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Strategies for providing care and support to children orphaned by AIDS

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Abstract *As a result of the severe HIV/AIDS epidemic in sub-Saharan countries such as Zimbabwe, where between 25–30% of the adult population are estimated to be infected, there are a growing number of orphans requiring care and support. Traditionally, orphans have been absorbed within the extended family but this is becoming more difficult because of the large number of young adults dying. The burden of care and support is falling on the very young and the very old. A number of strategies have been introduced to provide this care and support. Institutions. though popular, are very expensive to run, have limited capacity and only really cater for physical needs. Interventions which simply react to those who present to them may not reach the most needy and may encourage dependency. Community-based orphan care has been identified as the best and most cost-effective way of caring for orphans. An example of a community-based orphan visiting programme is presented. In the last six months of 1996, the FOCUS programme's 88 volunteers made a total of 9,634 visits to 3,192 orphans in 798 families at an average cost of US$1.55 per visit. The key elements of such programmes have been identified. They need to be implemented by a community-based organization (CBO) within a defined community. Volunteers should be selected from within the community. They need to be trained and supported as they enumerate orphans, identify the most needy and carry out regular visits. The volunteers should keep records of all their activities. These records can then be used as a basis for monitoring the programme. In order to cope with the increasing number of orphans in resource-poor settings like Zimbabwe, it is essential that such programmes be replicated and scaled up. This is not only an economic necessity but is also a way of providing appropriate and effective services to those who need them.*

Introduction

In 1994, it was estimated that there were 16 million people living with HIV in the world. Of these, 10 million were living in sub-Saharan Africa (Kwarting & Moody, 1995). Botswana and Zimbabwe are estimated to have the highest per capita infection rate in the world (WHO, 1995). Seroprevalence studies carried out in Zimbabwe estimate that 25–30% of the adult population are HIV-positive (MOH, 1993). The Ministry of Health estimates that 1.5 million people out of a total population of 11 million are HIV-positive.

It is estimated that life expectancy for women may fall from 57 to 30 by the year 2000. The percentage of maternal orphans may rise from 3% to 22% over the same time period (Gregson *et al.*, 1994; 1996). As early as 1992, a study in the Zimbabwean province of

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Manicaland revealed that one in five households contained orphaned children and 13% of children under 15 years had lost one or both parents (Foster *et al.*, 1995).

Community coping mechanisms

Orphanhood itself is not new. Traditionally in Zimbabwe, orphans have been incorporated into the extended family (Drew *et al.*, 1996a; Gelfand, 1973). This mechanism may be adequate to cope in areas with moderately high HIV infection rates (Urassa *et al.*, 1997). However, this is now difficult in areas where a very high number of young adults are dying. The burden of care is falling on the elderly and adolescents. As a result we are seeing the emergence of

- grandparent-headed households
- adolescent-headed households (Foster *et al.*, 1997b)

The impact on families starts well before parental death. Effects include loss of income and role reversal (Kwarting & Moody, 1995). One of the major problems faced by extended families seeking to provide for orphans is extreme poverty (Drew *et al.*, 1996b).

Strategies for supporting children orphaned by AIDS

Three different strategic approaches to this issue can be identified.

Institutional

There are various types of institutional orphanages. These often provide high quality care in terms of material needs such as food, clothing, etc. However, they have limited capacity and are very expensive to run and do not provide adequately for other needs such as belonging to a community.

Reactive

Various organizations react to orphans coming to them by providing for basic needs. These also provide mainly for physical needs. They may not reach the most needy and encourage dependency.

Community-based

Under this approach, community-based volunteers identify the most needy children within the community and visit them regularly. Material assistance, where provided, is channelled through the volunteers. Emphasis is placed on self-reliance.

The orphan policy developed by the Zimbabwean Department of Social Welfare clearly encourages community-based care as the best and most cost-effective method of caring for orphans (Figure 1) (DSW, 1995).

Community-based orphan support—an example

Families, Orphans and Children under Stress (FOCUS) is a programme which supports community-based orphan initiatives in four rural sites in Manicaland (Foster *et al.*, 1996).

1. Immediate family
2. Extended family
3. Community support to elderly/adolescent-headed households
4. Foster care/adoption
5. Village-type institutions
6. Dormitory-type institutions

Institutional care should be seen as temporary and a last resort

FIG. 1. *Places for provision of child care in descending order of preference (adapted from Draft Zimbabwian National Orphans Care Policy).*

It is administered by Family AIDS Caring Trust (FACT) and supported by PLAN International.

At each site, volunteers from different churches are identified. In most cases these are women, many of whom are widows themselves. They are provided with basic training so that they are able to identify and register orphans in the community. The most needy are then visited regularly.

In the last six months of 1996, the 88 volunteers made a total of 9,634 visits to 3,192 orphans in 798 families (Figure 2). Families receive an average of 1.5 visits per month. Each volunteer makes an average of 18.2 visits per month (Figure 3).

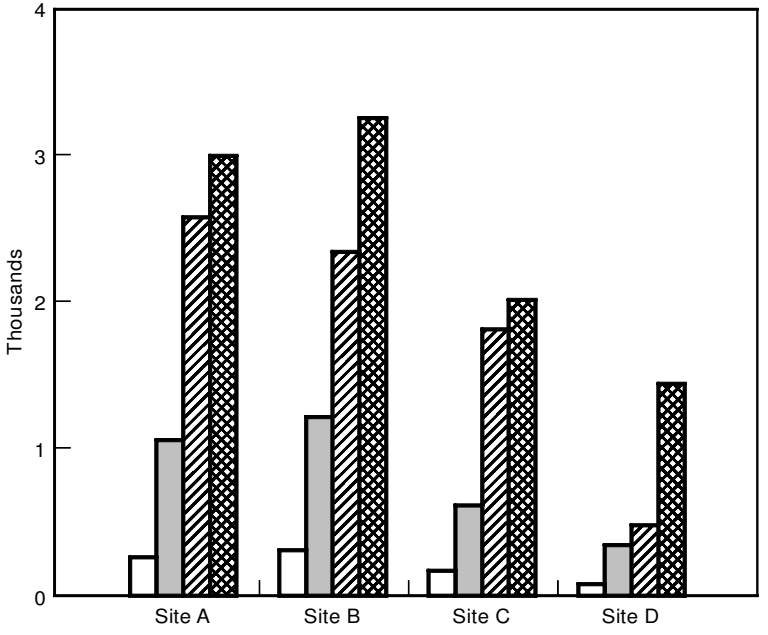

FIG. 2. *FOCUS Programme activities 1996.* □ *families;* ▦ *orphans;* ▨ *visits Jan–Jun;* ▩ *visits Jul–Dec.*

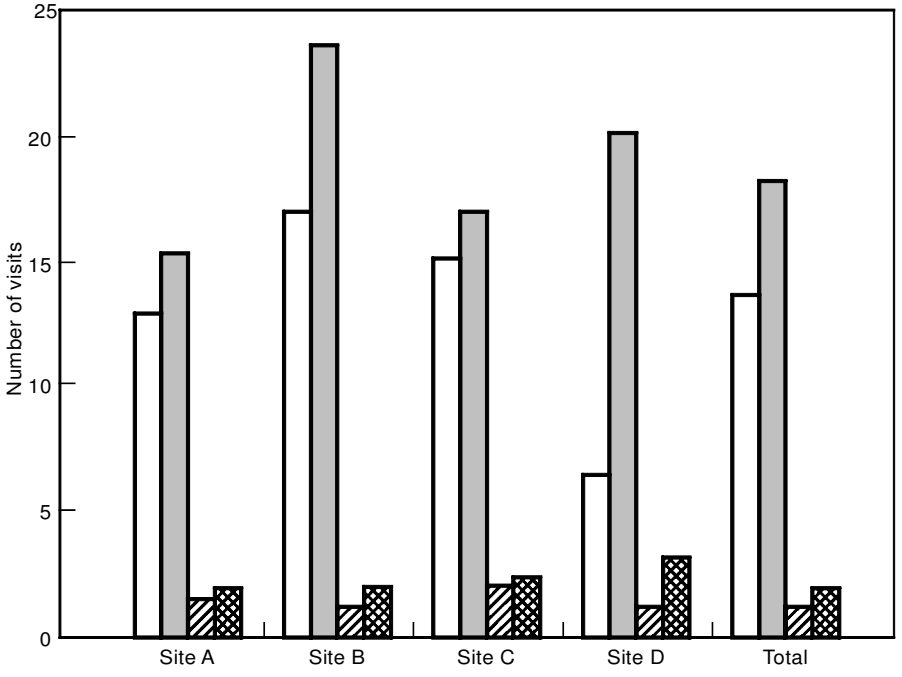

FIG. 3. *Visits per month: FOCUS Programme activities 1996.* □ *visits per volunteer (Jan–Jul);* ▦ *visits per volunteer (Jul–Dec);* ▨ *visits per family (Jan–Jul);* ▩ *visits per family (Jul–Dec).*

Some material assistance has been provided in the form of food, clothing, blankets and primary school fees. Projects have been started at each site to encourage self-reliance. The total cost of the programme in 1996 was approximately US$26,000. Of these costs, 51% was spent within the communities affected. This consisted of volunteers' meetings (11%), incentives (9%) and material assistance (31%). The indirect costs consisted of staff salaries (27%), transport (13%) and other office costs (9%) (Figure 4). The programme cost

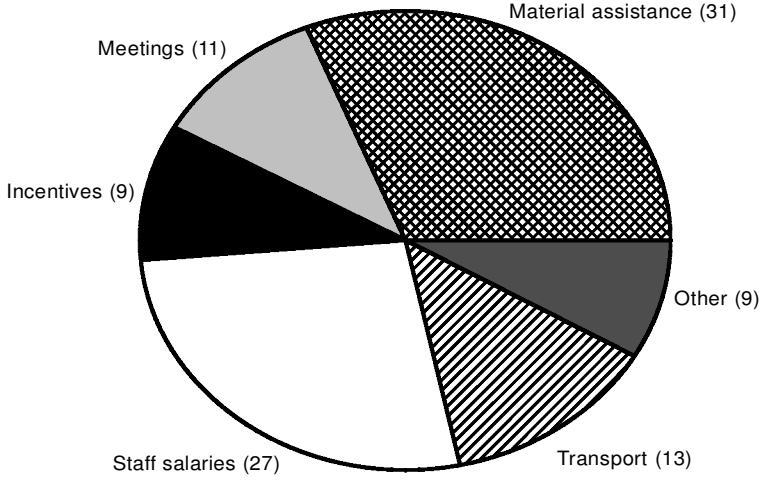

FIG. 4. *FOCUS Programme costs 1996.*

approximately US$2,200 per month, US$2.70 per family per month, US$0.68 per beneficiary per month and US$1.55 per visit.

A number of key steps have been identified in establishing community-based orphan support programmes (Drew, 1996; 1997). These include the following.

Organizational analysis

Only Community-Based Organizations (CBOs) can implement these programmes. There is a need to decide whether an organization is an implementing CBO or an organization that will play a supportive/mentoring role such as an NGO or government agency.

Community identification

The community where the programme is to operate should be identified. There should be a defined catchment area. The programme is more likely to succeed if it is based on and develops pre-existing activities.

Volunteers

The volunteers are the key human resource within the programme. Great care should be taken over their selection, training, support and motivation. Paid staff are not primarily implementors but should take on a co-ordinating role.

Client identification

Steps in client identification include defining the target group, enumeration, registration and needs assessment.

Monitoring and evaluation

A record system needs to be established and the volunteers trained in its use. Community mapping of the catchment area is a crucial activity in the development of the programme. Objective process and outcome indicators need to be identified and measured.

Discussion

Community-based orphan support programmes are able to support orphans in a way which complements existing coping mechanisms. Such support is cost-effective as it enables large numbers of orphans to be supported within their own communities. The cost per visit of US$1.55 is much lower than the US$14 to 38 per visit reported in some Zambian home care programmes (Chela *et al.*, 1994). This is largely because visits are carried out by volunteers who live in the same communities as the beneficiaries.

However, such programmes have not been widely adopted. There are a number of reasons for this. First, children are often not allowed to speak for themselves (Foster, 1997a). As a result, issues affecting children are often given less priority than those affecting adults directly. In addition, AIDS remains a problem that is largely hidden. Because of continuing stigma AIDS is rarely identified as a cause of illness or death. In some cases, the extent of the problem is recognized and acknowledged but no response is planned because the size of the problem is too great.

Politicians and the media do not seem to be aware of the value of community-based orphan programmes. They still continue to focus on institutional-based responses. New child care institutions continue to be established and to attract scarce resources. Such institutions, in marked contrast to health care institutions, have shown little initiative with respect to providing care within the community. Although the Department of Social Welfare has accepted the need for a community-based response, it lacks the resources to effectively support this.

The FOCUS model appears to offer cost-effective support to those seeking to care for orphans within their community. The programme, which was initially introduced and piloted at one site, has been successfully replicated at three further sites. In each of these sites, the programme has been implemented by a church-based CBO with support from a local NGO (FACT). It might be possible to introduce similar programmes with different CBOs provided that they have a commitment to providing care and support for orphans and have a pool of committed people from whom the volunteers can be drawn.

In order to cope with the increasing number of orphaned children, such programmes will need to be scaled up. Doing this, whilst preserving the key elements which have been identified presents a challenge which needs to be grasped. Elements which are too easily overlooked include support and ongoing training for volunteers, monitoring and evaluation. These elements appear to be essential for the success of the intervention.

In order for such programmes to be replicated and scaled up, resources will be required. In order for these to be made available, decision-makers will need to be convinced of the value of such programmes. Research into the impact of programmes like FOCUS provides a basis for such lobbying and advocacy.

In the context of Zimbabwe and other sub-Saharan African countries, where HIV prevalence rates are high, mortality rates are rising and resources are scarce, community-based orphan support programmes, like the one presented here, are not only an economic necessity, they are also an appropriate and effective way of providing child care for the large number of orphans found in such settings.

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