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The Growing Crisis of Africa's Orphans
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African Orphans, Causes and Impact

"If all orphans formed a country of their own, it would be among the 10 largest nations in the world"[1.] Indeed, at figures ranging between 150 M (UNAIDS) and 153 M (UNICEF; UNHCR)[2], that country would be the world's 9th largest, ahead of the Russian Federation. At 56 M the Orphans' country in Africa would be the fourth largest after Nigeria, Ethiopia and the Democratic Republic of Congo.[3]

This submission sets out to explore the phenomenon of orphans: who constitutes an orphan; why are there so many orphans in Africa proportionate to the Continent's population, what and who are the major drivers of orphanhood? We shall attempt to understand what it means to be an orphan. In examining the impacts of orphanhood on the affected children, we shall consider the many ways orphans themselves respond and react to the loss of parents. We shall examine the responses from family, including extended, the community and community based organizations, national and international non-governmental organizations, faith- based institutions, national governments and the international community. We shall explore how best to respond to this phenomenon, especially from the orphans' perspectives.

Definition of an orphan. To many people, an orphan is a child whose both parents have died. The Joint United Nations Programme on HIV/AIDS (UNAIDS) understands orphan to mean a child under 15 years. To the United Nations Children's Fund (UNICEF) on the other hand orphan refers to a child under 18 who would have lost one or both parents. Hence they coined the phrase 'single' or 'double' orphans. In some African societies, a child becomes an orphan when both parents or the mother dies. This has caused confusion in orphan numbers, as indicated above especially when key agencies hold different interpretations. In the last few years, the international community and African governments have adopted UNICEF's interpretation.

Some institutions interested in children fleeing conflict situations have put a case for broadening orphanhood to include children who are 'alone'.[4] When communities are forced to flee their homes, at night and at gun point many children get disengaged from their parents. They find themselves all alone. Take the case of Nyagonar, a 10 years old South Sudanese girl. Her father was shot in front of their house. The mother took her daughter and run for refuge in the woods. Four days later when things appeared to have calmed down, they went back to their house, only to be woken up at night by gunshots in the compound. The girl recalls how everyone ran out of their houses. In the dark, she lost her mother. She ran on with the others,

as shots could be heard from everywhere. When she got to the UNHCR shelter, she looked for her mother but could not find her, "I never saw her again", she lamented. Weeks later, with others, she left on foot on a two months journey to Pagak, a refugee camp 300 km away. "I only want my mother and to go back home. I have nobody else" she often cried.[5]
In May 2014, the United Nations Office for the Coordination of Humanitarian Affairs reported of one UN camp that at a single time sheltered 4,000 children.[6]

Ten years after the end of armed conflict in Liberia, children who had been taken to a refugee camp in Ghana still lived there. In 2008, Andy Jones founded Heartwood Orphan Home in Liberia and moved the children there in 2010. In 2014, the children remain unclaimed and alone.[7] The UNHCR has a long process that leads such children to gain orphan status. But, do they not deserve the orphan status from when they find themselves alone?
This submission confines itself to the officially designated orphans. However, there is a strong case for broadening the concept of an orphan, for indeed the many orphans like Nyagonar, alone and desperate, could be in as sad a situation as the accepted orphans. Numbers of orphans globally rise to 160 M if abandoned and alone children are included.[8]

Causes of orphanhood: In Africa, we could identify five major causes of this phenomenon--armed and civil conflict, AIDS, weak or non functioning health systems, natural disasters, and abject poverty.
Armed and civil conflict: During the last two decades, 25 countries in Africa have experienced armed conflict. Fourteen experience on- going conflicts in 2014. West and Central Africa have been ridden by lengthy armed conflicts that have left many soldiers and civilians dead or maimed. Majority of their estimated 22.1 M orphans in 2012 are a result of conflicts.
One country in West Africa will demonstrate the dire effects of internal armed conflict; one case in Eastern Africa will show how ethnicity can play a negative instead of positive role for children; and two examples in West Africa will prove how power structures, ethnicity and religion create civil conflict and orphans.

We read about the many atrocities committed against civilians in rural **Sierra Leone** in the late 1990s to early 2000s when the pro and anti- government forces let out their anger on civilians: men were killed in front of their families, women raped in front of their children, families separated as some were killed and others, especially women, taken by soldiers to act as carriers and 'bush wives.' Children were captured, boys as soldiers, girls as sex objects, while others were left to fend for themselves. Survivors have told stories of how, later, the child soldiers, some as young as 8, terrorized captured women and other children. Children who did not manage to get away were killed, but those who got away wandered the countryside without parents or adult family members. Some managed to reach the 'safety' of the capital city, Freetown, where they ended up on its streets. Others found their way to refugee camps in neighboring countries, as unaccompanied minors.[9]

We read and watch documentaries about the horrors of the 1994 **Rwanda** genocide. Here, too, children were separated from their parents. Memories of what happened lived in the

consciousness of many children, some babies at the time, for a long time. Some of the raped women carried and gave birth to children they grew to hate because of what they reminded them of. These women were known in their communities as having been raped and worse as having carried the children of those who perpetrated the massacres. They were shunned; their children were not only hated by their mothers but also held in contempt in their communities and schools, while other children avoided them. Their households did not get any help from funds the Government allocates to assisting orphans in the households where they live.[10] This outcome of soldier abuse of sex as a weapon of war may be observed in other countries with conflict experiences (Sierra Leone and the Democratic Republic of Congo, as examples).

Many African countries have experienced brutalities from State security forces. Citizens have resorted to demonstrations as the only non violent way to express their discontent. In many cases, these have resulted in deaths as armed forces opened fire on them A case in point is **Guinea** where after protracted politically driven conflict, citizens resorted to demonstrations. Since 2010 and as recent as May, 2012, these have been brutally put down. Guns have been fired indiscriminately into crowds, killing many adults who left orphans behind. Ethnic and religious battles have also taken their toll in the country.[11] But perhaps Nigeria has the best known and most devastating civil conflicts.

In **Nigeria**, conflicts have taken many forms: armed ethnic- driven conflicts, and conflicts in the Niger Delta where both government organs and oil companies have unleashed weapons of destruction on the communities who have protested over many issues, from environmental damage to some share in the proceeds. Over the years, many people have been killed during protests. The military has been used to suppress communities, and they have been accused of house/village burnings and thousands of killings. Some reports have put deaths of civilians in the Niger Delta to about 1,000 each year since 1994.[12] The present Government has a more democratic stance, giving citizens of the Delta Region some hope for peace. Nigeria has also suffered from religious-based conflicts. The North in particular has been in the news in the last few years with regard to religious- driven strife: villages and schools have been burned, people and school children killed and/or kidnapped. It is not surprising, therefore, that in 2012, Nigeria was home to 11.5 M orphans. Only 2M of them were orphans of AIDS.[13]

HIV and AIDS:

AIDS and Orphans, 2012, by region (millions)

Region	Living with HIV/AIDS		New infections		Deaths		AIDS orphans		Orphans all causes		Total population
Global	35.3		2.3		1.6		17.8		150.0		1393.7
Sub-Saharan Africa	25.0	71%	1.6	70%	1.2	75%	15.1	85%	56.0	37%	913.1
West-Central Africa				-		-	4.4	12%	28.1	-	441.5
East & Southern Africa				-		-	10.6	30%	27.9	-	149.7
Southern Africa				-		-	6.04	17%	-	-	-

Source: UNAIDS reports

The above table shows that AIDS is the single largest driver of orphans in the Eastern and Southern sub-regions, Southern Africa contributing a larger portion.

There is no definitive cause of the above situation in Southern (and Eastern) Africa. Many reasons have been advanced: societal tolerance of multiple partners, urbanization, inter country migration particularly to South Africa which at 17.9% has the third highest prevalence rate in the sub-region, higher levels of sex workers, a strong network of men. Existence of a more portent HIV restricted to the sub-region. The fact remains that this sub-region has experienced higher levels of infection and deaths. While the prevalence rates have been going down, the rates in most countries in the sub-region remain between 10% and 15%, one country recording 26.5% in 2012, the highest in the world.[14]

In the last few years, Africa has recorded declining prevalence rates and resulting deaths. Southern Africa enjoys the highest uptake of antiretroviral treatment in Africa, as well as of prevention of mother to child infection transmission (PMTCT). In 2012, 68% of people living with HIV and AIDS in Africa could access treatment, countries in Southern Africa recording 78-95% uptake. Why then does the Region continue to experience such impacts from the disease? A few possible explanations: first, the roll out of treatment is most uneven. For example, Botswana has reached 95% coverage, South Africa 80%, while the Democratic Republic of Congo has reached 38% of eligible people only. In some countries up to 80% of eligible people have not received treatment. Moreover, the gender gap in access to therapy has been observed in many of the countries.[15] UNAIDS further reports that 75% adults in Africa had not achieved viral suppression in 2012. In 2006, UNICEF wrote: "In recent years, there has been a surge in leadership and resources for the fight against AIDS, with 8.3 billion available in 2005 alone for responding to the epidemic in low- and middle-income countries. The impact of the epidemic on children, however, has yet to receive the priority attention it deserves."[16] Indeed, in 2012 children received less than 25% of antiretroviral treatment given to adults. Moreover and in all cases, the poverty of most people has not facilitated improved diet for effective therapy outcomes

As the table above shows, in the 2012 Africa recorded the highest new infections and AIDS related deaths, creating more orphans of AIDS. But there is much hope in Africa because of the declining rates, the roll out of treatment, and the containment of MTCT. Led by Botswana and South Africa, each year more governments increase budget allocations to HIV and AIDS, although many of them remain dependent on external support, thus putting at risk uninterrupted supply of treatment drugs. But the numbers of orphans of AIDS especially in Eastern and Southern Africa are not declining. To the contrary, the high numbers of people living with HIV and AIDS, including adolescents, most of them not on treatment, signal a likely increase in the number of orphans in the next few years.

Challenged and weak health systems. The Council for the Development of Social Science Research in Africa took a historical perspective to analyze the weakening health systems in the

Region. After attainment of independence, many African governments invested heavily in public health systems: in structures, equipment, drugs and training of medical staff. Most of the public medical centers functioned relatively well , and many urban and some rural people could access medical care. From mid 1980s, however, many countries suffered economic crises, resulting in severe setbacks to the health sector from which many are yet to recover. Governments subjected the sector to severe budgetary cutbacks, and health institutions experienced sharp deterioration of the physical infrastructure and equipment base. Severe shortages of drugs and other necessary supplies became the norm. Alongside, and perhaps because of, this the sector witnessed a mass exodus of doctors and nurses to wealthy institutions in the West. To help the sector to remain functioning, governments introduced policies such as cost-sharing. As people got poorer, such policies, against the backdrop of weakened public health systems, "acted as a disincentive for continued popular access to and use of the services of the public health institutions."[17]

The crises spurred the emergence and/or expansion of private health systems. Private medical providers have grown in numbers and offer complex and quality services. International providers have joined this market; some local doctors have returned to their homes; while a number of newly qualified doctors have chosen to remain in their countries. Some of these moonlight their services to private providers. Others have set up private clinics or hospitals. They work in the public sector but also make time to service their private institutions. Alongside this has emerged and expanded the private health insurance market.

This state of health systems has led to three things: (i) majority poor, among them most of the orphans, have to do with the public health system such as it exists. Many, even in urban centers, do not see any doctors; they have to wait in long lines to see a nurse or medical orderly; and sometimes they do not get to be seen by any one. In rural areas long distances to health centers discourage many from accessing what available services there are. Many poor people self- diagnose and treat, or they seek alternative medical care from herbalists, traditional or faith healers. The downside of this is that, often, they wrongly self-diagnose and medicate themselves; some traditional or herbal 'doctors', whose numbers have surged, at pace with the weakening public health systems, are not sufficiently qualified in today's diseases. This author is not aware of any concerted study on faith healing, but word out there is that some of the healers see gaps in the public health system as a way to make money.

(ii) There has emerged in African countries a dual system of health service provisioning. The poor cannot afford private services. The small percentage of the rich and middle class Africans, who also make policies, utilize the private institutions. Take an example of South Africa, a country endowed with a rich medical infrastructure, including research and medical innovations, whose health care expenditure as percentage of GDP in 2007 was higher than that of the United Kingdom, yet it records one of the worst dual systems in health service provisioning in the world.[18] The inherited discriminatory system is yet to be sufficiently dismantled. Thus, to majority poor, good and accessible health services remain unattainable.

(iii) Unequal access to health services in much of Africa has contributed to the Region's high numbers of orphans. In addition to AIDS, other diseases and medical challenges have played a significant role in the creation of orphans. Of these, malaria and cervical cancer top the list. John Hopkins' Malaria Research Institute states that 10% of hospital admissions in Africa are due to malaria.[19] Globally, numbers of people who died of malaria in 2012, was put at 627,000 (down from 660,000 in 2010). 90% of these deaths occurred in Africa, 54% of them of children under 5 years.[20] But we do not have the actual numbers of orphans the disease has created.

Cervical cancer threatens the lives of many women. Inadequate early detection facilities have contributed much to this. For example, a woman in the United States of America has a 70% chance of surviving cervical cancer. In Africa, she has a 21% chance.[21] In 2008, World Health Organization (WHO) recorded 275,000 deaths globally. 50,000 deaths occurred in Africa. WHO further estimates that in Africa, 53,000 women die of the disease every year.[22] Challenges that public health services have faced against a backdrop of poverty make it almost impossible for majority women in Africa to access available resources for managing cervical cancer. As in the case of malaria, we do not have the exact figures of orphans this disease has created. But in the absence of armed and civil conflicts, after AIDS the two have contributed significantly to deaths of parents and creation of orphans.

Natural disasters: Natural disasters have hit almost every sub-region of Africa. The Sahel region has experienced persistent droughts, subjecting many citizens to untold suffering. The UN Food and Agricultural Organization have analyzed the effects of the changing climatic expressions over the last 50 years: the Sahel dryness has expanded; the West African region has experienced fluctuating weather patterns: in more recent past, 2009 brought irregular rains and drought conditions. These resulted in food shortages and intense malnutrition. 2010 experienced heavy rains, leading to improved food supplies in some areas, but generally resulting in serious floods. 1.8 M households were affected. Against a background of poor governance, trans-boundary animal diseases, socio-economic crises, the effects of natural disasters continue to dig deeper, including leading to death and affecting many families and children.[23] UNAIDS has blamed natural disasters as part drivers of the spread of HIV. These disasters have intensified poverty, forcing many young women and girls to prostitute themselves in order to provide for their families.[24]

Eastern and the Horn of Africa have not been spared. In 1998-2000, droughts hit Ethiopia and Eritrea, striking at a time of armed conflict between the two countries. Millions of dollars were diverted to the war effort, leaving citizens in both countries without much support. 100,000 deaths from starvation were recorded in Ethiopia. We do not have casualty figures for Eritrea, but we know that about 750,000 fled their homes. An unspecified number died from malnutrition and starvation. Together with Eastern Africa, the Horn was hit by the drought of 2010-2011. A total of 13 M people were reported affected, including 2M in Ethiopia, 850,000 in Kenya, and 455,000 in Somalia where 150,000 were children and mothers. Tens of thousands died. The UN declared the food crisis in Somalia as famine, the first in the 21st century.

Earlier in 2006, the East African sub-region had suffered another drought when 11 M were reported hit. In 2008-2009 yet another severe food crisis occurred because of irregular rains. Then, 10 M people were affected. Some children became orphans.[25]

Abject poverty: In itself poverty does not cause death, but it underlies and influences how people respond to some of the causes outlined above. Today, Africans are some of the poorest in the world, despite the Continent's many natural resources and minerals. Poverty has augmented many internal conflicts. Well off people, in influential positions, may engineer the conflicts, but many inhabitants join the struggle because of poverty. Some feel that they have nothing to lose since they are poor; others are led to believe that by supporting a conflict instigator, they might benefit once that person is in a leadership position. People have joined protests believing that their concerns, driven by poverty, might receive some attention. Instead, many end up losing their lives. AIDS has been linked with poverty precisely because poverty has pushed especially young women (and boys) into relationships that have exposed them to the virus. Some adolescent heads of families have picked up the disease in this way. Poverty has also affected the impact of antiretroviral treatment. Poor people are not able to follow the nutritious diet required for treatment's effectiveness.

Poverty and wealth have determined which side in the dual health system one ends up on. Poor people cannot afford tests for many of the diseases and thus they easily succumb to them. Cervical cancer that has not received much investment is a case in point. But perhaps a direct link with poverty is more easily and directly demonstrated by natural disasters. These affect access or non to food, death of parents, and orphanhood. When crops fail, better off people do not starve. It is always the poor who lack food and water, who die of starvation. It is poor people's children who become malnourished, their women and babies who suffer during pregnancy and breast feeding periods. Unless and until poverty is eliminated, or at best alleviated, orphans will remain challenged, whether they live with relatives or by themselves.

The Impact on orphans: Almost every African from Eastern, including Ethiopia, and Southern Africa has been touched by loss of a close family member: parent, brother, sister, niece, nephew, or close friend. The present author falls in this category. They share experiences, to learn from each other and to draw strength as they shoulder responsibility of the orphaned children. Some of them have formed organizations to assist many other orphans who may lack adequate support. Thus, they know from their contacts with family orphans and those they support some of what orphans go through after loss of parents. First is the emotional impact: to kids under age five, there is a sense of bewilderment as to why "mummy/daddy has been put in a hole"; after a while: "when will s/he come back from that place?" Later, because the parent does not come back: "does s/he not love me?" They fear loss of love. When old enough to understand death, they get angry: at the world; at those who are alive including their care givers; and at the deceased parent/s. In Africa, there are not sufficient counseling facilities. To many orphans these feelings remain for a long time, so that some develop death wishes.

At times, the community may not help. Often, neighbors conclude AIDS as cause of husband and wife deaths. They express these conclusions in many ways to the orphaned children, who may end up withdrawing into themselves. The stigma is more savagely and openly expressed by fellow children within the community and/or at school. Some orphans have stopped going to school because of this, while others may be transferred to a caregiver in a different part of the country for their protection. Yet, as they grow older, orphans treasure education, considering it a means to a better future. Consequently, often there is underlying fear of loss of school. Indeed, some orphans have been pulled out of school, either because of lack of funds by the hosting family or s/he would have to be taken to a rural area to live with a grandmother who lives miles away from a school. Thanks to the emergence of community schools, the ratio of orphan school attendance at elementary and primary levels has been rising, and actually reaching 100% in seven countries.

Some orphans have ended up with relatives who may have taken responsibility of other orphans. The family may be crowded in one room. But children can adjust rather quickly, if they are well loved and happy. A bad scenario is where the orphan is abused. Stories are told of especially girl children being treated as free labor and in some cases as sexual objects for males in the hosting family. Male orphans are not preferred because in most cultures girls and not boys help with household chores. Unloved, many boys have moved to the streets.[26] But some girls have run away, to join children of the streets.

***Child-headed households**:* Perhaps the worst scenario is where children are left to fend for themselves. Cases have been witnessed where on the death of the surviving parent, relatives come to mourn and bury the dead person but also to take some property left by the deceased. It is possible that in such cases not much thought would have been given to the children, perhaps assuming that the State or some organization would come to their aid. Thus have risen households that are headed by children. The worst case the author has come across in Zambia involved a seven year old girl who had two younger siblings. None of the relatives checked what would happen to the children. After the funeral, they all left. Fortunately, a community organization had worked with the family during the parents' illness. Upon finding themselves in that situation, the seven year old went to the organization to seek help. Children have remained in the house; the organization has seen to their needs and provides protection.[27] Zambia Orphans Aid, USA, has assisted this family of youngsters over the last four years.
In Southern Africa, many such households are headed by girls. When boys become heads, as in the Democratic Republic of Congo, the tendency has been for them to work with girl-headed households so that the girl ends up as the *de facto* head of both households. In Uganda, there are more boys than girls with the responsibility of heading households.

Some scholars have argued that the numbers of such households are too few to warrant much concern within the broad spectrum of orphans. Our stand is that children as young as 7, 8, 11 years should not take on such responsibilities, even where there is an adult person from a local organization, church or government to check on them from time to time. Cases have been told of girls as young as 11 and 12 years in Eastern and Southern Africa who have been sexually

exploited in order for them to raise money to buy a bag of corn meal or beans to feed their siblings. In some such situations, these heads have become pregnant, causing concern of their own safety from HIV and that of their babies. This author agrees with Charlotte Phillips who concludes that such households should not be seen as permanent. Any help to child-headed households should be short-term, governments indicating when the household would be phased out, by when alternative care arrangements would have been put in place.[28]

This critique is not to be interpreted that all orphans become miserable misfits. Some find the growing process very difficult; others receive love from family, foster parents, faith- based institutions and other care givers. With assistance in reaching their potential, they grow up into fulfilled and capable citizens. Nevertheless, orphanhood is a challenging condition that needs to receive serious and action-oriented consideration by both national and international communities.

Response: When impressionable orphan numbers showed up in the late 1980s and 90s, initial response came from within countries: from family members, including extended, community and non- governmental organizations, and orphanages. Close family members, or extended, responded, embracing their 'daughters', nieces and nephews. Within a few years, orphan numbers rose so sharply that in some situations one family could care for more than ten orphans. With many younger people dying, grandparents became and remain major providers of homes for the orphaned children, some inheriting up to 30 babies and children. If babies, grandmothers have had to dry- breast feed them, too poor to buy milk.[29]

In the early days, governments did not have programs to support these care givers. With time, family members, including grandmothers, have not been able to maintain the big families. As poverty levels rose, families started to live below the accepted poverty line. Care giving families have become overwhelmed. It has become very difficult for them to continue fulfilling the responsibility. What had been taken for granted, in African culture, has become a burden.

In a few societies, children have been fostered out to families not related to them. But in the early stages official monitoring had not been sufficiently developed, raising questions of their effectiveness. However, in some countries, such as Ghana, traditional care systems have stepped in. In rural Ghana, Queen Mothers train the care givers and monitor them.[30] Elsewhere, some communities have formed groups to assist orphan- hosting families, to undertake income generating activities to meet school requirements for the children and to provide food where needed. With the entry into this area of international organizations, community groups have turned themselves into community- based organizations, to apply for financial and technical assistance.

Alongside these, individuals, families, community based organizations and faith- based institutions built and ran orphanages. Some were built out of genuine concern for orphans. To some, however, orphan support became an industry. As middle class citizens with connections to the donor community and/or Africans in the Diaspora, they were able to raise money.

Because governments were slow in setting up policies to guide the care of orphans (and other vulnerable children), standards in some orphanages were not acceptable. Cases have been reported of registered orphanages that did not exist. Later, when governments set up systems for monitoring orphanages, some of such orphanages were shut down; others disappeared.

There has been much debate recently about the efficacy of orphanages. Some researchers see this care as something that should be transient, to keep the kids until their extended family members are identified. Some international institutions, including within the UN system, advocate this approach. They believe that the interests of the child are best served in a family environment; institutions are expensive per child; while staff turnover is high. This author is not versed enough in the research on this issue for a stand to be taken in this submission. But she has visited orphanages and children's villages in a number of African countries, in the context of her World Bank work on HIV and AIDS, and social protection. Yes, some of the orphanages are questionable. But probably more time needs to be allowed to examine different types of orphanages on one hand and the family situation and condition of children in the receiving homes on the other. Based on this, definitive conclusions may then be made. This would be a more realistic position because we know of some faith- based institutions that have been in existence for decades, deliberately organized to emulate family environments. We also need to understand social and economic pressures families are put to. Why do they take family orphans to churches; why do they leave babies on convent door steps; or at orphanage gates?

The international community has responded quickly on all fronts: to unaccompanied children in conflict situations, to provide emergency needs when natural disasters struck, in HIV and AIDS. The NGO *modus operand*i has been to identify local organizations to work with. They have brought financial and technical resources. Some Africans in the Diaspora have created organizations to mobilize financial support in the West, reaching orphans through community organizations and schools, and faith- based institutions. The AIDS field has received much attention in the last decade. PEPFAR is a case in point. Support through this mechanism has reached orphans through local organizations. The UN system has been active in supporting orphans, both at creating information to guide action and at mobilizing financial support. UNICEF, WHO and UNAIDS in particular have been very active at awareness raising within the system. Adoption also assists orphans. Inter country adoptions are slowly gaining recognition on the Continent, but to date this is in its infancy in Africa to make an big dent in the problem.

Conclusion: The main causes of the high numbers of African orphans seem poised to remain for some time. Yet, at this time, the millions of orphans whose needs are not met constitute a humanitarian imperative that will endure for at least a decade. The following offer opportunities at least for a minimum response:

- greater political will is needed at the national level to put in place result- based programs in support of orphans. Voices need to be heard on behalf of orphans
- funds should be established for orphans for their easier access to better health care
- higher education funds are needed for orphans, to include technical and entrepreneur skills training

- cash and in- kind support to child-headed families need to be intensified but for a specified timeframe, after which alternative care options must have been identified and offered to the children
- support to national and international organizations to develop tools for effective natural disaster preparedness
- support to be flexible enough to respond to shifting orphan care priorities.

Shimwaayi Muntemba, Dr./Ms. June, 2014

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Note: Africa, in this context, refers to Sub-Saharan Africa. Most of the documents cited hereunder may be found Online.

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