The Mechanisms Underlying Orphan Disadvantage: Evidence from Lesotho

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In Southern Africa, adult HIV prevalence rates of between 19 and 33 percent are fueling concern about the welfare of the increasing number of children losing parents to the epidemic. Emerging evidence suggests that parental death is negatively associated with a range of child outcomes. Explanations for orphans' differential disadvantage have clustered around three themes: household resource constraint, investment in children with greater "endowments," and biological affinity. Drawing on over 120 in-depth interviews with caregivers, children, and key informants in Lesotho, I look for evidence consistent with these explanations as well as new understandings of the mechanisms underlying orphan differential disadvantage. Analyses support biological affinity and resource constraint as mechanisms, and elaborate the way they work and interact. Though there is little evidence of the "endowments" mechanism, the interviews suggest caregiver "character" and child behavior also matter, as do community expectations regarding the treatment of orphans.

Introduction:

This paper investigates the mechanisms underlying the differential disadvantage of orphans[1] in a part of the world that has seen a massive increase in adult mortality due to the AIDS epidemic. The adult HIV prevalence rates range between 19 and 33 percent across Southern Africa and, with the exception of Zimbabwe, there is little evidence of declining epidemics (UNAIDS 2006). The high rates of HIV are fueling concern about the social and economic fabric of the countries of the sub-region. The welfare of children is of particular concern, as the experience of parental death is exceedingly common in the absence of widespread access to treatment.

Emerging evidence suggests that parental death is negatively associated with a range of child outcomes. The most extensively studied outcome to date has been child schooling, with numerous studies finding evidence that orphanhood is inversely

[1] Consistent with standard practice, orphans are defined here as children who have lost one or both parents (UNAIDS & UNICEF, 2003; WHO 2004).

associated with educational enrollment and attainment (Bicego et al. 2003; Case et al. 2004; Case and Ardington 2006; Evans and Miguel 2007; Mishra et al. 2007; Nyamukapa and Gregson 2005; Yamano and Jayne 2005). Negative effects of orphanhood on child health, nutrition, and emotional well-being have also been documented (Ainsworth and Semali 2000; Atwine et al. 2005; Wood et al. 2006; Miller et al. 2007), as has increased mobility and residential instability (Ansell and van Blerk 2004; Ford and Hosegood 2005).

Researchers have suggested explanations for orphans' differential outcomes. Most have been based on survey research, though several qualitative or mixed method studies have also illuminated particular aspects (e.g., Foster et al. 1997; Nyambedha et al. 2003; Ansell and Young 2004; Nyamukapa and Gregson 2005). The explanations put forth to date have clustered around three themes: household resource constraint, affinity for biological children and close relations ("biological affinity"), and investment in children with greater "endowments."

Resource constraint

Some researchers have concluded that orphans are in fact not disadvantaged relative to equally poor nonorphans. This was particularly common in research conducted in the earlier stages of the epidemic (e.g., Ryder et al. 1994; Foster and colleagues 1995; Lloyd and Blanc 1996; Panpanich et al. 1999). For example, Lloyd and Blanc (1996) found that across seven countries in sub-Saharan Africa the education of the household head and the household standard of living were more important determinants of schooling than orphan status. Several recent studies have also come to similar

conclusions. Ainsworth and Filmer looked at the relationship between orphan status, household economic status, and child school enrollment across 51 low-income countries, and concluded that "the orphan enrollment gap is typically dwarfed by the gap between children from richer and poorer households." (2005: 1113) Yamano and Jayne's 2005 analysis of Kenyan panel data indicated a conditional effect: children's school attendance was adversely affected by the death of working-age adults among the bottom half of households ranked by initial asset levels, but no significant effects were detected among households in the top half of the asset distribution.

Others have presented evidence that resource constraint tells only part of the story. For example, Case and colleagues (2004) found in an analysis of Demographic and Health Survey (DHS) data across ten sub-Saharan African countries that though orphans in wealthier households were more likely to go to school, the gap in enrollment between orphans and nonorphans did not decrease with wealth. Case and Ardington (2006) determined using longitudinal data from South Africa that a correlation between mothers' deaths and children's schooling outcomes persisted over and above wealth, though a correlation with fathers' deaths did not. Ainsworth and Semali (2000) found that in Northwest Tanzania adult deaths had an independent relation with two measures of child health over and above household and community economic variables. Mishra and colleagues (2007) determined that both orphaned and fostered children in Kenya were significantly less likely to be attending school than children of HIV-negative parents, controlling for household wealth and other child and household characteristics.

"Biological affinity"

A second line of explanation for orphan disadvantage has centered around the idea of differential treatment based on degree of relatedness to the caregiver. This may arise because of a normative or even evolutionary affinity to one's close relations, as well as assumptions that one's close relations will be more likely to provide resources to one later in life.

Case and colleagues refer to "Hamilton's rule" (1964a and 1964b as cited in Case et al. 2004: 484), from evolutionary biology, which says that "altruistic behavior between any two individuals is an increasing function of the degree of genetic relatedness between them." They found in their analysis of DHS data from ten sub-Saharan African countries that children who lived in households headed by "other relatives" were less likely to be enrolled in school than were children who lived with parents or grandparents, and that those who lived in households headed by nonrelatives were least likely to be in school. Similarly, Bishai and colleagues (2003) developed a measure of children's biological relatedness to household members, and showed that reduced biological relatedness was independently associated with reduced child survival in Rakai, Uganda.

Researchers have also provided evidence that in households with biological and non-biological children, caregivers may prioritize their biological children over more distant relatives or non-relatives. For example, Nyamukapa and Gregson (2005) provide evidence that maternal orphans' low primary school completion rates in Zimbabwe may have been due in part to stepmothers giving greater priority to the needs of their biological children. Case and colleagues found using household-level fixed effects that orphans were less likely to be enrolled in school than were nonorphans with whom they

lived (2004). Yamano and Jayne (2005) found in their study in Kenya that "nonrelative" children were less likely to be in school compared with household heads' own children. Respondents in a study in Western Kenya suggested that caregiver concerns that orphan children might "outshine" their biological children may have driven a discriminatory attitude toward orphaned children (Nyambedha et al. 2003).

In their analysis of perceptions of orphans in rural Zimbabwe, Foster and colleagues combined resource constraint and biological affinity arguments, writing that, "Some families treat all children equally, but others discriminate against orphans; this may be due to poverty since caretakers struggling to provide for their family sometimes ration scarce resources to benefit biological rather than inherited children." (1997: 396) Similarly, Ansell and Young, in an analysis of the migration of AIDS orphans in Lesotho and Malawi, write that "When households adopt children through a sense of obligation, as is usually the case with AIDS orphans, they are often treated differently from the family's 'biological' children, particularly if resources are scarce." (2004:5).

Investment in children with greater "endowments"

A third line of reasoning is based on the notion that caregivers invest more heavily in children they view as having greater "endowments" (Becker and Tomes 1976; Becker and Tomes 1979). If children whose parents die of AIDS are more likely to come from households of a certain type (for example, poorer households), then those "selected" into orphanhood could plausibly be in worse health than nonorphans or have experienced more deprivation in early childhood, such as lower levels of school enrollment (Case et al 2004; Case and Ardington 2006). Orphan caregivers may choose not to invest in these

children because they are in any case less "endowed", and by extension less likely to provide returns on the investment.

There is limited evidence of this kind of selectivity. In their analysis of longitudinal data from South Africa, Case and Ardington (2006) found no evidence that lower educational enrollment and attainment among maternal orphans was simply a matter of "innate quality" (415). Children whose mothers later died did not lag behind other children in school enrollment or educational attainment at baseline.

However, in their recent longitudinal study in Western Kenya, Evans and Miguel (2007) found that children whose parents later died had significantly lower academic test scores at baseline than children whose parents did not, though these differences were small in magnitude. They also found that parental death affected more adversely the schooling of children with lower baseline academic scores, which they suggest may reflect a household decision to "focus their increasingly scarce resources after a parental death on more promising students" (52).

Most of the studies mentioned above address one or two of the three primary explanations given for orphans' differential disadvantage, and one addresses all three (Case et al. 2004). Much of the evidence is indirect, in the form of data patterns consistent with these explanations. In this paper I extend and complement existing scholarship by drawing on direct conversations about differential disadvantage with 124 caregivers, children, and key informants in the Southern African country of Lesotho. These data allow for a systematic examination of the mechanisms underlying the differential disadvantage of orphans. I look in the narratives for evidence of the three

main explanations posited to date, as well as for new explanations. A more detailed understanding of why and how the differential disadvantage of orphans arises can inform future empirical analyses, as well as help to tailor policies and programs more effectively to the realities of orphans' lives.

Lesotho Context

Lesotho is a highly relevant case for the exploration of these themes. A full 23 percent of adults were HIV-positive in 2004 (Ministry of Health and Social Welfare, Bureau of Statistics, and ORC Macro 2005). These high HIV prevalence rates contributed to a situation in which 28% of children below age 17 had lost at least one parent to death. (Parker, Short, Goldberg, and Hlabana 2007).

Life expectancy in Lesotho in 2005 was 36 among men and 33 among women, down from 38 and 40, respectively, in 2000 (United States Census Bureau 2007). Though access to antiretroviral treatment is increasing (National AIDS Commission, Lesotho, 2006), rates of treatment have been low in recent years—estimated at 14 percent in 2005 (UNAIDS 2006). Rates of HIV testing have also been low, with only 12 percent of all women and 9 percent of all men 15-49 reporting in 2004 that they had ever been tested and received their test results (Ministry of Health and Social Welfare, Bureau of Statistics, and ORC Macro 2005).

The HIV/AIDS epidemic in Lesotho takes place in a context of extreme poverty. Lesotho ranks 149th out of 177 countries in the world in its human development index value (UNDP 2005). More than half (56 percent) of the population live below an income poverty line of $2 a day. Approximately 75% of households in Lesotho are located in rural areas (Bureau of Statistics, Lesotho, 2007).

Children's wellbeing indicators are largely reflective of the poverty indicators given above. For example, at the national level, 38 percent of children under five years of age are stunted, an indicator of long-term nutritional deprivation. In rural areas, a full two-thirds of children are moderately stunted. However, despite high poverty, children in Lesotho are quite likely to be enrolled in school. In 2004, these figures were 85% for girls and 78% for boys aged 6-17. (Ministry of Health and Social Welfare, Bureau of Statistics, and ORC Macro 2005)

Finally, as is typical of most of South Africa's neighbors, Lesotho is characterized by substantial labor migration, for formal and informal work. As a consequence of migration and other factors, many children in Lesotho do not live with parents who are alive. In 2004, roughly 40% of children had fathers who were alive but absent from the household, and roughly 30% had mothers who were alive but absent (Parker, Short, Goldberg, and Hlabana 2007).

Data and Analytic Approach:

This paper draws on in-depth interviews conducted in 2004 as part of the Lesotho Children's Project, an ethnographic data collection effort aimed at better understanding of family reorganization in the context of HIV/AIDS and its implications for child well-being. In-depth interviews were organized around 74 focal children ages 0-15 who were selected for variation along three main axes: presence or absence of biological parents; socioeconomic level; and residence in a "town" or "rural" village. The "town village," which was technically a rural area, was located approximately one hour from the capital city. Its main road was partially paved, and access to the capital and to services was

relatively high. In contrast, the "rural village," technically a cluster of very small villages, was two hours from the town village by foot up a mountain.

Semi-structured in-depth interviews were conducted with the primary caregiver of each of the 74 focal children. In addition, those 35 focal children that were seven years of age or older were also interviewed directly. Finally, interviews were conducted with 15 key informants. These were influential community members familiar with the situation of children, including, for example, teachers, health care workers, and police.

The current analysis utilizes the interviews with all three categories of respondent, and benefits from the fact that the perspectives of the caregivers, key informants, and children were elicited in a variety of ways across the interviews. First, the analysis draws on spontaneous discussion throughout all of the interviews related to respondents' experiences living with orphans, the situations of orphans known to respondents, and respondents' own experiences as orphans (in the case of the focal children), as well as more general discussion of child and orphan wellbeing. Second, it draws on responses to direct questions posed to the caregivers and key informants about orphan care. Finally, the analysis also draws extensively on discussion generated by two vignettes in the caregiver interviews. These were a series of hypothetical situations designed to systematically explore normative ideas on the care of orphans. In the first of these vignettes, the caregivers were told a story about three children whose mother died, and were asked a series questions about the best living arrangements for them. In the second vignette, a multi-generational household with two biological and three orphan children was described, and respondents were asked a series of questions about the treatment of the children that led into direct discussion of differential treatment of orphans.

A strength of this analysis is thus the ability to triangulate information from a multiplicity of sources and vantage points to explore the topic of orphan disadvantage. The breadth and depth of information present in this data makes it ideal for examination of *why* and *how* differential disadvantage arises. The analysis thus focuses not on the *what* (for example, the current situation of the orphan households in the sample), but rather on the explanations for orphan disadvantage that emerge in these discussions.

It should also be noted that this paper purposely centers on the concept of differential *disadvantage*, which encompasses but is not limited to differential *treatment*. This is because the differential outcomes seen for orphans may arise because of the active differential treatment of orphans from non-orphans within a household, and/or from the different treatment children may receive from different types of caregivers. However, they may also arise at least in part from differential resources in orphan households compared with non-orphan households, or for other reasons that do not involve the active discrimination against or prioritization of certain children inherent in the concept of differential *treatment*. I therefore conceptualize my analysis broadly in terms of differential *disadvantage*, to encompass the different mechanisms—more and less active—that may engender the differential outcomes seen for orphans. The two terms will thus not be used interchangeably throughout the paper, but will signify different but related concepts.

Data Analysis:

In line with standard qualitative data analysis methods (e.g., Miles and Huberman 1994; Patton 1990), I documented emergent themes during multiple reads of the

transcripts and developed these themes into a list of codes. I also ensured that there were codes for each of the explanations posited to date for orphan disadvantage described earlier. The codebook thus included two types of codes: 1) a small list of pre-determined codes generated to correspond to the three explanations derived from the literature; and 2) emergent codes. The former may or may not have also corresponded to themes emerging spontaneously from the data. The emergent codes included both new sub-codes (or "branch" codes) that added nuance to the pre-determined codes, as well as entirely new codes.

Text segments were coded using the QSR NVIVO 7 analysis package. Concordant with a view of qualitative data analysis as a "continuous, iterative enterprise" (Miles and Huberman 1994: 12), the process of coding and analysis led to new codes, which were then integrated into the coding scheme. The transcripts were coded in three iterative rounds of coding. In addition to coding thematically within transcripts, I also coded each of the transcripts for attributes such as age, socio-economic status, caregiver relationship to focal child, and focal child orphan status.

The analyses are based on queries of different forms generated in NVIVO. I conducted analyses by code, by combinations of codes, and crossing codes and attributes. I analyzed standard displays by code as well as matrix displays. As mentioned earlier, I privileged analyses of *mechanisms* with emphasis on the reasons suggested for orphan differential disadvantage.

Results:

Respondent characteristics

Table 1 summarizes the characteristics of the study sample. More than half of the respondents interviewed were residents of the town village. The majority of the caregivers and children were of low socio-economic status (SES), though there was some variation[2].

Of the 74 primary caregivers of children interviewed, the median age was 38.5 years. The caregivers were most commonly biological mothers (39) and maternal grandmothers (13) of the focal children, followed by paternal grandmothers (5) and aunts (5). Additionally, four were biological fathers, one was a grandfather, one an uncle, five were other types of relatives, and two were non-relatives. Twelve of the caregivers reported having orphans living in their households at the time of interview.

The median age of the focal children was 6.5 years. As mentioned earlier, only those focal children age seven or above were interviewed. Of the 35 that met this criterion, the median age was 11 years. Only nine of the children interviewed were resident with both of their biological parents at the time of interview. Five had experienced the known death of a father, and four of a mother. A full 21 of the 35 children interviewed had fathers who were absent at the time of interview, and 14 had absent mothers. Of the absent parents, the vital status of five was unknown.

Of the 15 key informants, six were teachers, two were health care workers, two were police, two were local chiefs, one was a religious leader, and two worked with NGOs. The key informants resided mainly in the town village.

[2] This variation was seen only in the town village. In the rural village, all respondents were deemed to be of low SES.

(Table 1 about here.)

The remainder of this section begins by examining the three main explanations posited to date for the differential disadvantage of orphans, establishing for all of them whether there was evidence of them present in the narratives, and, as relevant, elaborating them based on the interview data. It then describes additional explanations that emerged from the interviews. Third, it examines the extent to which age and sex figure into the respondent discussions of orphan disadvantage. I end the section with respondent reflections on institutional care, to extend the discussion of orphan disadvantage beyond the family level.

Resource constraint as a mechanism

Resource scarcity permeates the lives of the majority of the respondents interviewed. For households with or without orphans, it frames decisions related to everything from schooling to health care to migration for work. However, several themes of resource constraint did emerge in relation to orphan households in particular.

First, respondents spoke of the impact of the loss of a key breadwinner or breadwinners on a household. The words of an 11-year-old paternal orphan in the rural village are illustrative:

> *How is your life now?*
> It's now tough because when my father was still alive he was working and he bought us winter clothes, but now we have none since my mother isn't working.
> *Anything else?*
> We also lack food.
> ...
> *What happens when food isn't there?*
> My mother asks for it from other people and they sometimes give it to her.

In her interview, his mother elaborated: "I'm unable to carry out the school expenses for my children, due to having no money. I'm trying to sell things like beans, eggs, and eet-sum-more [cookies], but my business is very poor so we hardly live."

Second, respondents spoke of resource dilution in households that take orphans in. A common metaphor used by the respondents when referring to households receiving orphans was that of "luggage." The presence of orphans was said to dilute households' already scarce resources, increasing the already "heavy luggage" of those who take them in. For example, one key informant said, "Orphans are left with relatives but it's really hard since they also have their own big luggage of many children." (Religious leader, town village) A caregiver said of a hypothetical family receiving multiple orphans, "The luggage which isn't theirs is too heavy for them" (Mother, rural village)

Third, respondents underscored the potential for extreme resource scarcity in those households in which elderly, who cannot easily work, have taken orphans in. For example, one respondent said of orphan care by a grandmother:

> They [the orphans] are going to wonder about the quality of their life, as their guardian is now old and is not able to look for a job.
> …
> *So who'll assure their survival?*
> There is no one but the grandmother…she'll scrape everything she can together for them for survival.
> (Mother, rural village)

However, respondents also noted that grandparents were sometimes helped financially with the care of orphans by other non-resident family members, such as the children's aunts and uncles or great aunts and uncles. For example, a maternal grandmother from

the town village said of a hypothetical question related to grandmother care of orphans, "I think my brothers and sisters will help me to raise these children..."

Finally, the words of a caregiver father in the rural village remind us that children in households with both parents present and only biological children also often face difficulties due to resource scarcity:

> *Why did you leave your work [mining in South Africa]?*
> They were many strikes in the mines and most of them were closed. That's why lots of people were sent back home.
> *Did you like working?*
> I liked my work very much because we were getting a lot of money, which we can't get here in Lesotho.
> *Where do you now get money for sending your children to school and buying the family needs?*
> I sometimes sell sheep, but my daughter helps us with some money when she has it.
> ...
> In this place, life is really problematic. When your child is sick, you worry about where you'll get the R5.00 [approximately US$0.62] to take him/her to a far away clinic because we don't have one here. We only live on papa [staple food made of corn meal] and moroho [vegetables]. Life is tough, I'm telling you.

Biological affinity as a mechanism

Beyond resource constraint there is also much evidence throughout the interviews of biological affinity, or affinity to one's close relations, as a mechanism for orphans' differential disadvantage. A common theme is that there is no "love" like parental love. As one caregiver explained, "Because they don't have parents, the love and care that they would be given by other people is not going to be the same as the love that their parents would provide them." (Maternal grandmother, town village) Another said, "They [The orphans] won't enjoy their stay…because the love provided won't be parental love." (Maternal grandmother, town village)

Given the uniqueness of parental love, respondents asserted that if a caregiver has biological children in the house as well as more distant or non-kin, it is very difficult to love both equally. The words of several caregivers are illustrative:

> "It's difficult for [women] to raise children who aren't their own. Yeah, the love they provide to those kinds of children is not enough. They only look after their own children." (Step grandmother, town village)

> "It's a real bad situation because the calf is licked by its mother. [The stepmother] will only give love to her own children, not to those." (Maternal aunt, rural village)

Respondents equated this differential love with differential treatment, particularly when discussing households with both orphan and biological children. They described material as well as more affective differential treatment of orphans. Material differential treatment included differences in the kind of clothing orphans wear when compared with other children in the household ("ragged", "old", "light"), and differences in food given (orphans were said to "often be hungry" and to "not be given proper food"). Respondents also asserted that orphans are made to do more household chores than other children in the family, and are less likely to be sent to school. The following are some illustrative quotations:

> "They won't be alike because when they both attend school, I'll pay school fees for mine and those will be expelled, and when at home I'll tell them to herd cattle so as to get papa [staple food made of cornmeal]." (Mother, rural village)

> "After school, mine will sit to rest and those others will go collect firewood." (Maternal grandmother, rural village)

> "My children will be given papa and moroho, and the others will be given a little papa and a teaspoon of moroho only to make them say they've eaten" (Mother, rural village)

References to more affective differential treatment of orphans included being told that they do not "belong" in a family, being criticized or punished more frequently, and

being exposed to a general lack of "kindness." For example, one respondent said "…they [orphans] will always be scolded. They [caregivers] never talk to them politely. They are rude and harsh to them." (Mother, rural village) Another explained that a stepmother would tell the orphans in her care that, "They are not her kids. She'll keep on reminding them, you know. It's going to be their daily bread." (Mother, town village) A third caregiver elaborated, "When your child has done something wrong you don't see it, but when it's done by someone else you see it and the treatment provided will be unfair." (Maternal grandmother, town village)

Respondents were careful to make distinctions about the salience of this mechanism for different caregiver types. For example, maternal grandmothers were often said to be an exception to the rule, treating and loving orphans "like their real mother," in contrast to other types of caregivers. A mother from the town village echoed the sentiments of many when she said, "Staying with their [maternal] grandmother will be the same as staying with their mother. The grandmother will show the same care toward the children as the children's mother would have." This is consistent with empirical analysis of the 2004 Lesotho Demographic and Health Survey, which suggests that maternal orphans who live with a grandmother are just as likely to be in school as children living with a mother (Parker and Short 2008).

On the other end of the spectrum were stepmothers, who were often portrayed as providing care to their stepchildren that was entirely unlike maternal love. Some Cinderella-like scenarios were depicted. For example, one caregiver said, "She can be stingy with food and allow only her children to enjoy decent meals with her. Sometimes

these step children are the ones that do homely chores like drawing water and producing vegetables while her own do nothing." (Mother, rural village) Another said:

> "They are not going to live like those of the 2nd wife. They are only going to be slaves towards those of the 2nd wife…Only those whose mother is dead are going to work and clean the house, and they might not even be sent to school. *Have you ever seen it happening?* Yes, and again those of the dead weren't attending school, they were herding the cattle, and the [female orphan] was treated like a domestic worker." (Mother, town village)

Biological affinity and resource constraint as linked mechanisms

Several respondents linked resource constraint with biological affinity by describing caregiver decisions to prioritize their biological children in the face of scarcity. For example, one explained in response to a hypothetical question on orphan treatment that, "If life becomes tougher, I'll only look after my own children." (Paternal grandmother, town village)

The caregiver burden does appear to be lessened somewhat if orphans have inherited money from their deceased parents. For example, one caregiver said of a situation like this: "There is nothing I will have to do with my own money, meaning the upbringing of the children [will] be easy. The person will just be acting like an 'eye' to those children." (Maternal grandmother, town village) However, many respondents asserted that orphan money only mitigates differential treatment if the caregiver is trustworthy. Some caregivers were said to spend orphan money on either themselves or on their biological children rather than the orphans. For example, a caregiver from the rural village explained that it "depends on who is left with the money because some will consume it with their [biological] children and give none to those [orphaned] children, but others can use it for those [orphaned] children's needs." (Paternal aunt, rural village)

Another said of a stepmother discussed hypothetically, "She'll use [the money left to the orphans] to dress and feed her kids in a decent way while her step-kids suffer." (Mother, rural village)

Grandparents appeared to be seen by the respondents as the most trustworthy with orphan money, despite the fact that they were often also seen as the most likely to be poor. They were also seen as the most likely to care for orphans even in the absence of inheritance money.

Role of respondent socio-economic status (SES)

There is no evidence that the relative weight respondents attached to biological affinity or resource constraint as explanations for orphan disadvantage differed by respondent SES. In other words, respondents living in households of lower SES were no more likely to mention resource constraint as an explanation than respondents living in households of higher SES. Nor were respondents living in households of higher SES more likely to mention biological affinity as an explanation.

Investment in children with greater "endowments" as a mechanism

Across the interviews there was very little evidence of the "endowments" mechanism as an explanation for orphans' differential disadvantage. This mechanism includes the idea that orphan caregivers might choose not to invest in orphans because they are in any case less "endowed" (for example, in relation to schooling or health), and by extension less likely to provide returns on the investment. The respondents in Lesotho did not in the course of their interviews speak of orphans as less healthy, nor as less likely

to do well in school. The only evidence that orphans might be seen as less likely to provide returns on the investment of raising them came in several caregiver comments related to the idea that orphans might not feel compelled to provide financially for their caregivers in the future in the same way that biological children would. For example, one caregiver said of a hypothetical family taking in multiple orphans, "They thought that if they can raise and care for it [the non-relative orphan], tomorrow they won't even see a single cent." (Mother, rural village)

Beyond biological affinity, resource constraint, and endowments

Caregiver character

Though there is ample evidence from the Lesotho data of both biological affinity and resource constraint as mechanisms, respondents suggested that differential disadvantage could also be due to other factors.

For example, the respondents spoke of characteristics which, beyond kinship connection and socioeconomic status, refer to character traits rooted in the caregiver his or herself. One caregiver insisted, "When having a shortage of money, you just buy things for only your child, but it depends on that person's character." (Mother, town village) Another explained, "If God has given her mercy, she'll care for them, but if she's just a person, the problem is already there." (Paternal grandmother, town village) A third commented, "If she has God with her, she can stay with them even if there was no money left for the children." (Step-grandmother, town village)

That differential treatment is negatively equated with caregiver character can be seen in the very fact that respondents often insisted that while they saw others around

them treating orphans in a differential manner, they *themselves* would not do so, distancing themselves from the practice. Illustrative are the words of a maternal grandmother from the town village, who distinguished her family from others in her community by saying:

> When children of different families stay together, like here in my family, I teach them that they are one thing so they should share everything among themselves.
> *So, what happens in other families?*
> It seldom happens. Most of them are having favoritism.

A sibling caregiver from the rural village commented that orphan treatment "only depends on how rude or polite the person staying with the children is, because if I were the one I'd treat them like my own children."

Orphan behavior

References to orphan attributes centered much more frequently on difficult behaviors than they did on endowments like health or success in school. For example, some respondents described orphans as "troublesome," "stubborn," and not accepting of discipline or punishment. As one caregiver said of her experience with an orphan, "He didn't want to do anything. He couldn't listen to what we were saying…I don't know, maybe it's because he knew that I'm not the mother so he was just trying to be naughty." (Mother, town village) Another caregiver described her experience in these terms:

> "I'm trying to give him love because when a child gets quite lonely, it's hard for him to be…on the right track…I don't know why he's so troublesome…When you ask him to do things, he'll say (shouting) 'why me, why me, why don't you ask that one. Me, no!'" (Teacher, town village)

Respondents also frequently described orphans as "dissatisfied" or "ungrateful". "Even if you are kind to an orphan," one caregiver lamented, "he'll say he's mistreated

since that's not his mom." (Mother, rural village) Another said, "Orphans are not satisfied. Even if you do good things for them, they won't say 'thank you for doing this or that for me'." (Step-grandmother, town village)

Finally, some described older orphans as prone to delinquency. One key informant commented, "They break into houses so that they can go and buy alcohol. From there they break into their own homes." (Policewoman, town village) Another said that orphans "disrespect, and they are drug abusers and they even have bad weapons like knives…" (Teacher, town village)

The respondents linked difficult behavior and differential treatment in responses to a question regarding whether and why some children are loved more than others in a family. The traits said most frequently to engender caregiver love were respect and obedience, traits orphans were often said to lack. One caregiver asserted, "You end up giving more love to the one who is listening to you and obeying your rules." (Maternal grandmother, town village) Another explained, "Sometimes it is due to the behavior. If one misbehaves and when you talk to him he doesn't listen, you just have to favor the other one." (Mother, town village)

It is important to note that some of the difficult behaviors the respondents described as characteristic of orphans may be linked with psychological distress related to parental illness and death. Atwine and colleagues found in a 2005 study of AIDS orphans in Uganda that, when other factors are controlled, orphans had greater risk than non-orphans of anxiety, depression, and anger. Similarly, Nyamukapa and colleagues (2008) found recently in Zimbabwe that for both genders, orphans exhibited more severe psychosocial distress than did nonorphaned, nonvulnerable children. In a qualitative

study of older Zimbabwean children that had experienced parental AIDS-related illness and death, Wood and colleagues (2006) wrote that, "Adults appeared to misinterpret signs of distress as 'difficult' behavior, and consequently tended to label orphaned children as 'delinquent' or 'badly behaved'." (1931) Ansell and van Blerk (2004) suggested that for very similar reasons, those children in Lesotho and Malawi most traumatized and in need of support were among the least able to find and remain in a suitable home.

Normative environment

Finally, some respondents also highlighted the importance of the normative environment. They portrayed community pressure as a force counteracting differential treatment, because of orphan caregivers' fears of community judgment on the treatment of orphans in their care. For example, one respondent explained, "…they [a caregiving couple discussed hypothetically] might have argued when seeing that now the load is heavy and they don't have enough money. But still they treat [the orphans] the same way with the fear that the villagers will talk about their family." (Paternal aunt, town village) This underscores the notion of differential treatment and disadvantage as associated with caregiver character, and hence something that reflects negatively on an individual.

Conversely, some respondents also spoke of the stress this community pressure can put on caregivers who are struggling to provide for orphans in the face of resource scarcity. Several referred to unfair judgments by the community. For example, one lamented:

> "Even when raising orphans in a good way, other people will never encourage you, instead they'll let you down by saying that you're not treating them fairly.

> ‘Just see, it’s winter and this orphan doesn’t have blankets and shoes,’ though you’ll be struggling to find ways of buying that orphan those things.” (Mother, town village)

Considerations related to sex and age

There is a broad literature on allocation of resources to children that has examined sex and age as loci of differential treatment (e.g., Dreze and Sen 1989; Backstrand et al. 1997; Messer 1997; DeRose et al. 2000; Borooah 2004). Some of the researchers studying orphan wellbeing have also examined intersections with sex and age, mainly in relation to schooling outcomes. The evidence on an interaction between orphan status and sex has been mixed. Some have found no evidence (e.g., Case et al. 2004; Case and Ardington 2006), while others have found some evidence that female orphans are particularly vulnerable (Yamano and Jayne 2005; Yamano et al. 2006). Yamano and Jayne found girls to be more vulnerable before parental death, and boys more vulnerable after parental death (2005). In general, results have been more consistent for age, showing an increasing gap in school enrollment as age increases (Case et al. 2004; Kamali et al. 1996; Yamano et al. 2005).

My analysis suggests that sex and age are considered to be of minor importance to the differential disadvantage of orphans in Lesotho. In relation to the former, none of the respondents differentiated between male and female orphans when speaking of orphans and orphan disadvantage. Some did, however, speak more generally of differences between female and male children. These differences were described mainly in response to a series of questions about concerns caregivers had about children in their care. In relation to girls, respondents frequently spoke of the need to worry about rape and unwanted pregnancy, and of the consequences of these for the family. For example, one

caregiver said, “Girls can take care of the family when you’re sick, but I fear these unwanted pregnancies that are prevalent. That increases the family luggage.” (Maternal grandmother, town village) In relation to boys, respondents spoke of the need to worry about boys impregnating girls and more generally getting into trouble. Very few respondents actually voiced a preference for male or female children. Of those several that did, more voiced preferences for female children, with their reasoning generally centered on girls’ caregiving and their better behavior when compared to boys.

Thus, though no references to gender emerged in discussions of orphan disadvantage, and little was referenced in the way of more general differential treatment of female and male children, the interviews did reveal some differences in caregivers’ general concerns about the two sexes. It is plausible that though families do not discuss child sex as relevant to the differential disadvantage of orphans, they may consider gender-specific risks when deciding to take in male and female orphans.

The findings for age also suggest that age was not considered a salient axis of orphan differential disadvantage. Only a few of the respondents differentiated between older and younger orphans in their interviews. When they did, they appeared to view younger orphans as less troublesome, though older orphans were seen as more able to work and, not surprisingly, more able to live on their own.

Respondent reflections on institutional care

Since residents of institutional care facilities are generally not included in the surveys on which most orphan studies are based, and their populations are in any case small compared to the family-based orphan population, orphan homes have rarely been

studied in the literature on orphan disadvantage in sub-Saharan Africa[3]. In the Lesotho Children's Study, the caregivers and key informants that were interviewed were asked their opinions about orphan homes in a series of questions, and additional viewpoints also emerged spontaneously.

Respondent perspectives on institutional care are relevant to the study question at hand, as the mechanisms for orphan disadvantage discussed through this point are all based on discussion of orphans in family-based care situations. One can extend this analysis by asking whether orphan homes are seen themselves to be mechanisms for orphan disadvantage. Additionally, one can ask whether the same mechanisms for disadvantage are seen to be at play in orphan homes as in family-based care, and how they might differ. The orphan home contrast also allows us to learn more about how respondents conceptualize family care through their comparisons of the two modes of care.

It is important to note, however, that there are few institutional care facilities in Lesotho. Thus, respondent perspectives may not be based on direct knowledge or experience with institutions. Instead, they may to some extent reflect negative rumors, or in the other extreme, an idealized image of what institutional care could represent. Regardless, comments on institutional care, by providing contrast to comments on family care, further refine our understanding of the factors contributing to the differential disadvantage of orphans.

Many of the Lesotho respondents did voice a view of orphan homes as places "without favoritism," in contrast to family-based care. They were described by these

[3] One exception is a 1999 paper by Panpanich and colleagues, which compared the nutritional status and health problems of "village orphans", non-orphans, and children in orphanages in Malawi.

respondents as places without differential treatment, and without biological affinity in particular. The following quotes illustrate these sentiments:

> *What would you like to happen to orphans?* I'd like them to stay in one place where they'll be the same and be away from hearing these hurting words." (Mother, town village)

> "…it will be more pivotal when they are put in one place where they'll have the same meal, wear the same clothes, and they'll be satisfied, unlike when staying with me where my child will eat and he [the orphan] will suffer." (Mother, town village)

> "*Why do you think they should be put together?* Because they will be away from people who might ill-treat them; they will be under the control of one person who will be fair to them." (Father, town village)

Respondents also depicted orphan homes as places that do not struggle with resource constraint in the way families do. As one caregiver explained, "[the government] is able. It's not poor like us." (Maternal grandmother, town village) Here, too, the respondents combined biological affinity and resource constraint explanations, asserting that orphan homes possess the material resources needed to treat all of the children in them identically. For example, one caregiver said:

> "When they are together they are going to be easily cared for and in the same way because there are donations for them. They are going to eat the same thing, wear the same thing, and everything is going to be the same. (Mother, town village)

However, some respondents also spoke of characteristics of orphan homes that they feared would lead to orphan disadvantage. The mechanisms of disadvantage that they brought up were different than those described for family-based care. Their concerns centered most frequently around fears that institutions would inherently not be able to provide orphans sufficient love, that they would separate orphans from other children and from their communities, and that they offered less of a future for orphans. For example, one key informant asserted, *"*…damage comes when they stay at the

special home since they become selfish, and they won't know their relatives, and they'll lack the nation's love." (Teacher, town village) Another explained, "If they are regarded as orphans there where they stay together, they will be orphans forever. They will never improve." (Great aunt, town village)

This perspective is largely in line with the positions of policymakers, bilaterals, and program designers, who often de-emphasize institutional care as a policy solution for orphans in AIDS-affected countries in sub-Saharan Africa. The drawbacks of institutional care are said to include failure to meet young people's emotional and psychological needs, segregation of orphans from other children of their age group, promotion of dependency, disconnection of children from the cultures and customs of their communities and from traditional support systems, high staff turnover rates and child-to-staff ratios in the facilities, and high financial cost (UNAIDS, UNICEF, and USAID 2004; UNICEF 2006; MHSW 2005). More often emphasized is support of family-based orphan care[4].

Those respondents that were concerned about orphan homes largely felt that the best solution was to mix the positive benefits of orphan homes with the positive benefits of family-based care (or, seen conversely, to mitigate the mechanisms for disadvantage in both). For example, some suggested that orphans stay with relatives but receive financial support from the government and donors, similar to the program models being emphasized currently. The words of a caregiver are illustrative:

> "*Where would you like them [orphans] to stay?* I'd like them to stay with me and whoever provides help should bring it here…*Why don't you want the orphans to be taken to the government facilities?* I won't see if they are satisfied or not

[4] Other alternatives to institutional care include foster placements, local adoption, surrogate family groups integrated into communities, and smaller-scale group residential care in homelike settings (UNAIDS, UNICEF, and USAID 2004).

> because I'll be far from them. They might not be given enough love. What I want is for them to feel the warmth of being loved." (Maternal great-grandmother, town village)

Another suggested that orphans stay with families, but that the caregivers be given training, saying, "I'd like them [orphans] to stay at their homes with relatives, and for those relatives to have to attend workshops held by the church, government, and the chief…" (Religious leader, town village)

Finally, some respondents saw orphan homes as most appropriate and relevant for young children, while older children could more easily live alone or with relatives. As one caregiver suggested, "When they are independent, they should stay at their own homes because they'll see what to do on top of the help provided. But when they are still young, the government should take them to special homes." (Father, rural village)

Conclusions:

Recent literature suggests that parental death is negatively associated with a range of child outcomes, including schooling, health and nutrition, and emotional well-being. In Southern Africa, where adult HIV prevalence rates range between 19 and 33 percent, the question of the well-being of the increasing number of children losing parents to the epidemic is of critical importance. Lesotho is no exception, with 23 percent of adults HIV-positive and low rates of treatment and testing until very recently. Drawing on in-depth interviews with over 120 caregivers, key informants, and children in Lesotho, this paper has systematically explored the *why* and *how* of orphan differential disadvantage, with an eye to informing future empirical analyses and to helping to tailor policies and programs more effectively to the reality of orphans' situations. Building on the literature

to date, I have provided direct evidence of the theoretical explanations for orphan disadvantage that are most frequently cited. I have also used the narratives on differential disadvantage to elaborate these existing explanations, and to introduce additional themes emergent from the data.

My analysis supports the resource constraint and biological affinity explanations for the differential disadvantage of orphans. Resource scarcity framed the lives of virtually all of the respondents interviewed, but respondents underscored the particular difficulties orphan households face: of losing a key breadwinner, taking in additional children, and, for the elderly, supporting children while lacking the ability to bring in income. Resource constraint is clearly not, however, seen to be the whole story of orphan disadvantage. Respondents spoke in great depth about the material and affective differential treatment that orphans experience from non-parental caregivers, particularly when the caregiver also has biological children residing in the household. They asserted that the relationship of the caregiver to the child matters greatly, with the love and care of the closest non-parental kin (for example, maternal grandmothers) almost identical to that of a parent, and the love of non-relatives like stepmothers very different. The interviews also underscored the link between resource constraint and biological affinity in caregiver decisions to prioritize their biological children in the face of resource scarcity.

There was very little evidence in the interviews of the "endowments" explanation for differential disadvantage, nor was there significant evidence for orphan sex or age as axes of differential treatment. However, the interviews did suggest some explanations beyond resource constraint and an affinity to one's close kin. Respondents spoke of caregiver "character" as something that influences orphan well-being regardless of

money or kinship connection. Some also linked child behavior with differential treatment, citing an orphan proclivity to difficult behavior that, though likely related to psychosocial distress, may exacerbate differential treatment. Finally, the respondents spoke of the importance of community expectations regarding the treatment of orphans. Community pressure can be a force counteracting differential treatment, though it may also put immense stress on caregivers struggling to provide for orphans in the face of resource scarcity.

The current analysis also extended the conceptualization of differential disadvantage beyond the family level. Respondents were asked their opinions about institutional care facilities, and though some spoke of orphan homes as offering escapes from resource constraint and biological affinity, others cited different mechanisms of disadvantage that might be at play in these institutional settings (such as a generalized lack of "love", and separation of orphans from other children and from their communities).

Significantly, the analyses in this paper are based on a diverse set of interviews with caregivers, children, and other key informants. They do not rely solely on interviews with orphans and their caregivers. Given the aim of exploration of the *why* and *how* of differential treatment, rather than the *what*, the ability to triangulate information from a multiplicity of sources and vantage points can be seen as a strength of the current analysis.

The evidence described in this paper is based on data from Lesotho. How plausible is it that the same mechanisms are relevant for differential disadvantage elsewhere? The situation of children in Lesotho is likely similar to children in other

Southern African countries, where HIV prevalence rates are similarly high. It is also plausible that the theoretical implications of this research are also applicable to other high HIV, high poverty settings. However, inter- and intra-country differences in living arrangement patterns, child rearing practices, and policies and programs related to children and to orphans would be expected to influence the relative importance of the different mechanisms described in this paper.

The implications of the analysis presented for policies and programs are not the focus of this paper; however, several possibilities are suggested. First, children who are orphaned are in need of support. While the findings from this analysis point to resource scarcity as a major issue in orphan households, and to a need for financial assistance, the findings related to biological affinity suggest that some targeting of orphans (and other particularly vulnerable children) within households may also be important. This might include, for example, direct support for the schooling and health care of orphans and vulnerable children (OVCs), as the Lesotho government was planning at the time of writing (Department of Social Welfare, Lesotho, 2006). The interviews also underscore a need for increased psychosocial support for orphans, as well as sensitization and training for orphan caregivers in handling the distress associated with parental loss. Finally, the analysis suggests the potential importance of work at the community level, since normative context, including community pressure, appears to strongly influence the actions of community members with respect to orphan care.

While interventions in support of orphans are suggested by this analysis of differential disadvantage, the analysis itself is driven by the high orphan prevalence in this setting. Reducing orphan prevalence through reducing parental death due to AIDS

is, of course, optimal. In Lesotho, increased HIV/AIDS prevention, testing, and treatment are necessary to reduce adult mortality sufficiently to slow the incidence of orphanhood. At the time of writing, there were large new initiatives underway in Lesotho addressing all three (National AIDS Commission, Lesotho, 2006).

Bibliography:

Ainsworth, Martha and Deon Filmer. 2005. "Inequalities in children's schooling: AIDS, orphanhood, poverty, and gender." *World Development* 34(6): 1099-1128.

Ainsworth, Martha and Innocent Semali. 2000. "The impact of adult deaths on children's health in Northwestern Tanzania." Development Research Group, World Bank, Washington, DC. Policy Research Working Paper.

Ansell, Nicola and Lorraine van Blerk. 2004. "Children's migration as a household/family strategy: Coping with AIDS in Lesotho and Malawi." *Journal of Southern African Studies* 30(3): 673-690.

Ansell, Nicola and Lorraine Young. 2004. "Enabling households to support successful migration of AIDS orphans in Southern Africa." *AIDS CARE* 16(1): 3-10.

Atwine, Benjamin, Elizabeth Cantor-Graae, and Francis Bajunirwe. 2005. "Psychological distress among AIDS orphans in rural Uganda." *Social Science & Medicine* 61: 555-564.

Backstrand, Jeffrey R., Lindsay H. Allen, Gretel H. Pelto, and Adolfo Chavez. 1997. "Examining the gender gap in nutrition: An example from rural Mexico." *Social Science & Medicine* 44(11): 1751-1759.

Becker, Gary S. and Nigel Tomes. 1976. "Child endowments and the quality and quantity of children." *Journal of Political Economy* 84:S279-88.

---------. 1979. "An equilibrium theory on the distribution of household income and intergenerational mobility." *Journal of Political Economy* 87:1153-89.

Bicego, George, Shea Rutstein, and Kiersten Johnson. 2003. "Dimensions of the emerging orphan crisis in sub-Saharan Africa." *Social Science & Medicine* 56:1235-1247.

Bishai, David, El Daw Suliman, Heena Brahmbhatt, Fred Wabwire-Mangen, Godfrey Kigozi, Nelson Sewankambo, David Serwadda, Maria Wawer, and Ron Gray. 2003. "Does biological relatedness affect survival?" *Demographic Research* 8(9): 261-278.

Borooah, Vani K. 2004. "Gender bias among children in India in their diet and immunization against disease." *Social Science & Medicine* 58: 1719-1731.

Bureau of Statistics, Lesotho. 1996. *1996 Population Census Analytical Report Volume IIIB: Socio-Economic Characteristics and Population Projections*. Maseru, Lesotho: Kingdom of Lesotho with the United Nations Population Fund.

Bureau of Statistics, Lesotho (BOS). 2007. "2006 Population Census Preliminary Results." http://www.bos.gov.ls

Case, Anne and Cally Ardington. 2006. "The impact of parental death on school outcomes: Longitudinal evidence from South Africa." *Demography* 43(3):401-420.

Case, Anne, Christina Paxson, and Joseph Ableidinger. 2004. "Orphans in Africa: Parental death, poverty, and school enrollment." *Demography* 41(3):483-508.

Department of Social Welfare, Ministry of Health and Social Welfare, Lesotho. 2006. National OVC Strategic Plan: 2006-2011.

DeRose, Laurie F., Maitreyi Das, and Sara R. Millman. 2000. "Does female disadvantage mean lower access to food?" *Population and Development Review* 26(3): 517-547.

Dreze, Jean and Amartya Sen. 1989. *Hunger and Public Action*. New York: Oxford University Press.
Evans, David K. and Edward Miguel. 2007. "Orphans and schooling in Africa: A longitudinal analysis." *Demography* 44(1): 35-57.
Ford, Kathleen and Victoria Hosegood. 2005. "AIDS mortality and the mobility of children in Kwazulu Natal, South Africa." *Demography* 42(4): 757-768.
Foster, G., R. Shakespeare, F. Chinemana, H. Jackson, S. Gregson, C. Marange, and S. Mashumba. 1995. "Orphan prevalence and extended family care in a peri-urban community in Zimbabwe." *AIDS Care* 7:3-17.
Foster, G., C. Makufa, R. Drew, S. Mashumba, and S. Kambeu. 1997. "Perceptions of children and community members concerning the circumstances of orphans in rural Zimbabwe." *AIDS Care* 9(4): 391-405.
Hamilton, W.D. 1964a. "The genetical evolution of social biology." *Journal of Theoretical Biology 7: 1-16.*
Hamilton, W.D. 1964b. "The genetical evolution of social biology." *Journal of Theoretical Biology 7: 17-52.*
Kamali, A., J.A. Seeley, A.J. Nunn, J.F. Kengeya-Kayondo, A. Ruberantwari, and D.W. Mulder. 1996. "The orphan problem: experience of a sub-Saharan Africa rural population in the AIDS epidemic." *AIDS Care* 8(5):509-515.
Lloyd, Cynthia B. and Ann K. Blanc. 1996. "Children's schooling in sub-Saharan Africa: The role of fathers, mothers, and others." *Population and Development Review* 22(2): 265-298.
Madhavan, Sangeetha. 2004. "Fosterage patterns in the age of AIDS: continuity and change." *Social Science & Medicine* 58: 1443-1454.
Messer, Ellen. 1997. "Intra-household allocation of food and health care: current findings and understandings—introduction." *Social Science & Medicine* 44(11): 1675-1684.
Miles, Matthew B. and A. Michael Huberman. 1994. *Qualitative Data Analysis*. Thousand Oaks, CA: Sage Publications.
Miller, Candace Marie, Sofia Gruskin, S.V. Subramanian, and Jody Heymann. 2007. "Emerging health disparities in Botswana: Examining the situation of orphans during the AIDS epidemic." *Social Science & Medicine* 64: 2476-2486.
Ministry of Health and Social Welfare, Bureau of Statistics, and ORC Macro. 2005. Lesotho Demographic and Health Survey: 2004. Calverton, Maryland.
Mishra, Vinod, Fred Arnold, Fredrick Otieno, Anne Cross, and Rathavuth Hong. 2007. "Education and nutritional status of orphans and children of HIV-infected parents in Kenya." *AIDS Education and Prevention* 19(5): 383-395.
National AIDS Commission, Lesotho. 2006. National HIV & AIDS Strategic Plan (2006-2011). National AIDS Commission.
Nyambedha, Erick Otieno, Simiyu Wandibba, and Jens Aagaard-Hansen. 2003. "Changing patterns of orphan care due to the HIV epidemic in western Kenya." *Social Science & Medicine* 57: 301-311.
Nyamukapa, Constance and Simon Gregson. 2005. "Extended family's and women's roles in safeguarding orphans' education in AIDS-afflicted rural Zimbabwe." *Social Science & Medicine*: 2155-2167.

Nyamukapa, Constance A., Simon Gregson, Ben Lopman, Suzue Salto, Helen J. Watts, Roeland Monasch, and Matthew C.H. Jukes. 2008. "HIV-associated orphanhood and children's psychosocial distress: Theoretical framework tested with data from Zimbabwe." *American Journal of Public Health* 98(1): 133-141.

Panpanich, R., B. Brabin, A. Gonani, and S. Graham. 1999. "Are orphans at increased risk of malnutrition in Malawi? *Annals of Tropical Paediatrics* 19: 279-285.

Parker, Erin, Susan E. Short, Rachel Goldberg, and Thandie Hlabana. 2007. "Growing up in the context of high HIV prevalence: Adult death and illness, family living arrangements, and children's lives in Southern Africa." Paper presented at the 5th African Population Conference, 10-14 December, Arusha, Tanzania.

Parker, Erin M. and Susan E. Short. 2008. "Grandmother Co-residence and School Enrollment in sub-Saharan Africa." *Journal of Family Issues*. Forthcoming.

Patton, Michael Quinn. 1990. *Qualitative Evaluation and Research Methods*. Newbur Park, CA: Sage Publications.

Ryder, R.W., M. Kamenga, M. Nkusu, V. Batter, and W.L. Heyward. 1994. "AIDS orphans in Kinshasa, Zaire: Incidence and socioeconomic consequences." *AIDS* 8(5): 673-679.

UNAIDS (Joint United Nations Programme on HIV/AIDS). 2006. 2006 Report on the global AIDS epidemic. http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

UNAIDS and UNICEF. 2003. Report on Technical Consultation on Indicators Development for Children Orphaned and Made Vulnerable by HIV/AIDS, Gabarone, Botswana.

UNAIDS, UNICEF, and USAID. 2004. Children on the Brink 2004: A Joint Report of New Orphan Estimates and a Framework for Action. http://www.unicef.org/publications/index_22212.html

UNDP (United Nations Development Programme). 2005. *Human Development Report*. http://hdr.undp.org/reports/global/2005/.

UNICEF. 2006. Africa's Orphaned and Vulnerable Generations: Children affected by AIDS. New York: UNICEF, UNAIDS and PEPFAR.

United States Census Bureau. 2007. International Data Base (IDB). http://www.census.gov/ipc/www/idbprint.html.

Wood, Kate, Elaine Chase, and Peter Aggleton. 2006. "'Telling the truth is the best thing: Teenage orphans' experiences of parental AIDS-related illness and bereavement in Zimbabwe." *Social Science & Medicine* 63: 1923-1933.

World Health Organization (WHO). 2004. *National AIDS Programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support*. WHO: Geneva.

Yamano, Takashi and T.S. Jayne. 2005. "Working age adult mortality and primary school attendance in rural Kenya." *Economic Development and Cultural Change* 53: 619-653.

Yamano, Takashi, Yasuharu Shimamura, and Dick Sserunkuuma. 2006. "Living arrangements and schooling of orphaned children and adolescents in Uganda." *Economic Development and Cultural Change* 54: 833-856.

Table 1. Characteristics of study sample, by type

	Caregiver (n=74)	Focal child (all) (n=74)	Focal child (interviewed)[1] (n=35)	Key informant (n=15)
Median Age	39	6.5	11	--
Sex				
Female	67	40	22	10
Male	7	34	13	5
Household SES				
Low	43	43	21	--
Medium	20	20	8	--
High	11	11	6	--
Household location				
Town village	40	40	21	13
Rural village	34	34	14	2
Relationship to focal child				
Parent	43	43	--	--
Grandparent	19	19	--	--
Aunt or uncle	6	6	--	--
Other relative	5	5	--	--
Non-relative	1	1	--	--
Key informant occupation				
Teacher	--	--	--	6
Health care worker	--	--	--	2
Policeman/woman	--	--	--	2
NGO/charitable work	--	--	--	2
Chief	--	--	--	2
Religious leader	--	--	--	1
Parent status of focal child[2]				
Both parents alive and present	--	20	9	--
Father absent[3]	--	47	21	--
Mother absent[3]	--	26	14	--
Father dead	--	6	5	--
Mother dead	--	6	4	--
Orphan in household?	--			
Yes	12	12	9	--
No	62	62	26	--

Source: Lesotho Children's Project, 2004

[1] As described earlier, only those focal children age 7 and above were interviewed.

[2] The latter four categories are not mutually exclusive.

[3] Of the absent parents, the vital status of four fathers and one mother were unknown.