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Children in Jeopardy: An Evaluation of Interventions for Orphans of HIV/AIDS in Sub-Saharan Africa

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RUNNING HEAD: Children in Jeopardy

Children in Jeopardy: An Evaluation of Interventions for Orphans of HIV/AIDS in Sub-Saharan Africa

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Introduction

The Epidemic

First diagnosed in 1981 in Los Angeles and New York, the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) have transformed into a global epidemic (UNAIDS, 2009). Despite its recent discovery, HIV/AIDS quickly revealed its highly destructive nature. In 2008 alone, 33.4 million people worldwide were living with HIV/AIDS, and 2.0 million deaths were recorded (UNAIDS, 2009). The disease has made its most profound impact in Sub-Saharan Africa, a region where 24 of the 25 countries have the highest rates of HIV diagnoses (UNICEF, 2004c). Of the 33.4 million cases reported globally, 67% can be traced back to this region, which accounts for only 12% of the world's population (UNAIDS, 2009). With approximately 22.4 million diagnoses in Sub-Saharan Africa as of 2008, HIV/AIDS pervades every aspect of society. Communities are distraught, local economies are faltering, and households are broken. The spread of HIV/AIDS is fueled by social factors such as high levels of poverty and discrimination, and as a result, the impoverished region of Sub-Saharan Africa has been hit the hardest.

In Sub-Saharan Africa in 2008 alone, 1.9 million new HIV/AIDS infections were reported and 1.4 million deaths resulted (UNAIDS, 2009). Outside of the tragic implications of this statistic is another crisis that must be addressed: children orphaned by HIV/AIDS. Studies have revealed that approximately 1 in 4 households in this region is home to one or more orphans (Horizons, 2004). Defined by the United Nations, an HIV/AIDS orphan is an individual who has lost one or more parents to the disease (UNICEF, 2004c). Further, a maternal orphan is a child under the age of 18 whose

mother has died, a paternal orphan is a child under the age of 18 whose father has died, and a double orphan is a child who has lost both parents to HIV/AIDS (UNICEF, 2004c). In 2004, 12 million children in Sub-Saharan Africa had lost one or more parents to HIV/AIDS, and the number was expected to climb to 18 million by 2010 (UNICEF, 2004b). The pattern of growth of the orphan population is displayed in *Figure 1* below.

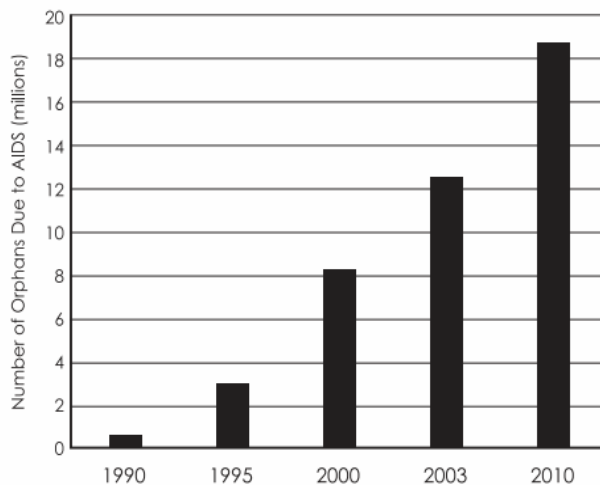


Figure 1: The growth of the orphan population in Sub-Saharan Africa from 1990-2010

Source: UNICEF, 2004c

Sub-Saharan Africa is the only region that has experienced a rise in the number of orphans since 1990. In both Asia and Latin America, the size of the orphan population has decreased significantly (UNICEF, 2004c). As shown in *Figure 1*, over the course of two decades, the orphan population in Sub-Saharan Africa has expanded from one to 19 million children (UNICEF, 2004c).

The growing population of orphans displayed in the above figure corresponds with the increased prevalence of HIV/AIDS in Sub-Saharan Africa since the first diagnosis in 1981. Despite the success of antiretroviral treatments and prevention initiatives in reducing the rate of new HIV/AIDS diagnoses, the orphan population will continue to grow. Mortality due to HIV/AIDS occurs, on average, ten years after diagnosis (Horizon, 2004). This window between death and diagnosis foreshadows the

continued development of the orphan burden long after the disease itself is eradicated. While there is great promise in our ability to decrease the population of individuals living with HIV/AIDS, the impact of the disease extends far beyond the diagnosed population. Therefore, conquering this epidemic will require much more than the treatment of current cases and the prevention of future cases. Rather, significant attention should be shifted towards the family members and communities bearing the social and emotional burden of the epidemic. There is no easy solution, and it is vital to recognize that HIV/AIDS will not be conquered overnight. Rather, there is need for the implementation of a response that will be sustained over the next two to three decades, and will reach out to all populations made vulnerable through this epidemic.

The Psychosocial Impact of the Epidemic on Orphans of HIV/AIDS

Many orphans of HIV/AIDS live in communities devastated by poverty, violence, discrimination, and stigmatization of the disease. These societal drawbacks are compounded significantly by the life-altering impact of their parent's illness. Due to the physical and financial demands of their guardian's diagnosis and treatment, children are frequently obliged to take on responsibilities uncharacteristic of their age (Bauman & Germann, 2005). Whether now the primary income provider to their family or the caretaker of their dying mother, children are forced to cope with overwhelming levels of emotional distress. Their parent's chronic illness is a stressor that has psychological implications including anxiety, fear of abandonment, chronic insecurity, and feelings of resentment towards their parents (Bauman & Germann, 2005). The forthcoming loss of a family member puts a child's basic needs for love, security, and guidance at risk, and

children often begin to view life as unjust and uncontrollable (Bauman & Germann, 2005). While their loved one is receiving treatment, these children are often left alone or to the care of an extended family member (Bauman & Germann, 2005). As a result, this void of mentorship could impact the child's personality development and threaten their hopes of a normal childhood experience.

It is impossible to quantify the level of suffering that these orphans of HIV/AIDS experience in their intimate interactions with death. In addition to coping with the loss of a loved one, many children are forced to overcome the trauma of witnessing their death (Bauman & Germann, 2005). The emotional toll of this disorder on children pinpoints them as a vulnerable population who demand special attention. Dealing with separation from their siblings, poverty and social dislocation, emotional distress from witnessing the death of a parent, and deprivation of life skills development, these children are fragile and emotionally unstable (UNICEF, 2004c). Due to the financial and emotional demands of becoming the caretaker for an orphan, it is very common for siblings to be divided among members of the extended family or friends. While separating brothers and sisters is sometimes the only option, it is like breaking something that is already broken. Having just experienced the death of a parent, the additional loss of a brother or sister as a primary provider of social support is likely to induce in children feelings of depression, anger, guilt, and fear for their futures (UNICEF, 2004c). Many children are left to single-handedly carry the burden of their parent's diagnosis without the necessary resources to cope.

The Social Impact

In addition to the emotional toll of a parent's diagnosis and death as a result of HIV/AIDS, these children are forced to manage the effect that the disorder has on their daily routine. In a study of approximately 5,000 households, 7% of children were not enrolled in school, and orphans had a higher prevalence of school dropouts than non-orphans (9 vs. 6 percent; Horizons, 2004). Once they fall behind in school, it is very difficult for children to catch up. On top of the trauma they face with their parent's illness, these children are forced to confront the social stigma that often causes emotional distress, unwarranted guilt, and feelings of shame and humiliation (Bauman & Germann, 2005). In addition, it often results in social isolation and bullying (Cluver & Gardner, 2006). Therefore, although school may have once been an escape from the poverty and stress of the home life, it is now a place that is likely to be feared. These children, in addition to falling behind academically due to lower attendance rates, are now forced to learn in an environment where they are actively isolated. Further, as children take on more of the emotional and physical burden of their parent's illness, they will become increasingly disconnected from their network of peers. This loss of social support threatens the psychological wellbeing of an already vulnerable population.

The Economic Toll of Orphans of HIV/AIDS

According to the Ministry of Public Service, Labour and Social Welfare (2004), 98% of orphans were cared for by members of their extended families in Zimbabwe. Despite this vast majority of orphans accounted for, approximately 15,220 in this one country alone are left homeless and unclaimed (UNICEF, 2004a). Interventions ranging from the building of orphanages to the establishment of foster care programs serve to

provide this population of vulnerable children with the necessary resources to survive. In order to grasp the economic toll of this orphan population, an operational definition of “support” in the context of this situation must be established. In looking at the resources that should be consistently allotted to each orphan, it has been estimated that approximately US\$1.7 billion will be needed annually in order to provide essential support services to the entire orphan population in Sub-Saharan Africa (Stover, Bollinger, Walker, & Monasch, 2007). The specific services needed by these children range from food and water to psychosocial support, and the cost per child ranges from US\$234 to US\$702 per year per child (Stover et al, 2007).

While there will be some variability from one institution to the next, there are vital components to any successful intervention that should be constants. The six categories of support, created by Stover et al (2007), include food, health care, education, family/home support, community support, and organizational costs. In this study, estimates were formed regarding the proportion each component of support consumed in tackling this crisis. The donation of food from external sources, often in the form of bulk grain, consumes 32% of the total budget for support for orphans in Sub-Saharan Africa, totaling approximately US\$546 million per year. Following the fulfillment of the hunger and thirst of these children, the costly yet vital component of education should take precedent. 27%, or approximately US\$458 million per year, is allotted for educational support which includes school fees, uniforms, school supplies, and any special fees and assessments. The component receiving the next highest amount of funding is family/home support, representing about 20% (US\$333 million/year) of the total support budget. This money is allocated for a variety of necessities, ranging from

microfinance funding to seed for food crops. Costs of administering, monitoring and reporting on these interventions are high, consuming approximately 16% of the total budget or US\$271 million per year. The factors representing the smallest proportions of the budget include health care support (US\$57 million/year, 3.4%) and community support (US\$46 million/year, 2.7%). Responsible for the routine health care and immunizations for the children as well as the general outreach to the children in the community, these two forms of support are equally essential to the wellbeing of this vulnerable population. Utilizing this comprehensive model established by Stover et al (2007), this paper will analyze the degree to which institutionalization, foster care, and community-support interventions address the widespread needs of orphans of HIV/AIDS.

The Long-term Global Impact of the Orphan Crisis

Already living in a society torn apart by the interaction between high poverty levels, low employment rates, neglect, abuse, violent and drug dependence, any child growing up in Sub-Saharan Africa is vulnerable (Streak, 2004). However, HIV/AIDS serves to compound this vulnerability. In addition to overcoming challenges common to individuals in Sub-Saharan Africa such as undying hunger, and inadequate means of shelter, and insufficient funding for basic necessities, orphans of HIV/AIDS also need to cope with the loss of loved one to a disease that is highly stigmatized in society (Bauman & Germann, 2005). Failure to provide psychological support for orphans of HIV/AIDS could have grave consequences ranging from a greater risk for psychological disorders and higher unemployment rates as these children reach adulthood. Therefore, while the disease itself will be removed from society over time, its impact will be long-term. The

various facets of this impact are portrayed in *Figure 2*, which is included below. This model, created by Bauman and Germann (2005), illustrates how avoiding the psychological wellbeing of these orphans will be costly at a community and national level as well.

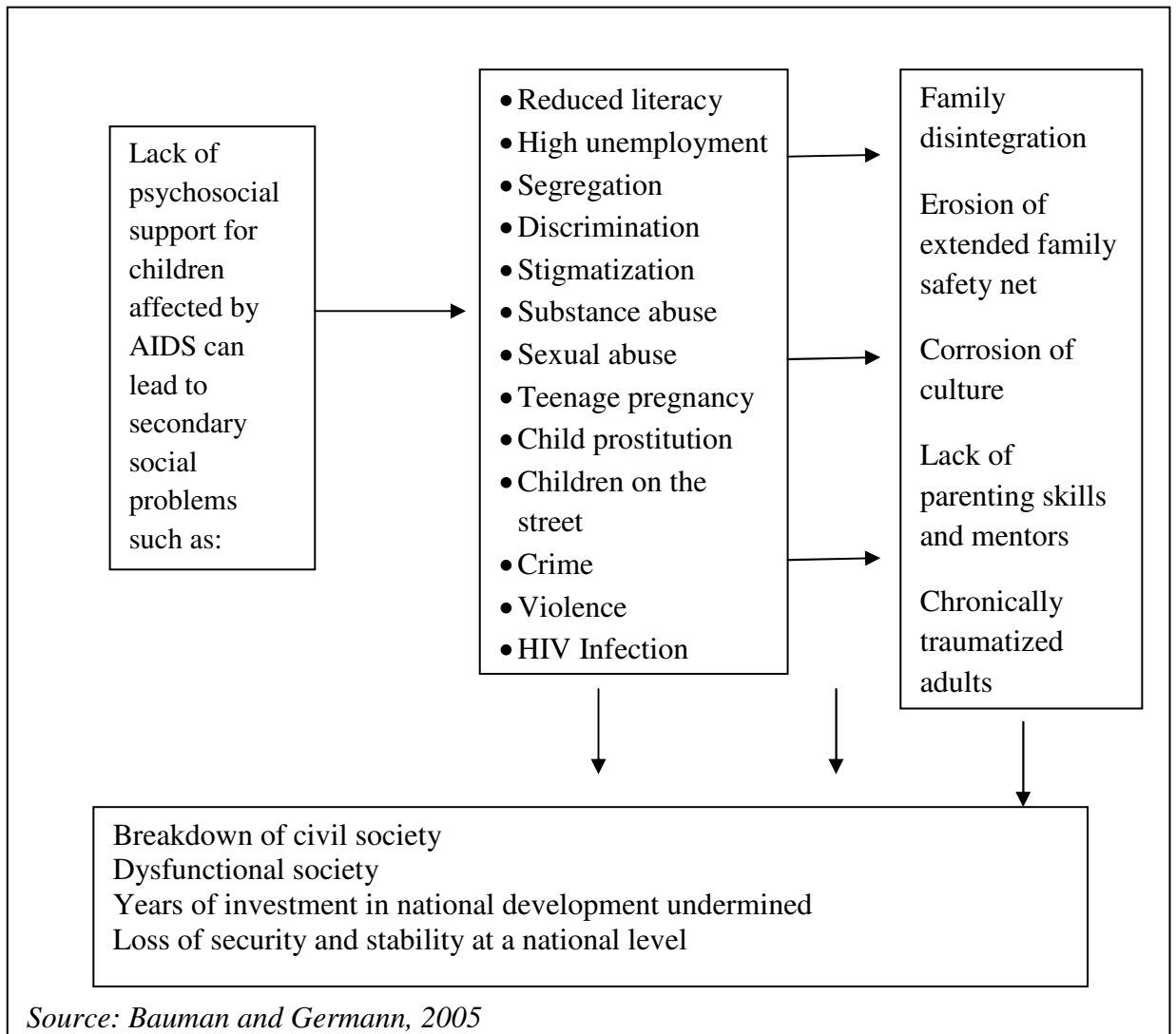


Figure 2: The potential long-term impact of poor psychosocial support systems on orphans of HIV/AIDS in Sub-Saharan Africa

Throughout the remainder of this paper, this model will serve as a guide for evaluating the effectiveness of institutionalization and foster care programs on addressing the needs of this population. A successful intervention will break this cycle, providing orphans coping with the loss of a parent to HIV/AIDS with the resources necessary to excel in society.

Models of Intervention

As shown in Stover et al.'s budget model explained above, the enormity of the impact of HIV/AIDS in society demands the implementation of complex interventions. In Sub-Saharan Africa, HIV/AIDS is infiltrating all aspects of society, affecting more than just the infected individuals and their families. Societal development is stunted by a lack

of economic growth, decreased school enrollment, and the social stigma surrounding the disorder (UNICEF, 2004c). As a result, many communities are unable to provide the fundamental resources to those orphaned by HIV/AIDS. The potential consequences of not attending to the needs of this population are enormous, as millions of children will lack the knowledge and skills to be functional individuals in society. In order to successfully alleviate the burden of the orphan crisis, a response must be facilitated at a local, national, and global level. Many multi-tiered models of intervention have been created in response to this epidemic.

One model, created by Phiri and Tolfree(2005), divides the intervention into three sections. First, the HIV/AIDS epidemic must be confronted at the local level. Referred to as the *front line*, this component of the model aims to take advantage of existing resources. By increasing the involvement of community centers, religious groups, and local families, the local community is held accountable for the wellbeing of these children. Therefore, when external agents are no longer providing resources, the community is able to sustain itself as a united front in the face of conflict. The next level is known as the *influence arena*, which is composed of external organizations who supply the local communities with additional resources including money, food, school supplies, or training for community groups. These supplies serve to aid the front line in its execution of a proper internal intervention. This level of the model acknowledges that it is not the duty of these organizations to come in and solve the problem themselves.

Rather, their role is to facilitate an individual community's fight against this epidemic. The final facet of this model is known as the *enabling arena*, and this extends beyond the local community to governmental and international organizations. At this level, the

influence comes in the form of policy making in support of child rights and rights to health care, as well as governmental support for NGOs and non-profits.

The most effective intervention will reach its highest potential at all three levels, creating a forceful mechanism that will sustain itself until every trace of the HIV/AIDS epidemic is eliminated. This model will provide the framework for the evaluation of institutionalization, foster care, and community based care; three well-known interventions in the fight against HIV/AIDS in Sub-Saharan Africa. In this paper, rather than analyzing the success of the interventions in reducing the prevalence of HIV/AIDS, I will evaluate how well the interventions address the psychological needs of the orphans. Studies have shown that children who are orphaned by HIV/AIDS will have clinically significant levels of psychological disturbance at some point during the process, and over half will qualify for the diagnosis of a psychiatric disorder (Bauman & Germann, 2005).

The interventions, to be discussed further below, will focus mostly on the role of the family and the community in protecting these children and restoring them to strong mental health. Failure to properly execute these interventions will have detrimental effects on these children's ability to attain normalcy in their lives. It is the front line, or those individuals who have direct interactions with the children, who are capable of preventing the onset of psychological disorders such as depression and PTSD. However, each intervention must be executed properly at a local, national and global level. Nelson Mandela once said:

“Of course, we need to do careful planning and deliberation about the actions we shall take, but any moment spent on deliberations that does not lead to decisive action in support of orphans and other children made vulnerable by HIV/AIDS is a moment tragically wasted.” (UNICEF, as cited in Germann, 2004, p. 93)

If the psychological needs of the children are left unaddressed, the global impact of this disease will extend far into the future with a high prevalence of psychiatric disorders.

Chapter 1: Institutionalization: A Controversial Model of Residential Care

What is Institutionalization?

Already in a state of extreme poverty, communities in Sub-Saharan Africa face an influx of children who need immediate financial and emotional support. In response to this heightened demand, institutionalization emerged as a prominent intervention.

Institutional care has been defined as “round the clock residential care for children” (UNICEF, 2004a). Imported from the industrialized Western world, institutions were initially tagged as a modern and improved form of outreach to orphans of HIV/AIDS, and therefore had high media appeal (Phiri & Tolfree, 2004). Often home to more than 120 children, these orphanages intend to bring at-risk children off of the streets and into the safety of a home (Meintjes, Moses, Berry, & Mampane, 2007). On the surface, this appears to be a logical intervention with the potential to significantly reduce the impact of the orphan crisis on society.

The Logic behind Institutionalization

The Children’s Protection and Adoption Act establishes six reasons why a child may be taken into care. Those reasons are:

- i. A child who is destitute or has been abandoned
- ii. A child whose parents are dead or cannot be traced and who has no legal guardian.
- iii. A child who is being maintained in circumstances that are detrimental to his welfare.
- iv. A child who is in custody of a person convicted of committing upon him offences such as abduction, child-stealing, assault, any sexual offence or bodily injury.
- v. A child physical or mental disability who requires special care and treatment which the parent or guardian are unable to provide.

(UNICEF, 2004a)

Prior to the AIDS crisis, orphans generally remained under the care of their own extended family. With the interaction of widespread poverty, old age and poor physical health of adult family members, and a growing orphan population, the extended family system in Sub-Saharan Africa extremely overwhelmed (UNICEF, 2002). Residential care provides an outlet for family members who provide care, despite having the resources, due feelings of obligation (Meintjes et. al., 2007). Orphanages aim to restore children to stable health conditions by addressing their basic needs such as hunger, thirst, and safety. In addition, these homes serve to provide orphans of HIV/AIDS with a community of children also coping with the loss of a parent, in an attempt to recreate the child's support system that fell victim to the HIV/AIDS epidemic (Meintjes et. al., 2007). Residential care addresses a child's need for social support, thereby facilitating the coping process.

Institutionalization aims to centralize the orphan population, bringing these children into homes in order to determine the true scope of the problem. For many external organizations providing aid to this population, institutions represent tangible manifestations of their donations (Phiri & Tolfree, 2004). Donors are able to research specific orphanages to support, and as a result they can monitor the growth of the orphanage and the wellbeing of orphans residing there. The donor's investment in a specific establishment is likely to increase their personal attachment and willingness to contribute to the cause. Research has revealed that many social services professionals favor institutionalization because it is organizationally convenient (Phiri & Tolfree, 2004). The structural appeal of institutionalization attracts supporters, but a deeper analysis reveals fundamental flaws worth noting.

Models of Institutional Care

There are two basic models of residential care that account for the majority of institutions in Sub-Saharan Africa. The first, dormitory style, has received the bulk of the criticism that surrounds institutions. In this model, children are housed in dormitories, where each aspect of their lives is communal; dining, sleeping, and even the attention of the orphanage staff is shared (Meintjes et al., 2007). In these setups, children are usually clustered into groups based on their age and gender. This form of residential care is commonly associated with deprivation of a normal childhood and low levels of psychosocial care and support (UNICEF, 2004a).

A more modern approach to residential care is family-based care. Unlike dormitory style care, this approach serves to replicate a family setting, placing children in a household with parental figures and siblings. In this “family”, the individuals work together to prepare food, perform household chores, and provide each other with a sense of consistency and support (UNICEF, 2004a). In general, these household units are made up of 10 or fewer “family” members (Meintjes et. al., 2007). This approach was created so that children could experience higher levels of support and stability in family-like arrangements. Through this, children will bond with their caregiver, receive more individual attention, and have “siblings” in which to confide. Studies found that children in family-based institutions were much happier than those in dormitory style institutions (Meintjes et al., 2007).

Many of the institutions have implemented a combination of both dormitory style and family-based care. In one model, younger children are placed in dormitory style care while the older children live in family-based care (Meintjes et al., 2007). The logic

behind this division is unknown, although it appears to prioritize the psychosocial needs of the older children over those of the younger children. The concern with placing younger children in dormitory style care is that they will be deprived of a normal childhood in the essential years of their development, and will leave the institution with greater psychological damage than they had when they entered (Meintjes et al., 2007). However, older children are more capable of completing household chores, and could therefore gain the life skills necessary to become efficient and productive members of society during their time in family-based care. Another organizational tactic implemented in various institutions is shorter term and emergency placements in dormitories, and longer term placements in family-based residential care (Meintjes et al, 2007). The rationale behind this division is to reduce turnover and increase stability in these close knit family units (Meintjes et al, 2007).

Concerns about this family-based institutional care center on stigmatization. In many cases, family based care is constructed in the form of a “Children’s Village” (UNICEF, 2004a). These villages vary in size, and are composed of cottages which provide homes for the family units to function independently. Some larger villages contain other facilities including clinics, preschools, and primary schools (UNICEF, 2004a). While these villages serve to create a community of “families”, they simultaneously isolate the children who live in them by restricting their access to the outside world. One child described his village by saying that it “has the appearance of a homely fortress surrounded by a barbed-wire fence” (Tolfree, 2003, p.9). Until the fences are taken down and the children are integrated more into the local community, the prison-like façade will heighten the stigma surrounding these mysterious establishments.

Critical Misconceptions of Institutionalization

Due to the grave impact of the HIV/AIDS epidemic in Sub-Saharan Africa, the number of children who qualify for residential care greatly exceeds society's ability to support them. Institutionalization remains a prominent intervention not due to its high success rates, but because it can house many orphans at once. They are still common in Sub-Saharan Africa because, with the recent onset of the HIV/AIDS epidemic, they serve as a last resort. This system of residential care is very different from Europe and North America, where orphanages as a form of intervention have been eliminated. This is because the economical nature and outreach of institutionalization, two components that give this intervention a high level of media appeal, appear to be critical misconceptions.

Research by UNICEF in 2004(a) revealed that poverty is the single most prominent factor contributing to the institutionalization of orphans. One controversial aspect of institutions is their tendency to attract local non-orphans whose caregivers lack the resources to financially and emotionally support them. In communities under severe economic stress, families are prone to giving into the misconceptions surrounding orphanages, believing that their child will receive higher quality care in an institution rather than in the relative comfort of their impoverished home (UNICEF, 2002). Therefore, there is a significant concern that these institutions are too easily being utilized as an outlet, not due to a child's lack of access to suitable care, but rather to the economic crisis (Meintje et. al, 2007). This magnet effect of residential care has been exacerbated by the onset of the HIV/AIDS epidemic and the growth of the orphan population. As a result, the number of orphans has exceeded that which can be controlled through institutionalization (Meintjes et al, 2007).

On the surface, institutionalization appears to be an economical establishment. By housing multiple orphans under one roof, it seems that the overall cost would be reduced. Supplies could be ordered in bulk, toys could be shared, and one or two caregivers could divide their attention across all of the children. However, studies have reported otherwise, revealing that institutionalization is between five and ten times more expensive than foster care (Phiri and Tolfree, 2004). In a 1992 study by the World Bank, it was found that institutional care in facilities in Sub-Saharan Africa averaged around \$1,000 per child, a number that is six times larger than the average cost of foster care (UNICEF, 2002). The high cost of institutionalization per child causes a concentration of funding on a small population of orphans, disregarding many children still in need of support. Therefore, arguments for these interventions as economically efficient mechanisms with high levels of outreach cannot be substantiated.

The Psychological Impact of Institutional Care on Orphans of HIV/AIDS

In addition to disproving the economic benefit of institutions, research on this epidemic appears to invalidate statements regarding the positive psychosocial impact of institutions on orphans of HIV/AIDS. While it may appear that orphans who are institutionalized are fortunate, the unsustainable and ineffective nature of the intervention was easily exposed. Recent studies have revealed that orphanages impede the socio-emotional development of the orphans (Altshuler & Poertner, 2002; Meintjes et. al, 2007; UNICEF, 2004c). Therefore, rather than emerging from institutions with the tools necessary to survive in society, these children find themselves setback and overwhelmed by the harsh realities of the modern world. Many children leave these institutions with a more significant psychological burden than when they entered (UNICEF, 2004c).

While the impact of institutional care on the psychological well being of orphans of HIV/AIDS in Sub-Saharan Africa is not constant, some common trends have been observed. Logically, addressing the psychological well being of a child will always fall second to providing these children with the basic necessities to survive. Therefore, when institutions drain their budget on food, water, blankets, and other supplies for the children, little money is left to evaluate the mental health of the children. In addition, some funding must be allocated for organizational costs such as paying staff members (Meintjes et. al., 2007). However, overcome with the trauma of their parent's deaths, avoidance of the psychological stability of these children has had dramatic and critical repercussions. Included in these is the child's lack of access to education and health care (Meintjes et al., 2007). Although some family-based institutions have built schools and health centers on their grounds, they seem to be rare additions. A child's lack of access to school and healthcare will cause reduced literacy rates and poor overall health. These two consequences of institutional care will result in higher adult unemployment rates and the deterioration of basic societal functioning for this orphan population (Meintjes et al., 2007).

Education, or a lack there of, is one of the primary factors that drives orphans of HIV/AIDS into isolation in Sub-Saharan Africa. Unfortunately, the obstacles these orphans face in institutional care are not limited to inadequate access to education and health care. Rather, studies have revealed that children are often exposed to overcrowding and a lack of privacy, and there have even been reports of physical, verbal, and sexual abuse (Meintjes et. al., 2007; UNICEF, 2004). In addition, institutions are likely to have high rates of staff turnover or employees that neglect the children's need

for a caregiver and mentor (Meintjes et. al., 2007). The interaction between stigmatization from the local community, neglect from caregivers and overcrowding in the institutions is likely to worsen the psychological burden of this population. Children will be left feeling dislocated from their families, communities, and cultural identity (Meintjes et. al., 2007).

Factors such as inadequate educational resources to institutional overcrowding have hindered the children's ability to cope with the loss of their parent from HIV/AIDS. Not only do institutions have the capacity to exacerbate these feelings of anxiety, fear, mistrust, anger and guilt that result for their parent's death, but they also serve to further isolate these children from society (Phiri & Tolfree, 2005). Studies reveal that institutions instill in these orphans feelings of rejection and abandonment, eliminating most opportunities for their attainment of a normal childhood (Meintjes et. al., 2007; UNICEF, 2004). Institutional care is said to threaten a child's development because it fails to attend to his or her need for attention, attachment, and opportunities for growth (Meintjes et al., 2007). Orphans of HIV/AIDS are often in a worse position to reintegrate themselves into society after their time in an institution, as they lack the critical skills necessary to function in modern society. One study, conducted by UNICEF in 2004(a), asked orphans of HIV/AIDS in Sub-Saharan Africa about their experiences in institutional care. The study revealed that, after the unimaginable amount of suffering these children have experienced, their most common fear was the fear of their future. The lack of transitional programs to facilitate the reintegration process of these orphans into society has left many feeling lost and isolated, unaware of what lies ahead (UNICEF, 2002).

Recommendations for Effective Institutionalization

While the flaws of institutionalization are discussed in this chapter, it is important to acknowledge the potential benefit it sustains. Studies of the impact of family-based versus dormitory style institutions revealed some positive outcomes have resulted from family-based residential care (Meintjes et al, 2007; UNICEF, 2004a). Therefore, a first step in enhancing the effectiveness of institutionalization would be to convert all dormitory style institutions to family-based care (Meintjes et al, 2007). By establishing family units in homes across the local community, children can receive the attention and stability that they need while still remaining a part of the community. Because this is an expensive endeavor, donor agencies can provide the most aid by making the funds available to facilitate this conversion (Meintjes et al, 2007).

A social worker at an orphanage that began as a dormitory style institution and converted into a family institution reflected on the benefits:

“ We see the benefits of working with houses and working with housemothers because children are happy. They experience stability and consistency in their lives. They speak of ‘in our house’. They see themselves as siblings and families. It is nice to see them relying and protecting each other and being loyal to their family and mother. The bonds they form I hope could help them in their future, but for now it really works. When house parents go on day-offs, children understand and the person who works in their place they also know.” (Meintjes et al., 2007, p 42).

A child’s ability to become attached to a caregiver and “siblings” in this setting helps to salvage his or her opportunity for a close to normal childhood. In addition, family-based care will provide children with the support system that they need in order to overcome the loss of their parent. An important factor that goes into the success of this conversion is the degree to which these family units interact with the community. The most

successful family based intervention will place families in homes that are scattered throughout the community, allowing them to interact with the community as they choose while still maintaining the organizational umbrella of the institution (Meintjes et. al., 2007: UNICEF, 2004a). This will allow for children to be integrated into the local community, supporting their formation of an identity independent of their status as an orphan (UNICEF, 2004a).

Once all institutions have implemented family-based units of care, the next step is to create transition programs that equip children with the necessary tools to cope in modern society. It is important that in this transition program, children acknowledge their fear of stigmatization, and that they are empowered to overcome it. This transition program should be implemented as soon as a child is placed into a family unit; it does not simply have to be incorporated into their last year at the institution (Meintjes et al, 2007). In fact, the more a child is able to witness how individuals in their local community develop over time, the less shocked they will be upon their release from the institution.

The success of the conversion from dormitory to family-based residential care is highly dependent on the community's willingness to accept and support this orphan population. Local communities should not only acknowledge the presence of this population, but they should aspire to mold these children into influential community leaders. This is a topic that will be addressed in Chapter 3's evaluation of community-based interventions.

Conclusion

The onset of the HIV/AIDS epidemic has resulted in the deterioration of the psychosocial support systems of orphans of HIV/AIDS. Until institutions are able to

empower children to rely on their individual strengths and to not be held back by the organizational flaws of institutional care, the orphan crisis will continue to have compounding effects at the local, national and global level. Failure to reintegrate orphans of HIV/AIDS into the local community will cause the loss of a proportionately significant population and its potential contribution to society. Reduced literacy and unemployment on an individual level will lead to a lack of economic and cultural stimulation in communities, which will isolate these struggling societies from the rest of the world.

Chapter 2: The Impact of Foster Care on Orphans of HIV/AIDS

What is Foster Care?

A favored response to the worldwide crisis of orphans is the implementation of foster care. It comes in multiple forms, with the most common types known as voluntary and crisis-led. Voluntary foster care is constituted of arrangements made between biological parents and the foster parents of their choosing (Madhavan, 2004). An example of this type of foster care includes a mother being diagnosed with terminal

cancer and asking a friend or extended family member to unofficially adopt her children. Unlike formal adoption, voluntary fostering does not involve the legal transfer of guardianship from biological to foster parents (Madhavan, 2004). Rather, it is an agreement between friends or family in order to secure a caring and safe environment for children upon the loss of their parents.

In contrast, crisis- led fostering is a community response to the local impact of death or economic hardship (Madhavan, 2004). This form of fostering is more retroactive in nature than voluntary fostering, as it implemented only in a state of crisis in the local community. Reacting to the spread of disease or heightened poverty levels, local community members attempt to prevent a complete societal meltdown. In doing so, they take responsibility for wellbeing of affected populations in their communities, attempting to increase a child's likelihood for survival by removing them from the source of the disaster (Isiugo-Abanihe, 1985). This form of foster care resonates highly with the HIV/AIDS crisis in Sub-Saharan Africa. Prior to the crisis, the majority of orphans were placed in the care of extended family members with voluntary fostering. However, the HIV/AIDS epidemic has caused the deterioration of the extended family network, thereby increasing the frequency of crisis-led fostering.

The Prevalence of Foster Care in Sub-Saharan Africa

With the first case diagnosed only three decades ago, HIV/AIDS is an epidemic that will continue to influence individuals, communities, and the Sub-Saharan region as a whole for many years to come. Despite successful efforts to reduce the number of new diagnoses, the ever-growing impact is evident in the increased prevalence of children in foster care. According to data collected in 1992, approximately 10 years after the first

HIV/AIDS diagnosis, 10% of the children in the Sub-Saharan Africa region were foster children (Deninger, Garcia & Subbarao, 2003). Data collected ten years later revealed that the number of foster children had doubled; and one in every five children was living without their biological parents in foster care (Deninger et. al, 2003). Further, foster homes for orphans represented approximately 15% of all Sub-Saharan households in 2002, a number that had tripled since 1992 (Deninger et al, 2003). Due to various interventions including treatment of the disease as well as improvements in sexual education and access to birth control, the number of new diagnoses has decreased over time. However, the higher proportion of parents living with the disorder positively correlates with the expanding orphan population in this region. Therefore, it is vital that the communities in Sub-Saharan Africa are not simply content with the reduction of HIV/AIDS cases, but that they also prepare themselves to fight for these children whose wellbeing is at risk.

Foster Care Prior to the HIV/AIDS Crisis

Parents seek foster families for their children when they are no longer able to parent themselves, usually for financial or health reasons. In response, community members will choose to take on the new identity of a foster parent due to the obligations they feel to the self, the extended family, and the community. Motives to voluntarily become a foster parent include familial responsibilities, household assistance, and increased opportunities for alliance building and social mobility (Madhavan, 2004). Prior

to the onset of the HIV/AIDS epidemic in Sub-Saharan Africa, it was very common for children to be traded among family members in childhood (Isiugo-Abanihe, 1985).

Generally, grandparents are the first family members asked to take on the role of a foster parent for their grandchildren. Viewed as wise and experienced caregivers, many parents take advantage of their parent's willingness to raise their grandchildren. In some communities, having the opportunity to raise grandchildren is viewed as an honor, and helps to substantiate the lives of the elderly. However, kinship foster care generally encourages the continued presence of the parents in a child's life. The child-parent relationship is often manifested in the form of occasional visits and gifts of money, food and clothing (Isiugo-Abanihe, 1985). The benefit of kinship fostering is that it allows for the reallocation of resources within a family unit, while simultaneously maintaining and often strengthening the ties amongst family members (Isiugo-Abanihe, 1985).

One of the benefits of foster care prior to the HIV/AIDS epidemic was the social, economic, and political alliances that it facilitated (Isiugo-Abanihe, 1985). Children were frequently sent to live with skilled artisans who served as caregivers and mentors (Isiugo-Abanihe, 1985). Living with an individual highly specialized in one trade allowed for children to acquire expertise and establish a career path that could enhance their opportunities for social mobility. A similar form of foster care common in Sub-Saharan Africa is domestic fostering, which intends to provide women with the skills needed to excel in the home (Isiugo-Abanihe, 1985). These examples of voluntary foster care speak to the importance of selectivity in a parent's search for a foster family for their child. Some living arrangements were highly beneficial, providing children with an advanced skill set as a supplement to their basic education.

Prior to the outbreak of the HIV/AIDS crisis in this region, it seems that parents had the luxury of utilizing foster care as a means of securing a safe and enriching environment for their children. The extended family network proved to be a sufficient and effective way to handle the orphan population in Sub-Saharan Africa. While familial kinship still serves to be a primary resource for aiding these children in need, priorities have shifted in response to the increasing number of orphans. Foster care was no longer voluntary; it was a necessary reaction to a developing crisis that demanded the resources of the whole community.

Changes in Foster Care as a Result of the HIV/AIDS Epidemic

With the dramatic growth of the orphan population resulting from the HIV/AIDS crisis, the need for external intervention became apparent. Prior to the development of this epidemic, orphans could mostly be accounted for by extended family and networks of friends within a community. However, as a result of the HIV/AIDS epidemic, communities were forced to overcome their reliance on the family and learn to accept alternative forms of care (Madhavan, 2004). This led to a shift from voluntary to crisis-led fostering, as the volume and pace of premature death overwhelms the extended family system (Madhavan, 2004). Therefore, non-kinship foster parents gained prevalence, and local community members often take on the burden of multiple orphans. Concerns arise when acquiring multiple orphans is too daunting a task for community members to overcome. Similar to extended family system, a community's ability to attend to the wellbeing of their local orphan population is limited. Once all of the resources and willing individuals within the local community have been expended, it is feared that there will still be children left unaccounted for.

Despite the shift from voluntary to crisis-led foster care, the same populations are stepping in first to assume the bulk of the responsibility for this orphan crisis (Madhavan, 2004). The only difference with crisis-led care is that the undertaking of this new foster parent identity is more obligatory. As a result, there is likely to be significant societal pressure on certain individuals to foster multiple orphans in response to gravity of the HIV/AIDS crisis. In crisis-led fostering, grandmothers remain the first demographic to assume the role of a foster parent (Madhavan, 2004). As stated earlier, the appeal of grandmothers as foster parents is rooted in their experience in the arena of child rearing. They have acquired a reputation of being loving and doting caregivers with extensive knowledge about raising young children (Madhavan, 2004). Despite concerns about their knowledge of modern standards of technology, education and health care, grandmothers remain a highly valuable and utilized resource in foster care interventions.

Another group of foster parents is founded in the older siblings in a family. In cases where sibling groups do not want to separate themselves, the oldest child is likely to raise the younger children, working to provide their loved one with the basic necessities to survive (Madhavan, 2004). While the use of siblings is representative of a valiant attempt to solve this problem internally, it requires an individual who also just experienced the loss of a parent to step in to now assume the role of a parent. A child overcoming the death of a loved one is likely to lack the psychological stability to be an effective caregiver. Child-headed households will consequently fail to provide the guidance and mentorship that orphans of HIV/AIDS require.

Concerns about Foster Care

In an attempt to analyze the effects of foster care on orphans, studies produced very inconsistent results. The success of the intervention is highly dependent on the relationship between the child and his or her foster parent, a relationship that varies on a case by case basis. In contrast to institutional care, foster care does not aim to centralize the orphan crisis. Rather, children move in with new families whose homes are scattered across the community. This distribution makes it difficult to track the number of orphans in foster care and to monitor the children's well being (Madhavan, 2004). A foster parent's lack of resources or tendency to favor biological children over foster children heightens concerns about the orphans' exposure to malnutrition (Bledsoe, Ewbank, & Isiago-Abanihi, 1988; Madhavan, 2004). One study revealed that foster children had a greater prevalence of illness than biological children, deprived of the nutrients needed to sustain good health (Madhavan, 2004). Other concerns include lower school attendance rates and higher involvement in chores, fieldwork, and marketing (Ainsworth, 1992 & Bahalatora, 2003 as cited in Morelli & Verhoef, 2007). In addition to coping with the loss of a family member, orphans of HIV/AIDS are forced to adjust to an entirely new living environment, a change that could pose a threat to their psychological wellbeing.

The acquirement of the additional family member is a significant burden that some caretakers make not have the resources to overcome. This caretaker burden represents another common criticism of foster care. A study by Foster, Makufa, Drew, Mashumba, and Kembeu (1997) revealed that many caretakers experienced financial and emotional stress, and were therefore unable to provide their foster child with the adequate resources to fulfill both their basic and psychological needs. Already a highly vulnerable population, orphans of HIV/AIDS are not in a position to be left unmonitored. Fear of

exposure to an abusive or harmful environment due to a foster parents stress is likely to fuel the development of more easily monitored interventions such as institutions.

Despite the controversy surrounding institutions, they bring great organizational value in terms of facilitating the community's awareness of the physical, emotional, and psychological needs of the orphan population (Meintjes et al, 2007).

The Advantages of Foster Care

Difficult to monitor, foster care is capable of providing a child with either the best or the worst of experiences. A child's ability to salvage what remains of his childhood is entirely dependent on how well he is integrated into his new family, a measure that cannot be monitored when each orphan is distributed across the community. However, the privacy of a home could provide children with a more ideal environment than the communal nature of institutionalization for coping with their parent's death. In many cases, it is likely that the transition from home to home is less drastic, allowing for children to maintain many aspects of their daily routine. Thus, while there are little data analyzing the overall success of foster care as an intervention for HIV/AIDS due to its individualized nature, it can be assumed that some children benefit from a loving and nurturing foster home environment.

While the success of this intervention is difficult to quantify, potential benefits can be discussed. A study by Deninger et al. in 2003 outlines some of the strengths of foster care as an intervention for orphans of HIV/AIDS in Sub-Saharan Africa. This study argues that individuals who are willing to adopt a child in response to the HIV/AIDS crisis are likely to be selfless individuals who genuinely want to benefit the lives of these children. Deninger et al (2003) also recognizes how the re-establishment of

a home and family environment provides children with a sense of stability which promotes their psychological wellbeing and intellectual development. Further, the integration of these children into new family units serves to diffuse the stigma surrounding HIV/AIDS. Foster care allows for children to not only become integrated into a new family, but to also be more readily integrated into their local community (Deninger et al, 2003). Higher community interaction will promote the local acceptance of these orphans and increase the local commitment the movement against the HIV/AIDS epidemic in Sub-Saharan Africa.

The potential consequences of low quality foster care programs are displayed in the model below. First inserted in the introduction, this model aims to portray the implications of failed attendance to the psychological needs of children affected by HIV/AIDS. The model has been altered in order to show how the cycle has been influenced by the implementation of foster care programs.

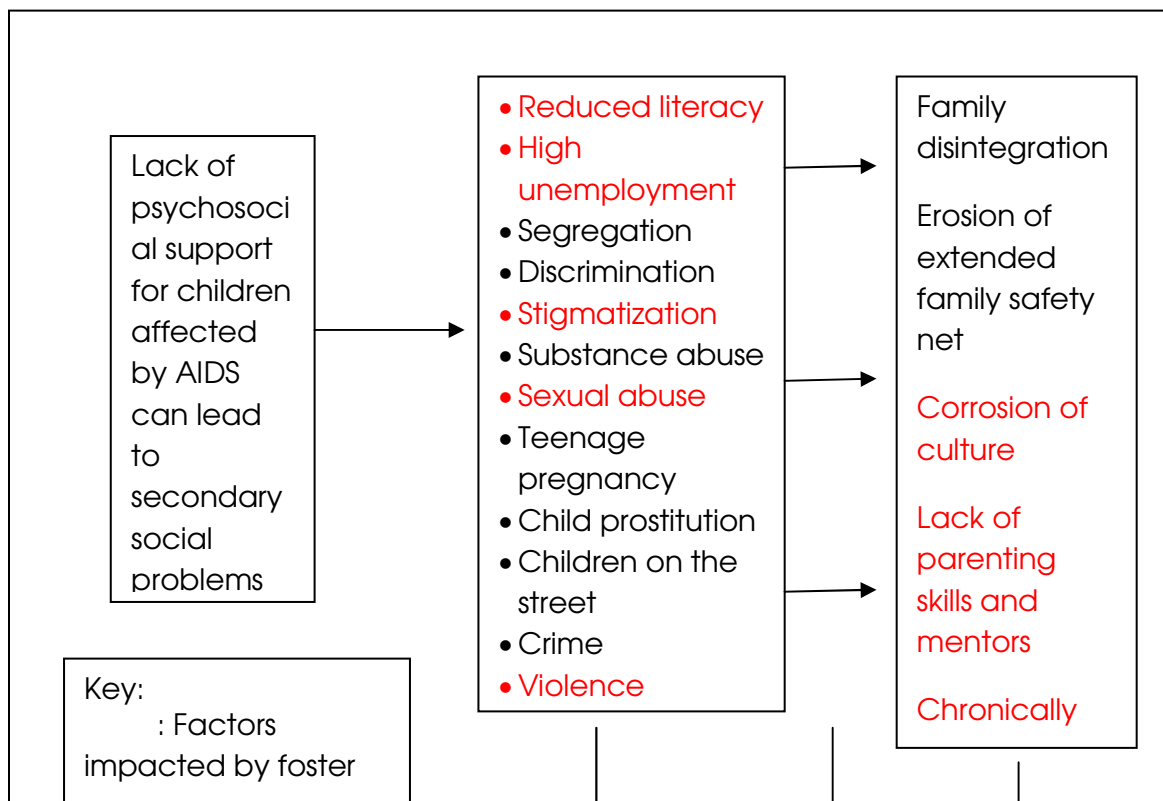




Figure 3: The potential long-term impact of foster care interventions on orphans of HIV/AIDS in Sub-Saharan Africa

While this paper has highlighted the individualized nature of foster care, it had possible local, national, and global repercussions as an intervention for orphans of HIV/AIDS. As displayed above, foster care could reduce a child's educational and occupational opportunities, promote their stigmatization in society and facilitate sexual abuse and violence due to a lack of monitoring from an umbrella organization. These problems not only increase the vulnerability of the orphan population, but they also have a negative impact on foster families and the community. The economic and psychological burden of acquiring new children could take a toll on a community's ability to maintain the traditions and norms that make up its culture. A community or family may be forced to sacrifice some of the resources that they allot for food or for pleasure in order to satisfy the basic needs of its foster child. Other consequences of foster care displayed in the above chart include the allowance for individuals with inadequate parenting skills, such as older siblings, to take responsibility for the wellbeing of this at-risk population. This void of proper mentorship in child-headed households

could have critical consequences on the development and wellbeing of the orphan population.

The impact of the HIV/AIDS epidemic extends beyond the orphans, their families, and the community, reaching a national and global level. As shown in the chart, the breakdown of the family unit resulting from negative foster care experiences could lead to the deterioration of culture in a community, and result in a loss of control at a national level. Due the lack of monitoring of foster care relationships discussed earlier, national government and external organizations may be unaware of the true nature of the problem and will therefore be unable to provide adequate resources to overcome the HIV/AIDS crisis. This is a problem that must be addressed.

The Solution

Finding the balance between the costs and benefits of fostering is the key to a successful foster care intervention. According to Madhavan (2004), traditional foster care was successful because the costs of raising the child were shared between the biological parents and the foster parents. However, the HIV/AIDS epidemic expended more resources than this system could handle, threatening to invalidate the effectiveness of this intervention. In order to rescue this system from destruction, it is necessary that foster parents are first educated on the basic skills of parenting. In addition, they should be enlightened on the potential benefits of taking in an orphan. This could be done, for example, by showing parents that a modest investment in the education of these children could produce long term benefits such as profit from a child's employment (Madhavan, 2004). Therefore, while the initial economic burden of acquiring a foster child is

daunting, support for the children in the short term could ensure financial reciprocation for the foster parents in old age.

In addition, an umbrella organization should be established in order to monitor the well-being of the children. This could be an agency that enforces more formal adoptions and agreements, thereby placing themselves in a position of power if a foster care agreement goes awry. Another more favorable option is the establishment of community programs and support groups for orphans, which will be discussed further in the next chapter. While foster care provides children with an alternative family, the opportunity to salvage their childhood and regain psychological stability, it is an intervention that is far from perfection. Possible ways of enhancing foster care programs will be discussed in the next chapter on community-based responses.

Chapter 3: The Local Impact: Community-Based Care for Orphans of HIV/AIDS

What is Community-Based Care?

Community-based care is a unique, informal approach to addressing the impact of the HIV/AIDS epidemic on youth in the local community. Foster care and institutionalization are two interventions whose implementation is driven primarily by an external response to the HIV/AIDS orphan crisis. Due to the growth of the orphan population and the high levels of poverty within Sub-Saharan Africa, the primary concern

of external organizations is to address the basic survival needs of the orphans. As a result, the provision of residential care such as a foster care or institutionalization takes precedence over other forms of outreach. However, as reflected in prior chapters, the complexity of this epidemic requires that multiple interventions be instituted in order to conquer it. Therefore, while foster care and institutionalization represent a means of providing an alternative family and home for these children, both often fail to address a child's integration within the local community. Support from the local community therefore plays a fundamental role in the wellbeing of this population. Community-based care serves to complement other previously instated intervention by expending the resources of the local community in order to support the orphan population.

In contrast to institutionalization and foster care, community-based care is a community's response to its first hand experience with children who are suffering from the impact of the disease. It is driven by a passion to bring these children off the streets and to restore them to a state of psychological well being. As discussed by Foster (2002), community-based interventions represent "the poor helping the destitute (p 1908)." Despite the general poverty that infiltrates the daily life of Sub-Saharan Africa as a whole, many communities have actively fought to alleviate the suffering of the highly vulnerable orphan population. Through raising awareness about HIV/AIDS and mobilizing communities to support these needy orphans, community-based interventions have made an enormous impact. While general models have been created to provided the framework for a successful community based intervention, it is vital to recognize that the community assets and the willingness to help this orphan population are not constants across the region. Rather, the beauty of this form of intervention is that it is established

by and tailored to each individual community, taking into account both the cultural norms and resources available.

Models of Community Intervention: A Bilateral Approach

In an analysis by Madhavan (2004) of responses to the HIV/AIDS epidemic, he proposes a bilateral approach to community-based interventions. Similar to many models of community intervention, Madhavan emphasizes the importance of internal activation of resources prior to any form of external influence. Internal community intervention from the viewpoint of Madhavan is rooted in the strength of the extended family network. In providing aid to orphans of HIV/AIDS, individuals with kinship ties to the population in need should be the primary resource called upon. Rather than demanding that all community members take on the burden of multiple orphans, the extended family should manage most of the weight of this orphan crisis (Madhavan, 2004). Local community members will make the most significant impact in their support of foster families and creation of programs that will integrate the orphan population into the community. Madhavan(2004) argues that in order to overcome the HIV/AIDS epidemic, change must come from within the extended family system.

The second stage of Madhavan's model comes into play when extended family members can no longer provide adequate care to their relatives in need. According to this model, external intervention is any aid provided by individuals or organizations outside of the extended family care or clan structure. Therefore, any form of community involvement such as the establishment of community centers or the creation of volunteer-run support groups make up the secondary phase of this model of community intervention. However, even with the establishment of community programs, Madhavan

continues to emphasize that the primary motive of any intervention should be to strengthen the remaining family structure, including donations from NGOs and non-profit organizations.

While Madhavan's bilateral model provides an interesting approach to community-based care, it is flawed in its lack of faith in the community. Emphasis on the extended family as a valuable resource is deserved, as it allows for families to reallocate resources and unite under the common cause of supporting their kinship in need (Isiugo-Abanihe, 1985). However, it is inevitable that the extended family system will become overwhelmed as the population of orphans expands and mortality due to HIV/AIDS increases in Sub-Saharan Africa. Volunteers from the local community are capable of complementing and supporting the system of families, while still fulfilling Madhavan's focus on change from within. In analyzing this model, it is vital to first recognize that community-based care and the extended family network are not two mutually exclusive resources in these communities, and both represent an internal response to this crisis. In contrast, external aid is the donation of material goods or establishment of programs by organizations outside of the local community.

Models of Community Intervention: Leadership in the Local Community

Community-based interventions will be most effective when local leadership takes initiative, organizing programs that will spread awareness of HIV/AIDS and raise support for the population of orphans (UNICEF, 2004c). The first step to a successful intervention is recognizing which community members are most likely to advocate for the affected population. In doing so, many religious leaders, women's groups, teachers and childcare administrators are recruited to form the volunteer base for this intervention.

Once community leaders are identified, they must take action in support of this population by ensuring that the basic needs of these orphans are addressed. They have an important role in analyzing the scope of the impact within their local community, identifying how many orphans are living in child-headed households without access to proper educational resources and health care (UNICEF, 2004c). In a study by Hasewinkel (1999) discussed in Sewpaul(2001), the role of the community leaders is acknowledged as the key first step in the fight for orphans of HIV/AIDS. Similar to the proposal by UNICEF (2004c), this study stresses the importance of evaluating how the disease has impacted the community's attitudes towards the orphan population. Further, local community leaders should determine the community's expectation of its role in the fight against the HIV/AIDS epidemic. This allows for the implementation of programming that addresses the needs of the specific community, and effectively provides psychosocial support to orphans of HIV/AIDS.

The local leaders should also work to ensure a physically and emotionally safe environment for the orphan population. As stated in previous chapters, orphans of HIV/AIDS are coping with immense loss and often psychologically unstable. By creating a community atmosphere that is accepting and supportive of this vulnerable population, children will not be driven further into isolation by the stigma surrounding the disorder. Stigmatization is often caused by a lack of awareness of HIV/AIDS or the flawed acceptance of misconceptions about the nature of the disease. Community leaders play an essential role in reducing the stigma by establishing programs such as community focus groups that aim to disprove myths, spread awareness, and invoke compassion from local community members (UNICEF, 2004). This will improve a community's ability to

support this population in a meaningful and effective manner, as individuals will have the knowledge base to truly understand what these children are experiencing.

In the study by Hasewinkel (1999), Child Care Committees were established as an alternative to focus groups. These committees represent the bridging of the gap between community leaders and local volunteers. They aim to “facilitate the development of sustainable community-based care for children in distress, by empowering communities to mobilize their own resources, and to lobby state authorities, local organizations and childcare professionals” to join the fight against HIV/AIDS (Hasewinkel, 1999 as cited in Sewpaul, 2001 p. 582). These committees serve many crucial purposes, including the establishment of an orphan registry and the placement of children into residential care (Sewpaul, 2001). Regular committee meetings will allow for the coordination of local volunteer-led support services such as daycare, afterschool programs, and support groups. In a study of over 50 successful community-based interventions for orphans of HIV/AIDS in Africa, it was found that success was dependent on the passion, commitment, and dedication of the local community members (Sewpaul, 2001).

Strengths of Community-Based Interventions

Community-based interventions are founded on the desire to create a supportive and empathetic environment for a population that is highly vulnerable to psychosocial distress and isolation. These interventions find strength in informality, because it is not their primary purpose to provide shelter and a family for these children. Rather, community-based care serves to complement residential care such as foster families and institutionalization in order to facilitate the reintegration of orphans into the local

community. By mobilizing resources such as the time and donations of local community members, communities are often able to implement a sustainable and cost-effective model of intervention. In contrast to interventions which bring external organizations in to implement programming, community-based care is dependent upon a local commitment to fight against the HIV/AIDS epidemic. The community is united under the common interest to help these children in need, and what begins as a group of local volunteers discussing the disease will transform into a community-wide movement. Interventions such as the Child Care Committees discussed in Hasewinkel (1999) allow for each respective community to tailor its own intervention depending on the scope of the problem. Therefore, the most effective form of external aid is the donation of money or material goods to these locally established programs.

A primary strength of community-based interventions is the ability for the local community to effectively channel support at a minimal portion of the cost of external intervention (Foster, 2002). In a study of two local interventions implemented in Sub-Saharan Africa each reported annual costs of \$20,000 to \$30,000, a range 1/10 of the cost of most external interventions (Foster, 2002). A likely cause of this is the community's knowledge of what resources a child needs to survive, and where these material goods can be purchased for the lowest prices. This speaks to the individualized nature of community-based care, which is appealing because, unlike many external interventions, it allows for the maintenance of the local culture (Sewpaul, 2001).

The expense of local community resources extends beyond the provision of material goods to the community's donation of time to support local programming. As support increases and programming expands, the most sustainable community based

interventions with the highest levels of outreach can be instituted. One program established in Zimbabwe began in 1996 with 15 volunteers reaching out to 815 orphans. By 2002, the program had 385 volunteers reaching 6000 orphans in the local community (Foster, 2002). In 19 other programs established in Zimbabwe alone, 247 more volunteers were recruited and able to reach out to 3462 orphans (Foster, 2002). With minimal external funding, these interventions still managed to provide support in the form of regular visits, psychosocial support, absorption of school fees, and the supply of food and clothing (Foster, 2002). These statistics highlight the incredible potential of local communities in the fight to overcome the HIV/AIDS epidemic. While community interventions alone are not enough to fight this battle, they are a huge asset that should not be overlooked.

Conclusion

Due to the enormity and complexity of the HIV/AIDS crisis, an effective and sustainable response must be activated. In order to most successfully tackle the many facets of this crisis, multiple forms of intervention will need to be implemented and will require support from a local, national and global level. The constant growth of the population affected by HIV/AIDS directly correlated to the intricacy of the intervention. Every family member lost, business uprooted, and child's education jeopardized needs to

be accounted for and addressed. In combining the strengths and diffusing the weaknesses of each form of intervention, the HIV/AIDS epidemic in Sub-Saharan Africa can and will be defeated. This paper does not intend to outline every possible type of intervention that has been or could be implemented in response to the orphan crisis in Sub-Saharan Africa. Rather, it aims to reveal the variability in response tactics, exposing the flaws and highlighting the strengths of three popular interventions.

Institutionalization, foster care, and community-based responses all have the potential to make a significant and lasting impact on the orphan crisis in Sub-Saharan Africa if executed properly. While each intervention has its strengths and weaknesses, it is vital to acknowledge that some interventions have produced more favorable results than others. Therefore, the HIV/AIDS crisis will be most effectively overcome if the resources that are making a positive impact on the children are expended first, and the other forms of intervention serve as alternatives.

Analysis of the Model (Figure 3): Residential Care Interventions for Orphans of HIV/AIDS

I have created a model that aims to summarize the conclusions reached in the previous three chapters. This model, displayed portrays how residential care, community-based care and support from external organizations can best interact to respond to the HIV/AIDS crisis. Through the research summarized in this paper, it can be concluded that the most effective interventions provide orphans with stability and support in response to the loss of their loved one. Interventions that fail to fill the

parental void with a long term caregiver will serve to prolong a child's coping process. Figure 4, displayed below, argues that the primary caregiver for children orphaned by HIV/AIDS should, if possible, be an extended family member (Isiugo-Abanihe, 1985; Madhavan, 2004). As explained in Chapter 2, remaining within the family will allow for an easier conversion to life after the loss of a loved one to HIV/AIDS (Madhavan, 2004). Foster care, if monitored effectively by complementary community-based programs, has the potential to provide children with the nurturing home environment they need to develop into a functional adult. However, the extended family system has limits, and its outreach in response to the growing orphan population is insufficient. Therefore, community members interested in supporting orphans of HIV/AIDS should serve as a secondary source of foster care.

Institutionalization, while a highly controversial form of intervention, has the potential to make a significant positive impact. Although dormitory style institutions are usually highly cost inefficient and have low success rates, family-based institutions have favorably influenced the lives of many children (Meintjes et. al., 2007; UNICEF, 2004a; UNICEF 2004c). Establishing an alternative family and community for these children, although likely to take some time to adjust to, could provide children with the support and guidance needed to cope with the loss of their parent to HIV/AIDS. While institutionalization should not be the first form of intervention considered, it can be a valuable alternative for children who do not have foster care as an option. The primary focus of institutionalization should be to facilitate a child's quest for normalcy, a goal that the communal nature of dormitory style orphanages cannot fulfill (Altshuler & Poertner, 2002; Meintjes et. al, 2007; UNICEF, 2002; UNICEF, 2004a; UNICEF, 2004c).

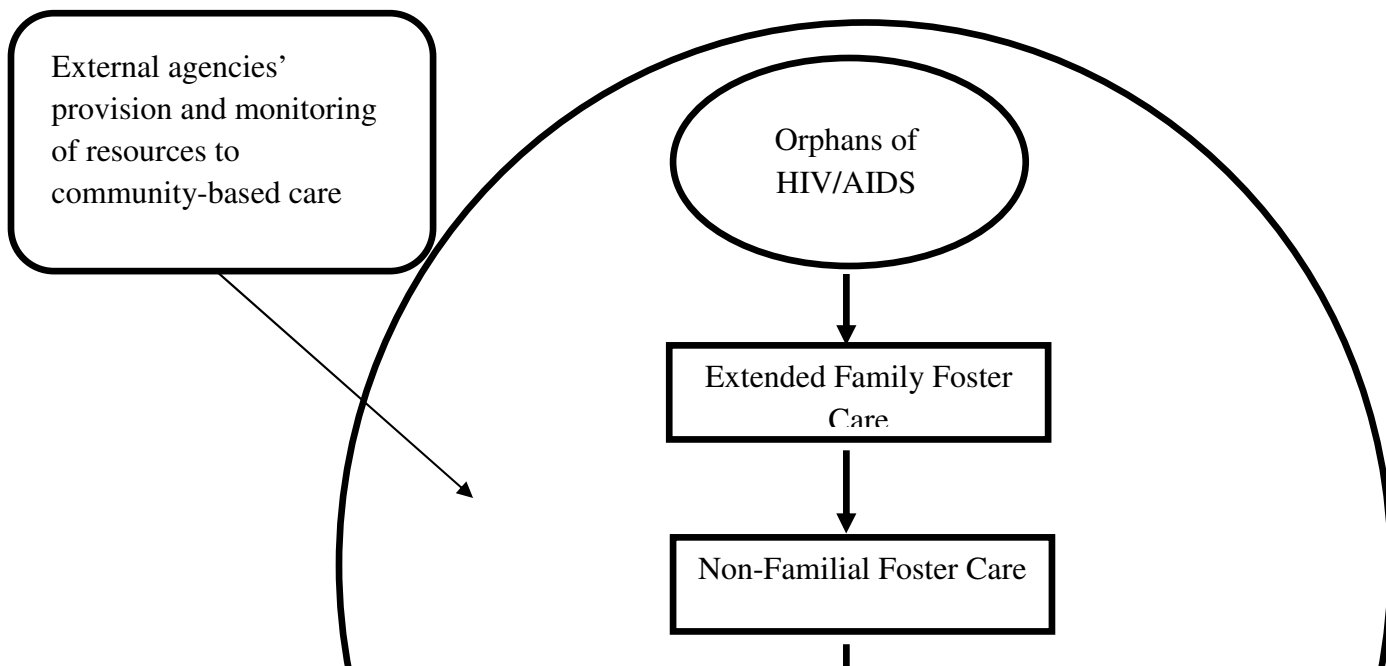
Therefore, dormitory style institutions must be eliminated as an option for residential care.

Analysis of the Model (Figure 3): Community-based Care for Orphans of HIV/AIDS

The primary goal of the two forms of foster care and two forms of institutionalization labeled in the model is to provide children with an alternative home, the basic necessities to survive, and a consistent support system. While this is an appropriate preliminary response to the crisis, it is not sufficient. As portrayed in the model, the community's response to the epidemic must be a constant presence across all forms of interventions. In order to create a sustainable response, community interventions as a supplement to residential care are essential. A primary fear of foster care and institutionalization is the extent to which it isolates children from the local community (Bledsoe et al, 1988; Madhavan, 2004; UNICEF, 2004a; UNICEF, 2004c). While both forms of residential care aim to provide long-term care to this population, they are still temporary interventions. These orphans, just like all children, need to develop the skills to become functional individuals in society. The more each orphan is integrated and accepted in society, the more self-sufficient they will be in the long term. Community programs such as support groups, day care, and extracurricular programs help to diminish any fear of stigmatization by the community, and help to encourage social skills development (Madhavan, 2004; Sewpaul, 2001; UNICEF, 2004c). In addition, community involvement in the fight against HIV/AIDS provides these children with another essential means of social support.

Community based care, represented by the circle in the model, will complement all forms of residential care implemented. Making community members responsible for

analyzing the economic toll of the HIV/AIDS epidemic on their local community will allow external organizations and local non-profits to evaluate the amount of material support to provide (Sewpaul, 2001). In order to effectively tackle this crisis, a multifaceted intervention needs to be executed. As proposed by Foster (2002), successfully combining local and external responses requires the establishment of a system to efficiently channel resources between external organizations and community groups. In his paper, Foster suggests the creation of locally administered trust funds and a network of participating organizations. In addition, he stresses the importance of partnership formation between local non-profits, external organizations, and community groups. Interventions executed by community members are better able to maintain the local culture and empathize with the struggles of the orphan population (Sewpaul, 2001). However, the limited resources in the local community could prevent an intervention from reaching its fullest potential. With more resources fed into these programs from external organizations, they outreach and programming could be expanded. Therefore, communities must work to prove to external organizations that they are worthy of donations by implementing effective and cost efficient programming (Foster, 2002).



**Community-
based Care**

Figure 4: A Model of Intervention for Orphans of HIV/AIDS in Sub-Saharan Africa

Conclusion

Driven by the passion of local communities directly impacted by the HIV/AIDS epidemic and the might of the extended family network, the needs of the orphan population can be met and exceeded. By strengthening the local, national, and global response to this crisis, a sustainable movement to overcome this epidemic will be established. Once each individual in the communities impacted in Sub-Saharan Africa recognizes their role in this fight, their motivation to attend to the needs of this vulnerable population will fuel the national and global response. As a plethora of nonprofit and governmental organizations are working to prevent future cases of HIV/AIDS, others need to acknowledge the impact that past and current cases have had on society and fight to overcome it.

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