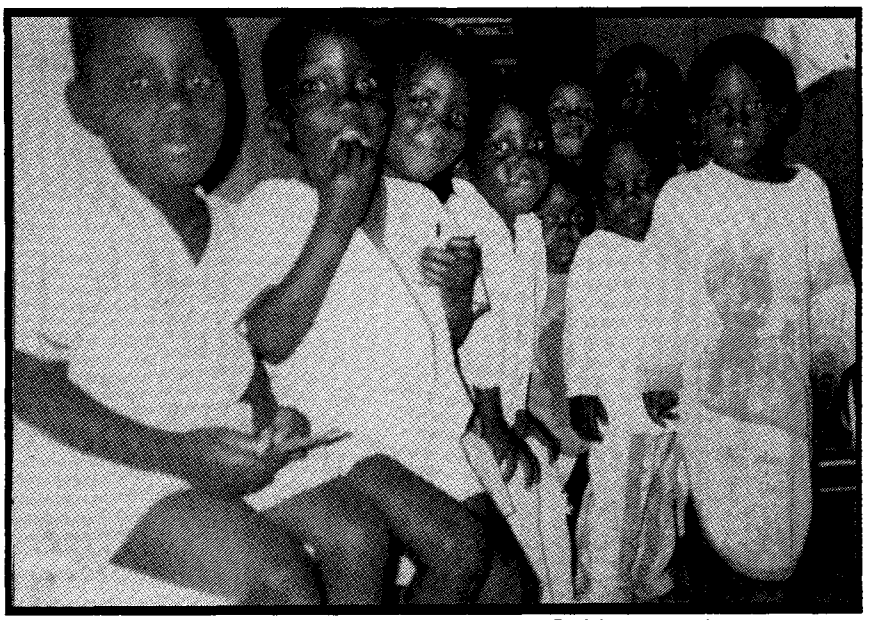
"The first problem of the elderly is the care of terminally ill adult children without much resources," said Tavengwa Nhongo, director of the Zimbabwe branch of HelpAge, an international NGO assisting the elderly. "They can't afford basic drugs, cotton wool, antiseptic or even a proper toilet. So a person sick with AIDS lies on the hard ground in a hut, having diarrhoea or vomiting. There's no latrine, so elderly parents must carry the ill to the bush five or six times a day, cleaning up afterward without rubber gloves and maybe not even a bucket of water to wash the sick. Then, the aged must care for the grandchildren, paying for school fees and uniforms. And kids have to eat. The needs are immense for the elderly struggling without support."

HelpAge conducted a study to find out how many elderly care-givers need help in the Karoi area, a farming region of northwestern Zimbabwe where the number of AIDS cases has soared. The main transport route to Zambia runs through the district, so there is a lot of prostitution connected with truck drivers who stop over in Karoi. Soldiers from nearby army barracks also play a role in spreading AIDS. Despite a swift increase in AIDS cases, which jumped from 16 in 1986 to 635 in 1989 and is much higher

today, the study found virtually no organized prevention measures or support programs for AIDS patients and their families. Health services are understaffed and ill-equipped. Further, the survey found that patients diagnosed with AIDS are often not informed of their condition precisely because the medical staff worry about the patients' reactions in the absence of counseling or support.

The study found that children make up 70 percent of the area's population, while the elderly constitute 5 percent. The remaining 25 percent is comprised of those aged between 17 and 45 years, the principal group to be infected with AIDS. Of the 90 orphans in the study group, none were attending school because their extended families cannot not afford the fees and uniforms. The onus of caring for the children orphaned by AIDS was aggravated by community prejudice. Normally, neighbors are supportive and will help fetch water or wood, cook food and clean. However, the study found none of this ordinary help is offered if there is a suspicion the deceased suffered from AIDS.

Institutions are not the answer



Harare Children's Home is almost at full capacity.

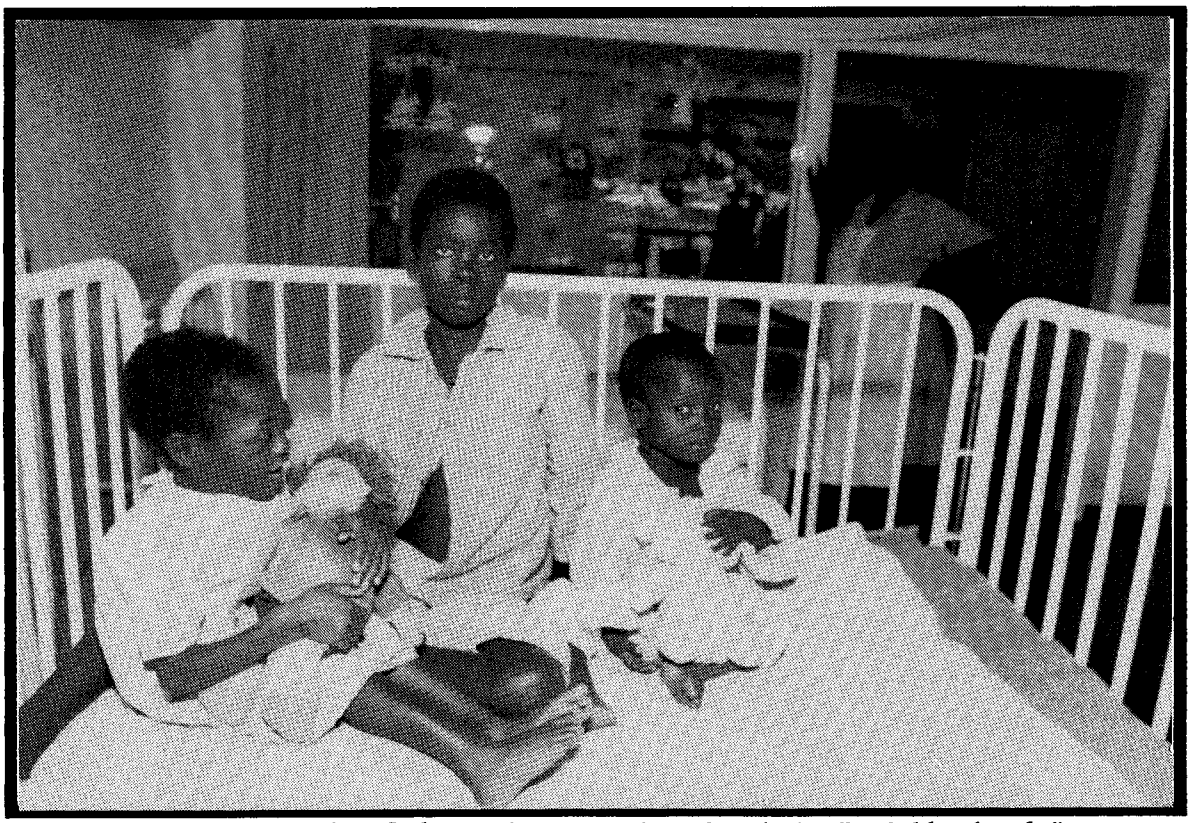
Although the extended family system in Zimbabwe lacks resources, the alternatives are limited. State-financed institutions are usually reserved for abandoned infants or for troubled children. The nation's 35 orphanages operate with tight budgets at capacity. Harare Children's Home, for example, houses 70 children between the ages of 4 and 18 and there are 20 babies in the nursery. Beds are open for a handful of new admissions, but Director Maria Sithole said the home is already struggling to survive: It can't take an influx of children orphaned by AIDS and certainly does not want to take orphans infected with the disease themselves.

"AIDS is my main worry," Sithole said. "What would happen to us? We have 13 to 15 children staying together in each dormitory.

We have one child, almost 7, who is HIV positive. He's not ill yet but I know it will come. We just don't have the facilities to look after him." And her worries stemmed from just one child. Many of the children's homes in Zimbabwe are privately run and those in charge have the right to accept or refuse a child.

There is little incentive to change their minds. Sithole and others say that state support for orphans, usually Z$110 a month or about US$17, is difficult to get from the state bureaucracy. Months, sometimes years, can lapse before the state begins to pay what it should have long ago. One community health worker commented that government officials continue to ask for the names of new orphans so they can enroll them for state support. "But if the government can't even pay for those they know about, how can they start paying for these other 'forgotten ones'?"

Institutional assistance can even undermine the mechanism of care by the extended family. Once relatives find that an institution will care for the orphaned children, they relinquish responsibility. For example, it's estimated that every major hospital in Zimbabwe now has up to eight or nine children who were dumped there or admitted with ill mothers who later died. Nobody comes to claim these children. Relatives abandon them because they are disabled or, if their parents died prematurely, they are seen as carriers of AIDS whether they have contracted

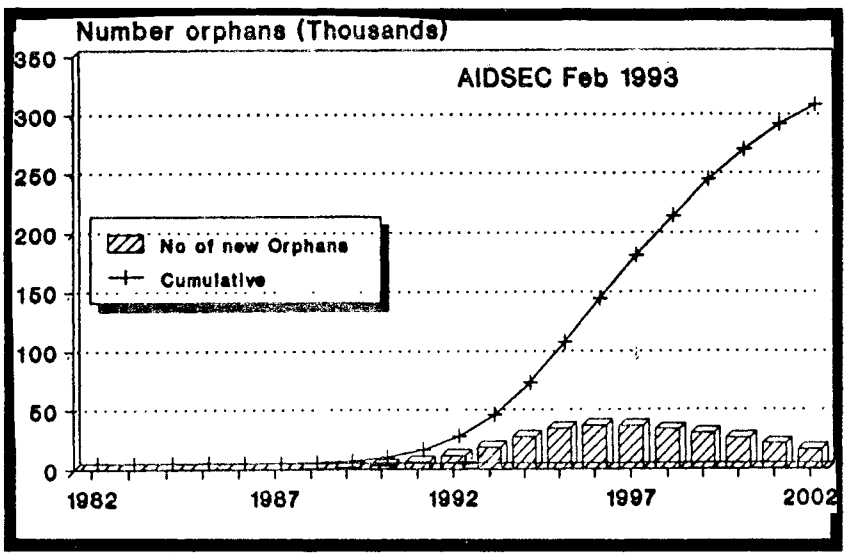


Angelica, Faustina and Tafadzwa play together in their "neighborhood."

the disease or not. These children grow up inside the hospital wards, where nurses act as surrogate mothers during breaks.

Several poignant examples can be found at Parirenyatawa Hospital in the capital city of Harare. Here, 4-year-old Tafadzwa has stayed for six months since his mother died following surgery. Insiders speculated privately that complications from AIDS contributed to her death. Angelica, whose mother died at the same hospital 11 months ago, suffers from tumors that are distorting her face and crippling her body. The tiny 3-year-old girl's father never came for her. A social worker visited the address listed by the mother but was unable to find relatives willing to take Angelica. Faustina, 12, was dumped at her grandmother's house with her four brothers and sister when her father remarried and moved to another city. Then, when Faustina began having heart problems and had to be admitted to the hospital, her grandmother stopped visiting her. "The cost of living doesn't encourage the extended family to step in," said Spiwe Mutare, matron of the children's ward. "When parents see that Child Welfare is looking after the kids, they're quite happy to walk away."

The search for alternatives



Orphans under 15 years old in Malawi assuming no HIV transmission from 1992.

Many governments in southern Africa realize that a catastrophe is looming: Most have begun to formulate strategies for the future care of orphans. In Malawi, for example, the government's task force on orphans drew up policy guidelines that focus state commitment on supporting the social security offered by extended families. States the policy: "Emphasis should be placed on assisting/empowering the extended families with skills to earn income to meet cash needs on the one hand, and inputs like seeds and fertilizer to enable them to produce enough food for the family on the other." The guidelines state that institutions should be considered only as a last resort.

Although there are more than 25,000 orphans in Malawi (the figure could rise to between 280,000 and 360,000 by the year 2000), focus group discussions held by UNICEF in March revealed that rural communities don't consider the care of orphans as a priority. Instead, people considered important issues to be development problems, such as a lack of schools, roads, clean water and health care. Although most rural villagers had heard of AIDS and knew that it was a big problem, none would privately identify a person who died of AIDS or any children orphaned by the disease. As a result, UNICEF facilitators concluded there is still a large degree of denial in the communities as well as a stigma attached to the children of AIDS sufferers.

Botswana's government is also at work on a new policy that recognizes the disease as not only a health problem but a social one as well. The policy, drafted by the Ministry of Health, calls on three key ministries to join its efforts. The Ministry of Finance and Development Planning would mobilize financing and coordinate foreign aid while the Ministry of Labour and Home Affairs would develop a social welfare network for families caring for orphans. The Ministry of Education would teach pupils about AIDS awareness, even in primary schools. The President's Office would also get involved by exerting political leverage to ensure the coordinated campaign is carried out. But while all these civil servants mobilize, public attitudes still lag behind.

A Catholic nun who founded Botswana's first home-based AIDS care program finds that her job can be difficult. Sister Christa Kibblestein often can't use her truck to visit the families in Ramotswa, a village about 30 kilometers south of Gaborone. It has been identified as "the AIDS vehicle," so Kibblestein has to walk to clients' homes to avoid drawing attention. Her support program for people with AIDS attracted only two or three participants at the area hospital, so she switched the get-together to a neutral place. Nobody showed up.

"There's a lot of denial in this country," said Susan Hamilton, information coordinator for Botswana's AIDS/STD unit. "We have good representatives, good studies and good research. The thinking is OK and the money is fine. But what we don't have is community partners. We're trying to coordinate but we (government officials) are having to implement everything."

In Zambia, the deputy minister of health, Dr. Katele Kulumba, said that until former president Kenneth Kaunda admitted in 1987 that one of his sons died of the disease, the government had ignored the epidemic sweeping the nation. By then, it was too late. Today, between 60 and 70 percent of hospital beds are occupied by AIDS patients. UNICEF estimates that 80,000 Zambian children have been orphaned by AIDS, with 12,000 of those children in the capital city of Lusaka alone. Kulumba said that in a worst case scenario the number of orphans may rise to half a

million by the end of the century.

Zambian President Frederick Chiluba is personally spearheading a vigorous AIDS publicity campaign. He appears in television commercials and full-page newspaper advertisements urging Zambians to use condoms or be faithful to their partners. Chiluba needs such low-cost strategies. Although government allocations to combat AIDS have increased from US $100,000 to $449,000, the disease is now undermining Zambia's economy. "Our budgetary capacity will not cope," Kulumba said. "Worse still, AIDS is beginning to hit the cream of Zambian society, the people we have invested in." And Zambia's health system is in ruins, with state hospitals poorly staffed, overcrowded and run-down. One doctor attends to an average of 500 patients a day in urban areas. In rural districts, few patients see a doctor.

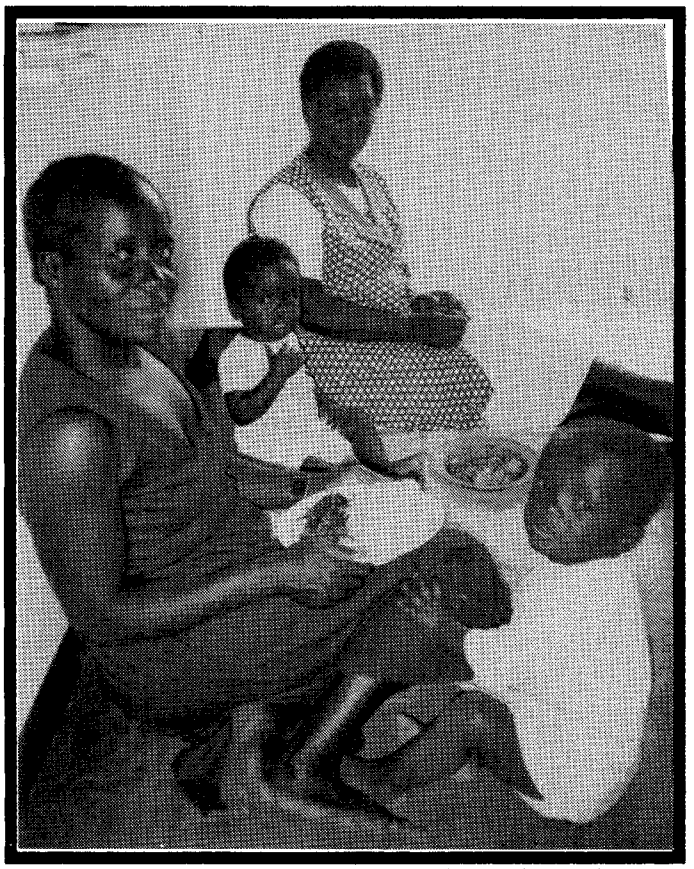
No wonder NGOs have stepped in to help extended families cope with Zambia's exploding orphan population. Dr. Shilalukey Ngoma, a pediatrician at Lusaka's University Training Hospital, founded the Children In Distress (CINDI) project with support from the non-profit Family Health Trust. He said the issue of children in distress now affects every member of Zambia's larger community. Said Ngoma: "CINDI is only a catalyst to increase awareness of orphans and also to increase care for them. Communities themselves are central to the care of these orphans."

In Lusaka's urban townships, CINDI helps set up committees of neighbors to act as foster parents for orphaned children. Members visit the children at the caretakers' homes and ensure they have basic necessities, such as clothes and food. Like others helping orphans, however, the group found assisting only the parentless child and not all members of the family can lead to division. "How would you feel giving one child new clothes when the others do not have?" asked one CINDI branch coordinator. Soon, CINDI may change its name to FINDI -- "Families in Distress" -- to better help entire families caring for orphans.

The government of Zimbabwe has not formulated a national strategy nor set up a policy-making body yet. Instead, it is waiting for the results of UNICEF-sponsored researchers who will study how extended families are coping with the care of orphans in Zimbabwe's southern province of Masvingo. The study will begin in November. "The issue is of utmost importance but it can't be handled haphazardly," said Claudius Kasere of the Department of Social Welfare. "We can't merely adopt traditional practices without knowing if they're still practical."

Non-governmental organizations and church groups in Zimbabwe have taken the lead in assisting orphan-raising families that get little state support. Their burden is great. In the Manicaland province, for example, 19 state-assisted institutions care for only 170 of the estimated 47,000 orphans in the province; 99.5

percent of the orphans are cared for in the larger community.



"Replacement mothers" at lunch with orphans

In the "village of waiting" described at the beginning of this essay, Catholic nuns from nearby Marymount Mission provide the families of orphans with food and school fees. In addition, they train villagers to care for people with AIDS and their children by assisting in household tasks. "Looking after orphans is not a new thing, it's part of our African heritage," Sister Kizita Chikamba said. "The community wants to help each other but they lack material resources to do so. All we have done is enable people to support one another."

At Makumbi Children's Home, about 30 minutes from Harare, some 85 orphans are living in artificially created "family care homes" in the Chinamora communal area. About 11 children stay with a matron in each house, while older male parishioners at Makumbi Mission act as visiting uncles. Older girls often help the replacement mothers run the households, assuming a role that's traditional in normal Zimbabwean families. The director at Makumbi, Father Konrad Landsberg, admits the program experiences problems in trying to make "an abnormal situation into a normal one." AIDS complicates matters. Two sets of children lost their parents to AIDS. A 10-year-old child has now tested positive for the virus.

"Society puts pressure on even healthy children, testing their strength, so it's even more difficult for these kids," Landsberg said. "They have emotional problems. They're very badly damaged because of the social breakdown of family units. The family doesn't exist any more for people in town." Landsberg frankly admits that he's scared of the future. "I'm aware of this huge number of AIDS orphans coming, but how to cope -- I don't know. There's need for some heavy thinking in this country but I'm afraid no one is ready for that. It'll be a big disaster."

Coping with change and changing to cope

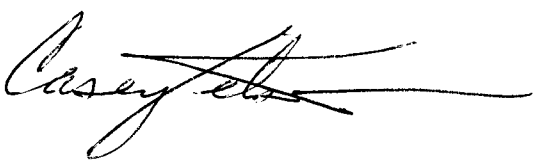
Others who are equally involved in assisting children orphaned by AIDS reject such a grim assessment. "From a journalistic perspective, an AIDS disaster makes a good story but I'm not sure that's the best picture to provide," said Dr. Geoff Foster, a pediatrician at the provincial hospital in the eastern city of Mutare. "It educates the (international) public to say: 'You poor African child!' and 'You pathetic African nation!' The extended family is functioning here. If the same situation struck in the United States or the United Kingdom, children would be dying homeless in the streets."

Foster has worked as a government doctor for seven years in Zimbabwe's eastern city of Mutare. At first, he traveled around the province to treat children with AIDS. Now the system is so overwhelmed that Foster treats 100 children in the hospital at any one time. He realized that the state medical establishment had effectively taken away from the community the responsibility of caring for the sick. "The community was under strain. I saw ruptures. But our institutions ignored the extended family system." In response, Foster founded a group called Family AIDS Caring Trust in 1987 to promote AIDS awareness and counsel those infected. Only in 1991 did FACT begin working on orphan issues.

The doctor, who once studied to be a minister, says that community coping mechanisms are constantly being adapted by families to accommodate changes taking place in society. For example, orphans were traditionally adopted by the father's side of the family. Now, however, the maternal family is taking charge, perhaps because orphans are no longer seen as cheap agriculture labor but as a drain on a household economy. Whatever the reason, the change is for the better because an orphaned child's emotional links are stronger with the mother's family, Foster said. "We don't need to design new western-style means of dealing with orphans, such as orphanages, day-care centers or paid foster parents," he said. "We need to sit quietly and let the community find its way. And not by default, but with resources."

In the fight against the AIDS pandemic, perhaps too much emphasis can be placed on HIV-testing, condom distribution and pricing, and AIDS awareness education. These are all important considerations, but they fail to address the social impact of AIDS on families and their communities. The question yet to be answered is how southern African societies will care for the huge numbers of children soon to be orphaned by AIDS. I think the real answer lies in finding ways to help individuals change their behavior and communities gain the resources to help the next generation survive.

Sincerely,



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