

AIDS

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IN REVIEW

A Growing Orphan Crisis

FROM THE EDITOR

In Focus is an online bulletin of the **UNDP International Poverty Centre (IPC)**. Its purpose is to present succinctly the results of recent research on poverty and inequality in the developing world.

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Large Standing Woman I, Tall Figure II
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Special thanks to Mark Connolly (UNICEF), Richard Humphries (SAPRN), Jill Kruger (HIVAN), Francisco Rossi (IPC), Aeromilson Mesquita and André Carvalho (IPEA) and the following colleagues from UNDP: Hakan Bjorkman (Bangkok), Viola Morgan (Gaborone), Caitlin Wiesen (New York) and Sonam Yangchen (New Delhi). We also thank Melissa Altman and Marty Stein for their permission to reproduce works from the permanent collections of the Museum of Fine Arts, Houston, and the Museum of Contemporary Arts, Los Angeles.

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Since the first case was diagnosed in 1981, HIV/AIDS has become the deadliest disease in history and a development crisis of unprecedented proportions. Only last year, over three million people died of AIDS and almost five million became newly infected with HIV, which now affects some 40 million people around the world.

Nowhere have the impacts of AIDS been more severe than in Southern Africa, where adult HIV prevalence hovers around 20% — up to nearly 40% in Botswana and Swaziland. In the worst-affected countries, up to 60% of today's 15-year-olds will not reach their sixtieth birthday if current infection rates continue. Already in Zimbabwe, life expectancy at birth dropped from 52 to 34 years in the last 15 years. Dramatic declines are also projected in the Caribbean, which has the world's second highest HIV prevalence.

Prevalence rates are lower in other regions but, in the absence of preventive measures, may rise steeply in the coming years. The epidemic is expanding rapidly in Asia, where India already has the largest number of HIV-positive people outside South Africa. Meanwhile, reported HIV cases have increased nine-fold in Eastern Europe in less than ten years, as the virus spreads from high-risk groups to the general population. Once this happens, it is society's most vulnerable who become more exposed. In the US, the black minority now accounts for about half of all new infections, while in Russia, where the proportion of sexually-acquired HIV cases quadrupled in just two years, women represent 38% of newly reported infections, up from 24% in 2001.

Elsewhere, too, women are increasingly at greater risk of contracting the virus. African women, for instance, are becoming infected at an earlier age and in greater numbers than men. The difference is most pronounced among young Africans, where females aged 15-24 are over three times more likely to acquire HIV than males of the same age group. In fact, AIDS is imposing a double burden on women. Apart from being increasingly affected by the disease, they provide the bulk of care for the sick, the dying and the orphaned. Women make up 75% of all caregivers for persons with HIV in Viet Nam and two-thirds in South Africa, a quarter of them over the age of 60. Yet in many countries, women are systematically denied the right to inherit and own land, which condemns them and their children to certain destitution after a partner's death.

Countries stricken by AIDS face a growing crisis in delivering public services. The epidemic is taking a severe toll on nurses and other health care workers at a time when AIDS-affected people have started crowding out other patients in public hospitals. Education also suffers due to increased absenteeism and dwindling numbers of qualified teachers. As the quality of education worsens, more and more children are being withdrawn from school to care for sick relatives or compensate for lost income and greater expenses arising from AIDS. Most affected are girls — such as in Lesotho, which has seen a 25% drop in female enrolment over the last decade. Steep rises in adult mortality also mean growing numbers of orphans. Nigeria alone had 1.8 million AIDS orphans in 2003. In Botswana and Zimbabwe, the share of children who are orphans has tripled since 1990, while in Haiti it is more than double the average for its region.

There is nothing inevitable about HIV/AIDS, as the huge reversals in Thailand and Uganda unambiguously show. Providing antiretroviral drugs to infected women could halve the risk of mother-to-child transmission in countries like Swaziland, where HIV prevalence among pregnant women rose from 4% to 39% in the span of a decade. But this will not happen if the current 'prevention gap' is not closed, if only one in ten women can access treatment and care services during pregnancy and childbirth, if levels of coverage remain so dismally low and the price of HIV medicines so prohibitive for most countries — or if, despite increased global funding for AIDS, spending per person living with HIV continues to be a thousand times lower in Africa than the US.

Lack of progress against HIV/AIDS is not an option. The cost of inaction would be too high for something as priceless as a human life.

Alejandro Grinspun

Thailand's Response to HIV/AIDS

*by Wiput Phoolcharoen,
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The first case of AIDS in Thailand was registered in 1984. Within the next few years, a handful of other cases were reported, predominantly among men having sex with men.

As in other Asian countries, Thailand's initial response was tame. It was believed that the disease only affected high risk groups, such as injecting drug users and men who had unprotected sex with other men. Since HIV can remain asymptomatic for many years, there were few indications that the virus was spreading rapidly across the country. The government, therefore, chose to follow a standard public health approach, focused on reporting AIDS cases through the medical system and ensuring a safe blood supply.

By the late 1980s, however, there were clear signals that the disease was not confined to the margins of society but had gained a foothold among the Thai population at large. The detection of high infection rates among female sex workers in parts of the country — with HIV prevalence reaching over 40% in some areas — sounded the alarm bells. Since commercial sex was widespread across Thailand whereas condom use was consistently low, the uncovering of a severe epidemic among sex workers meant that AIDS could easily spin out of control as the male clients of sex workers contracted the virus and transmitted it to their wives and partners.

This realization quickly transformed the perception of the disease and prompted immediate action by a new government that was sworn in 1991. The creation of a national AIDS Committee that same year signaled a momentous shift away from the narrow health sector approach of the early years towards a bold multi-sector response that would involve all layers of government and integrate public

education, prevention and treatment into a single nationwide strategy. Chaired by the Prime Minister, the new AIDS Committee was given the responsibility to develop an aggressive prevention strategy, coordinate all the public information campaigns, and monitor the implementation of the new AIDS policy.

The following year, the government approved the first national AIDS Plan, which was formally integrated into Thailand's five-year development plan to underline the fact that tackling AIDS had become a key development challenge for the country. Drawn up by the central planning agency, the new AIDS Plan sought to ensure smooth cooperation between the government, civil society and the private sector in the implementation of Thailand's AIDS strategy. Whereas the health ministry had previously been the only government agency with a specific budget for HIV/AIDS activities, now all the line ministries were asked to submit funding requests in accordance with the priorities specified in the national AIDS Plan.

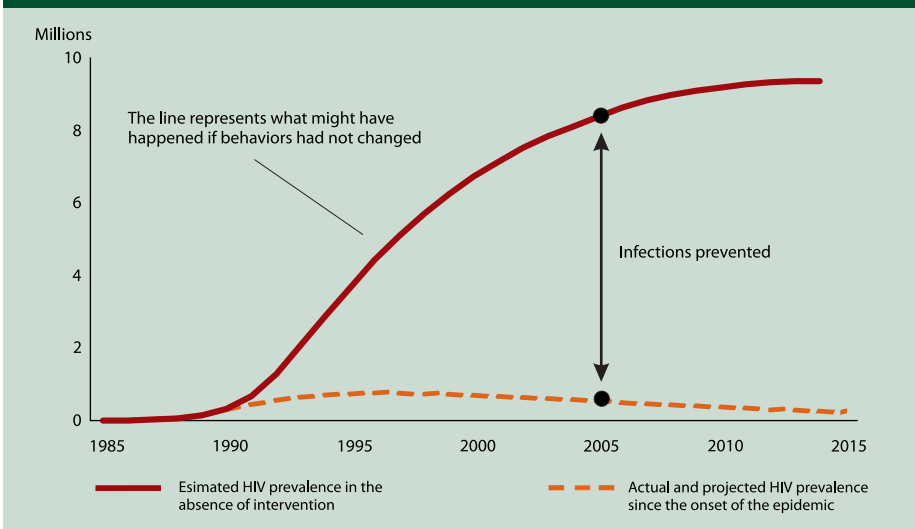
Surely, the Ministry of Public Health continued to play a crucial role in the areas of surveillance and treatment. But the government understood that preventing HIV transmission required a massive public information and education campaign aimed at promoting condom use in all sex establishments and discouraging the demand for commercial sex. This signified an important departure from the earlier prevention strategy that had largely focused on individual risk factors.

Using the country's well developed public communication network, an aggressive safe sex campaign was launched in 1992. The campaign targeted sex workers and their clients, forcing brothel owners to take responsibility for condom use

Thailand's early decision to mount a frontal attack on HIV/AIDS has brought down the number of yearly new infections from a peak of 140,000 to less than 20,000 last year.

While it is still too early to claim a definite victory over the disease, Thailand's extraordinary success shows that, with strong political commitment and a clear-minded strategy, countries can effectively halt the spread of HIV in a matter of years.

Thailand's prevention strategy Number of HIV infections averted, 1985-2015



among their workers and making it nearly impossible for clients to find condom-free service. It also provided for the distribution of free condoms and routine health examinations of commercial sex workers for sexually-transmitted diseases.

The massive condom promotion campaign played a crucial role in curbing HIV transmission during the early 1990s. After peaking at 143,000 in 1991, yearly new infections fell to about 19,000 in 2004 — a resounding success that makes Thailand one of the few countries in the world that has achieved the Millennium Development Goal on HIV/AIDS, well ahead of the target year of 2015. Along the way, HIV prevalence among sex workers plummeted, and millions of lives were saved.

Critical factors in Thailand's success were the unwavering political commitment from its top leadership and the adoption of a multi-sector response that mobilized the entire Thai society behind a seemingly intractable goal. Equally important were Thailand's comparatively strong health care infrastructure, the systematic gathering of epidemiological information from across the country, and a pragmatic approach that targeted the main hub of HIV transmission and concentrated its efforts on brothel-based sex workers and their clients.

These achievements would not have been possible if the Thai government had not devoted large and increasing

levels of spending to its AIDS program. As late as 1988, the total AIDS budget stood at less than US\$ 1 million, mostly financed by external donors. Within three years, spending on HIV/AIDS had grown more than ten-fold, and by 1996 it reached US\$ 90 million, with the bulk of the funds coming from the government. So within a few years, a program that had been heavily reliant on donor support was being funded almost entirely from the national budget.

But Thailand's accomplishment does not mean that its epidemic has vanished. By the late 1990s, large numbers of people infected during the earlier phases were becoming ill and dying. In 2003 alone, the disease claimed some 53,000 lives — over 90% among people aged 20 to 49 —, making AIDS one of the leading causes of death in the country. It is estimated that more than a million Thais have been infected since the beginning of the disease, with about 600,000 living with the virus today. This implies large numbers of people requiring treatment, care and support.

Over time, the epidemic has matured so that the spread of HIV is more heterogeneous now than a decade ago, making it more difficult to detect and prevent. In 1990, about 85% of new infections were related to the buying and selling of sex. HIV transmission through sex work certainly remains a threat, but other modes of transmission have since come to prominence. And a shift has occurred in the sex industry itself, away from brothels towards less easily regulated settings.

In the meantime, the decline in commercial sex patronage by young men has been accompanied by an increase in extramarital and casual sex, often unprotected. About half of new HIV infections involve women who would appear to be at low risk of contracting the virus. Most, in fact, are infected by their husbands or boyfriends. In parts of the country, HIV prevalence remains high among pregnant women — an indication that the virus continues to spread in the general population.

Thailand now seems poised for a resurgence of infections. Prevalence levels are unacceptably high among

injecting drug users, men who have sex with men, and mobile populations. New patterns of risk behavior have emerged among sexually active young people, including drug and alcohol use. Yet less than 5% of them are being reached by adequate prevention services.

Indeed, current prevention efforts are not proving effective to curb HIV transmission. Not only has overall AIDS spending dropped significantly since the late 1990s (to US\$ 35 million in 2002), but the share devoted to prevention programs is a fraction of what it used to be. Not surprisingly, public information and education campaigns have lost momentum, while public concern about HIV/AIDS has all but faded.

By contrast, Thailand has lately stepped up its efforts to expand access to treatment for people living with HIV/AIDS. The 1997 Constitution paved the way for a universal health care system by guaranteeing the right to health care for all Thais. As a consequence, the government has been allocating larger proportions of its AIDS budget to the provision of medical services for AIDS patients and the prevention of HIV transmission from mothers to newborn children.

Already by the late 1990s, the lag between the introduction of new antiretroviral drugs (ARV) in industrialized countries and in Thailand had shortened considerably. But the cost of the patented imported drugs was simply out of reach for most Thais. The lifting of patents has since allowed cheaper generic versions to be produced and distributed locally, thereby making ARV therapy more readily available in Thailand. The country's public laboratory now produces seven ARV preparations, which are two to 25 times cheaper than the cheapest brand equivalents.

Generic drugs manufactured in Thailand at cut rate prices have thus created the potential to expand the government's treatment program significantly. It is estimated that some 100,000 to 200,000 people urgently need ARV treatment in order to survive. To address this critical demand, the Thai government has set the target of providing antiretroviral drugs and therapy for opportunistic infections to around 50,000 AIDS cases annually.

As a country with a well organized health system and the capacity to manufacture generic ARVs at less than US\$ 300 per patient per year, Thailand should be in a position to surpass the WHO target of 50% coverage set for less developed countries. But for this to happen, it needs to allocate more resources to treatment, incorporate antiretroviral therapy into its universal health coverage, and search for alternative and multi-sourced financing to ensure the sustainability of its treatment program.

However, the Thai government has come under considerable external pressure not to produce certain generic drugs. There is wide concern that bilateral trade negotiations with the US may result in restrictive patent legislation that could affect the country's ability to produce generic HIV drugs under the public health safeguards agreed in 2001 at the Doha talks of the World Trade Organization. This would result in much higher drug prices and undermine current efforts to expand treatment to all of those living with HIV/AIDS.

Ironically, the wider availability of generic drugs, coupled with the rising number of HIV infections, will once again test Thailand's response to the disease. Broader access to ARV therapy is resulting in longer life spans for those infected. In a few years, therefore, there may be more people infected, who will in turn live longer.

Addressing their evolving needs will pose a big challenge. Not only does AIDS strike chiefly among people in their most productive years, but the medical expenses it generates are typically compressed into a short period. As a result, the financial toll of AIDS generally outstrips that of other chronic diseases by a wide margin.

An effective response to the challenge of supporting people with HIV/AIDS will require a reinvigorated public education drive to overcome the persistent stigma and discrimination that often keep them from finding productive employment to sustain themselves and their families.

In just a few years, Thailand transformed a small AIDS program that had relied heavily on donor support into a massive response financed domestically.

by *Erick O. Nyambedha,*
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Child Vulnerability and Migration in Western Kenya

Early parental death due to AIDS has greatly affected childhood among the Luo of western Kenya. Growing up in deep poverty and without parental guidance, many orphans are forced to migrate and work to earn their sustenance. They miss schooling opportunities and become more vulnerable to HIV infection.

The experience of migrant Luo children has exposed gaps in existing HIV/AIDS programs, which need to address the issue of child mobility and strengthen fostering arrangements for those who fall out of family care.

With sero-prevalence rates estimated at over 30%, the Luo people of western Kenya are among the communities in East Africa that have been most heavily affected by the spread of HIV/AIDS.

Their proximity to the fish landing beaches of Lake Victoria has long exposed Luo women to frequent contacts with refugees from Uganda's war zones, where high incidences of HIV/AIDS were first reported, as well as itinerant petty traders with whom they would sometimes engage in casual sex. Many of those women have even entered into leviratic unions with Ugandan men after the death of a husband.

Another reason for the high incidence of HIV among the Luo people is their proximity to the Northern Nairobi highway corridor that connects Mombasa with Uganda, Rwanda and Burundi, ferrying goods from the port to these landlocked countries.

Many existing HIV/AIDS programs in Kenya explicitly target the fishing communities along the shores of Lake Victoria as well as the villages straddling the Nairobi highway corridor. What is missing in these programs is a deliberate strategy to protect young and vulnerable children in those communities from getting infected with the HIV virus.

As a matter of fact, many surveys reveal that sexually active Kenyans are aware of the ways through which HIV/AIDS is contracted. They also know how to protect themselves from infection. Their sexual practices, however, are evidently not matching their knowledge about HIV transmission.

A detailed analysis of the problems faced by migrant Luo children suggests one

possible explanation. According to a number of studies, most of the sexual practices that carry a risk of infection can be traced to poverty and, perhaps, lack of nurturance from responsible adults in the community. It was found, for instance, that orphaned girls who drop out of school prematurely and do not have proper residential arrangements and adult protection tend to engage in high-risk sexual behavior as a survival strategy.

Migration among Luo orphans is often caused by a lack of resources in the adopting households. It is not uncommon for the adult caretakers to send orphaned children to other homes to work as domestic servants. Children are thus forced to drop out of school and engage in wage labor as a means of raising extra income for poverty-stricken families.

This practice has become less rampant following the government's introduction of free and compulsory primary education in 2003, but the policy has its own limitations. Children born out of wedlock who lose their mother to AIDS may find it difficult to ground themselves in the Luo patrilineal kinship structure. Without proper fostering arrangements, many end up migrating from one village to another in short intervals and are not able to benefit from the country's free primary education program.

The predicament of children born out of wedlock is further complicated by the fact that their paternity is usually kept secret — to them as well as others in the community. Such veil of secrecy poses a challenge to both research and policy. Indeed, much has been written about street children, but little knowledge exists about children who live in a home environment but were born out of wedlock and suffer neglect after the death of their mothers.

Long-term follow up of migrant orphans shows that they are exposed to a high risk of HIV infection, particularly girls who may become victims of sexual abuse and exploitation in their new homes. Orphaned boys have also reported cases of discrimination and mistreatment, on occasion by their mother's new partners. For both boys and girls, these are traumatizing experiences that demand paying greater attention to the conditions in which they and their widowed mothers live.

Greater knowledge of the situation faced by these children is particularly important now that family life is facing rapid change in many sub-Saharan countries. Single motherhood is presently far more common throughout the region than it was in the past, and the presence of HIV/AIDS means that parents die young, leaving behind an increasing number of orphans.

These orphans usually find it difficult to adjust to their new homes. Those who

migrate to rural areas may have an especially hard time dealing with the change of environment that follows a parent's death. For many of these children, asking a caretaker to cater to their needs is not easy, especially when the foster home can itself ill afford its basic necessities.

Deprived of proper parental support, many orphans try to cope with their new situation by earning an income. Being allowed to work part-time for a wage in subsistence farms is one means through which they manage to earn their sustenance, without interfering with their schooling. This implies that blanket condemnations of child labor may need to be tempered so as to account for the particular circumstances faced by children orphaned or made vulnerable by AIDS.

The migratory experiences and practices of Luo children also shed light on the conflicting perceptions about their needs, as seen from the perspective of

Poverty in the adopting households often forces Luo orphans to migrate in short intervals, exposing them to health risks, abuse and even violence.

adults and the children themselves. It is a common practice in the Luo community to place orphaned children in households headed by other adults. Once the parents die, orphans are separated and distributed among various relatives, some of whom may live far away from the children's paternal home. In many cases, the fostering adults neglect the children's emotional demands of associating with their larger patrilineal kin and hardly allow them to visit their relatives.

But this practice has its costs. Studies have shown that children who do not have frequent contacts with their paternal kin tend to abandon their foster homes to go back to their own. They often return to households that lack an adult presence and are much less endowed with resources, where they willingly stay with their siblings to fill an emotional need. There is evidence, nonetheless, that some orphan-headed households are functional in their community and have served to keep orphans together after the death of the parents.

This suggests that the availability of material resources in a household cannot be the only or main determinant of child support. Policies seeking to address the situation of orphans and other children made vulnerable by HIV/AIDS should also consider strengthening support for child-headed households, especially when they are located close to the children's extended kin network.

■

E. O. Nyambedha, S. Wandibba and J. Aagaard-Hansen, 'Changing patterns of orphan care due to the HIV epidemic in Western Kenya', *Social Science and Medicine*, Vol. 57 (2), 2003.

Social customs and AIDS

The practice of 'wife inheritance' has long been embedded in the patrilineal kinship structure of the Luo people of western Kenya. It involves a leviratic union between a close paternal cousin of a deceased man and his widow. In cases where no man from the extended family was found to be willing or appropriate to 'inherit' the widow, it was not uncommon for the clan to 'hire' an outsider to perform the ritual. Over time, this traditional institution began to erode as modernity brought new value systems that questioned the merits of polygyny.

The spread of HIV/AIDS has further weakened this centuries-old custom. When a woman's husband dies from a disease, the surviving young men in the clan often reject the widow for fear of contracting HIV. Consequently, the young widow has to look for men outside the community to ritually free herself from the bondage of her husband's death. Many marry Ugandan war refugees and petty traders who have settled along the shores of Lake Victoria. These 'outsiders', locally known as *jokowiny*, have thus entered into marital unions with young Luo widows who were thought, but not known, to be HIV/AIDS carriers.

For the women, marrying a *jokowiny* typically means leaving their communities and moving with their new consorts. Some even migrate to Uganda with their orphaned children. Interestingly, returning widows are normally welcome back into the community and guaranteed their inheritance rights to assets owned by their deceased husbands. Even those who die after moving away are occasionally brought back to be buried next to the husband's grave, especially if they had children together.

It is widely believed that the casual unions between Luo widows and outsiders have contributed to spreading HIV/AIDS, particularly among the communities living along the fish landing beaches of Lake Victoria.

*by Jan Vandemoortele,
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Catch-22: HIV and Education

For the foreseeable future, education will remain the only 'vaccine' against HIV — a powerful tool for halting its spread.

But education's efficacy is being undercut by the pandemic's unrelenting progress, through its effects on the supply as well as the demand for schooling.

Breaking out of this cycle requires action on both fronts — investing in child education and increasing access to ARV therapy, for parents as well as teachers.

In 2000, we coined the term 'education vaccine' against HIV as we noted a change in the social epidemiology of the AIDS pandemic. In its initial stage, educated people seemed particularly vulnerable to HIV infection. But with increased information, knowledge and awareness, their behavior quickly changed in terms of delayed sexual activity, reduced number of partners and increased condom use.

Our hypothesis was that beyond the initial phase, education would reduce the risk of contracting HIV so that new infections would gradually become concentrated among illiterate and poor people. Such an inverse association with education exists for most infectious diseases, and we pointed out that HIV/AIDS would ultimately follow the same pattern.

Some contested that hypothesis, based on surveys conducted in the early stages of the pandemic that showed a positive relationship between education and HIV prevalence. We attributed this result to the main propagation channel of HIV, which initially exposes the mobile, better-off, urbanized and educated people.

But subsequent surveys quickly revealed an inverse relationship. The change in the social epidemiology takes place during the time lag between initial HIV infection and the onset of full-blown AIDS, creating an apparent paradox between the high level of mortality among educated people — such as teachers and nurses — and the existence of an 'education vaccine'.

The stylized display of our hypothesis shows that the HIV infection pattern for people with education follows an

inverted U-shaped curve. The epidemic spreads quickly from the nascent to the concentrated stages but declines before reaching the generalized stage. By contrast, the pattern for those without education shows a moderate increase during the initial stages, followed by an exponential growth in the generalized stage before leveling off.

We concluded that education is the first line of defense against the spread of HIV, especially girls' education because gender-specific infection rates are closely related to the overall HIV prevalence rate. At low levels of HIV prevalence, infection rates are typically higher among male adolescents than among young females, but the latter become more vulnerable as a country's prevalence rate increases. We therefore predicted that young illiterate women would become disproportionately represented among the newly infected people.

Unfortunately, these predictions have turned into reality. UNAIDS recently reported that women — young and old — already represent more than half of the HIV-positive population in every country in sub-Saharan Africa. Even worse, young women now account for a full three-quarters of all Africans aged 15-24 living with HIV and AIDS.

Reversing this trend will require a much greater emphasis on education, especially for girls. But while evidence supports the argument that education helps prevent HIV transmission, it also shows that AIDS is seriously undercutting the education sector in the worst affected countries.

In Lavumisa, a small town in Swaziland near the border with South Africa, primary-school enrolment fell by one-tenth over the past five years. At a

nearby secondary school, the number of students who had lost at least one parent increased from 40 to 73 in the past nine months. Obviously, the AIDS pandemic is creating a Catch-22, affecting both the demand for and the supply of the very 'medicine' that can best arrest its spread.

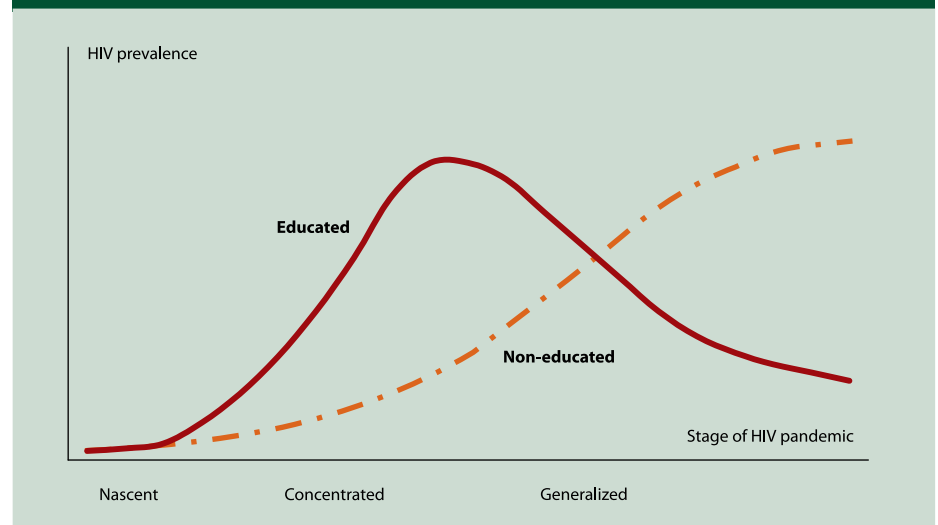
HIV/AIDS will reduce the *supply* of education due to higher levels of morbidity and mortality among teachers. Already, several African countries are reportedly losing more teachers every year to AIDS than the number of annual recruits of teacher training colleges. Absenteeism among teachers is bound to increase because of AIDS-related illness, care for sick family members, attendance of funerals of community members, and increased moonlighting to compensate for falling real wages.

Supply is also likely to be affected by decreased public spending on education as a result of the economic and fiscal impact of AIDS. In Swaziland, secondary schools are given a state subsidy per orphaned student, but the amount covers less than one-fifth of the actual cost. As a consequence, many schools are deeply in debt, with utility bills unpaid and salary payments overdue.

The AIDS pandemic will likewise affect the *demand* for education in very profound ways. Children will attend school intermittently and eventually drop out as their parents will no longer afford the school fees and related out-of-pocket costs due to reduced family income or increased health spending. Girls, especially, will be kept out of school to care for sick family members or supplement family income.

Indeed, one-fifth of the pupils at Lavumisa's primary school no longer pay the fees. That share soars to two-thirds in the nearby secondary school. Both recently decided to enforce the fees by barring non-paying students from attending classes. When this happens, it is normally girls who drop out first. Moreover, as schools are not always sanctuaries and safe havens for children, parents may increasingly choose to keep their daughters at home out of concern about sexual activity at school.

HIV diffusion by level of education and stage of the pandemic



The AIDS epidemic is also bound to erode the quality of schooling because of fewer number of qualified teachers and fewer teaching materials. Children will thus lose interest and parents will grow less willing to invest scarce family resources in education.

Finally, social stigma is likely to exclude children living with HIV and AIDS. AIDS orphans, in particular, face towering odds for attending primary school. Surveys confirm that they are less likely to attend classes and more likely to be involved in child labor. And once the epidemic reaches the generalized stage, it will overstretch the extended family and undermine the ability of the traditional solidarity system to support the orphans in the community.

Frank discussions about HIV remain rare in many families, communities and countries. The four allies that make the virus so prevalent start with the letter *s* — silence, shame, stigma and superstition. They thrive in a climate of ignorance and illiteracy. Education is vital for defeating their deadly alliance.

Preventing HIV infection must begin with basic education. AIDS is a disaster, but it does not just happen. It unfolds. And its unfolding will depend in large part on how quickly all girls and boys are guaranteed the right of completing, at least, a primary education.

Worldwide, some 115 million children are reported to be 'out-of-school'. But the number of children who fail to acquire basic literacy and numeracy is much larger, even if some may attend school for a few years. In fact, we estimate that up to 500 million children are 'out-of-education'. The large majority are girls, who thereby become extremely vulnerable to HIV infection.

Under normal circumstances, an *ounce* of education is better than a *pound* of medical care. But these are not ordinary times. While the 'education vaccine' is likely to remain the only one available for the foreseeable future, its potency will depend on the availability of antiretroviral medicines, including for HIV-positive teachers. Thus, investments in education must go hand in hand with making ARV treatment affordable — for instance, by removing restrictions on the procurement of generic HIV drugs.

Without determined action on both fronts, several countries and countless communities will have no chance of achieving the Millennium Development Goals by 2015. Many may already have missed the opportunity for achieving 'education for all' for decades to come.

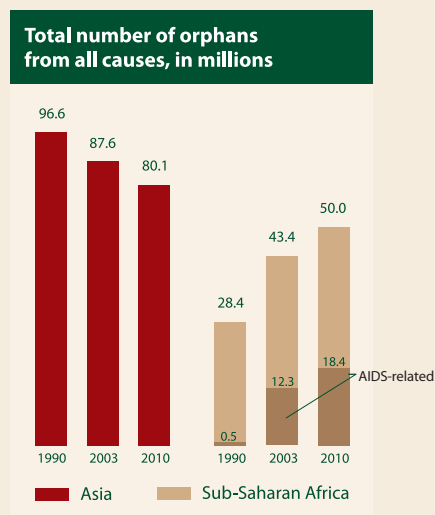
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Jan Vandemoortele and Enrique Delamónica, "The 'education vaccine' against HIV", *Current Issues in Comparative Education*, vol. 3:1, 2000.

IN REVIEW

Worldwide, AIDS is the leading cause of death for people of child-rearing age. Among those without access to treatment — the vast majority in poor countries —, the epidemic is having a devastating effect, sapping livelihoods, obliterating families and leaving millions of orphaned children behind.

Without the guidance and protection of their primary caregivers, many of these children cannot develop their full potential and become vulnerable to health risks, violence and exploitation. Far too many are contracting HIV and will suffer a premature death.

This is clearly one crisis that cannot wait.



AIDS and the Orphan Crisis

Of all the tragic consequences of HIV/AIDS, none is more disheartening than the growing orphan crisis that affects the countries hit hardest by the disease. Exact figures of the number of orphans caused by AIDS are hard to come by. But a new report that contains the latest global estimates of orphaned children under age 18 presents a sobering picture. Based on data from 93 countries in Africa, Asia, Latin America and the Caribbean, the report indicates that, in 2003, as many as 15 million children had lost one or both parents to the disease. Four out of five of them lived in sub-Saharan Africa, which is home to 24 of the 25 countries with the highest levels of HIV prevalence in the world.

Children orphaned by AIDS often lose both of their parents in quick succession. The sudden loss of household income, the cost of treating a prolonged, debilitating disease, and the subsequent funeral expenses frequently leave them destitute — and at great risk of suffering neglect, abuse and exploitation. Orphans are sometimes separated from their siblings and even dispossessed of their property and inheritance. High levels of stigma only exacerbate the trauma and dislocation that follow a parent's death. Without the protective environment of their home, many orphaned children grow up in deprived circumstances that may seriously compromise their life chances.

Normally, the percentage of children who are orphans would be expected to decline over time as health and nutritional conditions improve and tend to push adult mortality downward. But the spread of HIV/AIDS has reversed this trend. In just two years, from 2001 to 2003, the global number of orphans due to AIDS increased by an astonishing 3.5 million. In Africa alone, their numbers grew from less than one million to more than 12 million between 1990 and 2003 — and could reach more than 18 million by 2010 if parents infected with HIV do not get access to effective prevention services and life-prolonging treatment.

Because of AIDS, Africa now has almost twice as large a proportion of orphaned children (12.3%) as Asia (6.2%), even though there are about four times more children in this region. Not surprisingly, countries with high infection rates are the ones with the highest percentage of orphans. Already, nearly one in five children has been orphaned by AIDS in Botswana, Lesotho, Swaziland, Zambia and Zimbabwe. In absolute numbers, Nigeria had 1.8 million AIDS orphans in 2003, with South Africa, Tanzania, Uganda and Zimbabwe trailing behind with about one million each.

Shocking as these numbers are, they only offer a glimpse of what could happen in the absence of urgent action to arrest and begin the reverse the spread of AIDS. In some countries, 15% or more of all orphans is a *new* orphan — they lost a parent only last year. Many more children are living with a chronically ill parent who may soon die.

This means that several countries have yet to experience the full impact of the disease. In South Africa, for instance, the number of orphans is expected to rise from 2.2 million in 2003 to 3.1 million by 2010 — that is, from 12% to 18% of all children in that country. These numbers could also grow dramatically if large countries such as China, Indonesia or Pakistan, where the epidemic is only at the initial stages, should allow it to expand to the levels of Cambodia or Thailand. Even where HIV prevalence has stabilized, the number of orphans may continue to rise over the next decade due to the time lag between contracting the virus and dying from AIDS.

The spread of AIDS is not only impacting the numbers and rate of orphaning, but also its patterns. Maternal orphans now out-number paternal orphans in the most affected countries of Africa, the only region where women have higher rates of infection than men. AIDS is also more likely to create double orphans than other deadly diseases. Over 60% of the 7.7 million double orphans in Africa lost one or both parents to AIDS, and the region has almost as many double orphans as the whole of Asia.

Orphans in general are more vulnerable to health risks and more likely than other children to fall behind or drop out of school. But the changing pattern of orphaning should be an added cause for concern. Studies suggest that mothers are more likely than fathers to care for their children after the death of the spouse. In many countries, only a fraction of maternal orphans live with their biological father. More often, they end up living under the care of the extended family or in another household after their mother dies.

Double orphans, in turn, are consistently shown to be more disadvantaged than single orphans. Research done in Tanzania showed that the school-attendance rate among single orphans was only 71%, but it was even lower (52%) among those who had lost both parents. Double orphans also seem to be at greater risk of falling out of family care and becoming street children or victims of exploitative labor.

Sadly, the heroic efforts of extended families are not proving enough to hold back the ravaging effects of AIDS. Extended families are already responsible for more than 90% of orphaned children in Africa. In the southern tip of the continent, 20% of households with children now care for one or more orphans. These traditional support systems are under great strain and may soon crumble.

In the most affected countries, the burden of care is rapidly shifting to female and grandparent-headed households. African women — many of them poor and infected with HIV — are typically more willing to take in other orphans. In Zambia, for example, female-headed households are twice as likely to care for double orphans as those headed by men. As these women grow older or die, the burden passes on to grandparents, who increasingly are becoming surrogate parents to their bereaved grandchildren, often with few resources. Grandmothers already care for about half of all orphans in Botswana and Thailand, while in Namibia the proportion of double and single orphans living with their grandparents rose from 44% to 61% between 1992 and 2000.

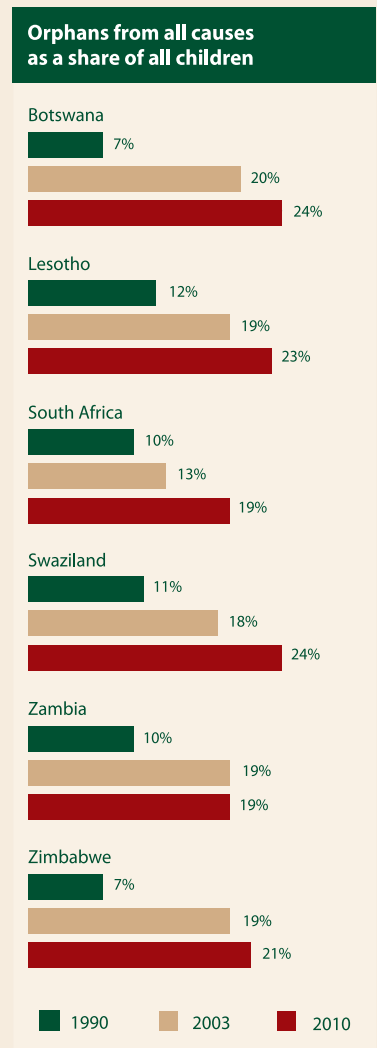
Given the scale of the problem, it is surprising that funding for children affected by AIDS is so small compared with other HIV/AIDS funding. But it is worth remembering that AIDS hurts children in multiple ways. Some may lose one or both parents to the disease. Others may live in poor households that have taken in orphans or face discrimination because of a relative's HIV status. Others still may be infected with the virus themselves — a stark reality for an estimated 2.1 million children under age 15 around the world.

Consequently, programs should not single out orphans for help. Targeting specific categories of children can actually exacerbate stigma and discrimination. Instead, programs need to target geographic areas stricken by the disease and find ways of enhancing the capacity of families and communities to cope and protect their children.

There is an equally urgent need to reach out to those highly vulnerable boys and girls who are living outside of family care. To be effective, these programs have to be integrated into routine primary health care services and ensure that children orphaned or made vulnerable by HIV/AIDS have the same access to social support services as other boys and girls.



UNAIDS, UNICEF and USAID, *Children on the Brink 2004: A Joint Report of New Orphan Estimates and a Framework for Action*, July 2004.



Orphans due to AIDS as a share of all orphans, 2003

Zimbabwe	78%
Botswana	77%
Swaziland	63%
Zambia	60%
Lesotho	56%
Malawi	56%
Namibia	48%
South Africa	48%
Uganda	48%
Tanzania	40%
Sub-Saharan Africa	28%



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