HIV/AIDS and Children's Migration in Southern Africa

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EXECUTIVE SUMMARY

Southern Africa is the region worst affected by the global AIDS pandemic and also experiences very high levels of migration. The two countries examined in this paper, Lesotho and Malawi, have estimated adult HIV prevalence rates of 31% and 16% respectively. Both also have long histories of labour migration, although migration patterns have changed significantly since the end of the apartheid regime in South Africa.

The co-existence of high levels of both HIV/AIDS and migrancy in Southern Africa is not entirely surprising. Not only does human mobility play a very significant role in the pandemic's spread, but migration has been shown to make people particularly vulnerable to HIV infection. A third aspect of the relationship between HIV/AIDS and migration has thus far received much less attention, particularly in Southern Africa: namely, migration that takes place as a result of the pandemic. AIDS imposes heavy costs at a number of levels, not only for those directly infected, but also for their families and wider communities. Coping strategies must be employed, and these sometimes involve the relocation of households or of individual household members.

Children are a key vulnerable group in relation to HIV/AIDS, being affected by the disease in a number of ways. Significant numbers contract HIV themselves, usually at birth or during lactation. Many more are orphaned. Already around 17% of children in Lesotho and Malawi have lost parents, about half of them to HIV/AIDS. Children are affected by HIV/AIDS long before they become orphans, however. Adults with AIDS suffer debilitating illness over a period of months or years, which often reduces household income, imposes medical costs and diminishes the capacity of the household to care for children. Children may be required to take on tasks usually performed by adults - domestic and agricultural work, wage earning and caring for the sick - as well as suffering AIDS-related stigma. Following the death of a parent or guardian, the difficulties children face often increase, with financial hardship exacerbated by problems relating to inheritance and absence of childcare within the household.

At this, or any other, stage in the course of the disease, children may be required to undertake migration. The fact that extended families in Southern Africa are often dispersed across widely separated households means that many children move considerable distances to live with kin.

A children-focused approach was adopted in this study of Lesotho and Malawi in order to examine: (a) the forms of migration that young people affected by HIV/AIDS engage in; (b) the difficulties they face; (c) the coping strategies they employ and forms of support that are

available to them; and (d) the ways in which they might be better supported.

Many children were found to engage in migration, both locally and over longer distances, of whom significant numbers were migrating in response to sickness or death that was likely to be HIV/AIDS related. In many cases migration that was not directly related to AIDS was nonetheless an indirect outcome of sickness or death of family members. Longer distance AIDS-related migration was predominantly urban-to-rural and in several cases international. Many children engage in multiple moves. Sometimes multiple moves are circular as children move between the households of different family members over the course of a week or between institutions and extended families. The clustering of AIDS-afflictions among families and communities, and the cost of caring for many children, complicates the migration strategies employed and often separates sibling groups.

In most cases, children affected by AIDS move to live with matemal grandparents. Others live with aunts, uncles, brothers, sisters and sometimes more distant relatives. A minority of AIDS-affected children enter institutions or resort to living on the streets because relatives lack the resources to offer sufficient care. The decision-makers in such situations may be children themselves, who employ migration as a coping strategy.

Three sets of considerations contribute to decisions as to where AIDS-affected children should live: who is responsible for the children; who is able to provide for their needs; and who might usefully employ their capacities. These considerations relate to both the characteristics and needs of individual households, and of children themselves. Children's needs include shelter, economic support, schooling, supervision and psychosocial support. They are able to contribute to households by helping with domestic and agricultural work, earning wages and caring for the sick - a role that is in growing demand in families affected by HIV/AIDS. Children's age and gender play significant roles in determining what are thought to be their specific needs and capacities.

Sometimes there are no households within the extended family that are willing and able to provide the care that children need or want. Such children may leave the extended family. Some marry young; others go away to work; some enter institutions and others resort to the streets.

The complex migration experiences of AIDS-affected young people create a range of difficulties related to children fitting into 'new' families and 'new' communities. When adoption of children into a household is through obligation, as is the case with AIDS orphans, young

migrants are often treated differently, particularly if resources are scarce. Migrant children are sometimes given different foods to eat, not adequately provided with clothing, beaten and overworked. Even where foster parents are supportive, divisions may arise, as biological children may not want to share their resources, both financial and emotional, with 'new' siblings. This is especially problematic if they are coming to terms with parental death and need extra attention.

Many children moving to a new home as a result of HIV/AIDS are expected to undertake more and different work from that which they are used to. They may perform domestic, agricultural or other productive work, or care for children or sick adults. Some young migrants are incorporated into households specifically as workers in payment for their keep. This changes their relationship with the household, as they are not an equal part of the new family. Other children are sent to engage in wage labour away from their households to support younger children. Children migrating from urban to rural environments find it particularly difficult to adapt to agricultural chores; principally herding in Lesotho and field work in Malawi.

Children moving over long distances need to develop new social contacts and many miss their friends. The trauma of losing a parent makes integration more difficult and guardians noted that newcomers were often withdrawn and found it difficult to engage with other children. This is exacerbated for those children who have to learn new skills, as work and play are often inter-related. Further, the increasing association between orphanhood and AIDS, makes integration into community life difficult. This was particularly the case in Lesotho where AIDS is more recent and less widespread.

Many children drop out of school after migration, particularly those who return to live with rural grandparents. Others move to new schools, but find that they must follow a different curriculum, or even learn in a new language.

Children's incorporation into new households, new communities and new schools needs to be facilitated, in part to reduce the extent to which they have to undertake repeated migrations. Since young AIDS migrants are supported mainly through the extended family, support needs to be channelled in ways that support the children themselves and the families that receive them. Policy makers should be more questioning of the roles that communities are able to play with respect to incoming children.

- Empowering children: many of the difficulties children face could be overcome if they were more familiar with the place and people they were moving to. Discussing their migration preferences with those making the decisions would help to alleviate

such problems. For many children, the only way out of a difficult household situation is to move to the streets.

- Enabling households: children's difficulties fitting into new homes are exacerbated by poverty. If the costs of caring for children, particularly school-related costs, were reduced, children would be more readily accepted into households. This would enable them to stay with those relatives (e.g. grandparents) best able to meet their non-material needs. Furthermore, as most migrations are triggered by economic factors, reduced costs would diminish the need for multiple migrations.
- Questioning communities: much policy concemed with AIDS in Southern Africa emphasises the role of the community. In practice, communities had little involvement in caring for orphaned children. Instead the burden lay with extended family households, sometimes located in other places. This points to the importance of family units as the appropriate level for targeted interventions to assist children.

HIV/AIDS IN SOUTHERN AFRICA

Southem Africa is the region currently hardest hit by the global AIDS pandemic, but also experiences unusually high levels of migration. The two countries examined in this paper, Lesotho and Malawi, have estimated adult HIV prevalence rates of 31% and 16% respectively.[1] Both also have long histories of labour migration, although migration patterns have changed significantly since the end of the apartheid regime in South Africa in 1994.[2]

The HIV/AIDS pandemic has gained in intensity as it has spread southwards through Africa, such that today the countries with the highest infection rates are the most southerly. Malawi has suffered high prevalence rates for over a decade: already in 1990 about 20% of pregnant women in the major urban areas were HIV positive.[3] Since the mid-1990s, prevalence in Malawi has stabilised (Table 1). In Lesotho, the first AIDS case was reported in 1986, but prevalence remained low until the mid-1990s (around 4% in 1993).[4] Between 1997 and 2001, Lesotho witnessed an almost four fold increase in HIV prevalence, the most rapid increase of any country in Africa, taking it from the tenth worst affected SADC country to the fourth worst.[5] It is not easy to explain why Lesotho remained relatively protected for so long and yet experienced such a dramatic increase in infection rates: the factors blamed for the severity of Lesotho's epidemic differ little from those in other Southem African countries. An important characteristic of the

Table 1: HIV/AIDS Prevalence Rates in SADC Countries

Adult Prevalence Rate			
	1997	1999	2001
Angola	-	2.8	5.5
Botswana	25.1	35.8	38.8
Democratic Republic of Congo	4.4	5.1	4.9
Lesotho	8.4	14.0	31.0
Malawi	14.9	16.0	15.0
Mozambique	14.2	13.2	13.0
Namibia	19.9	19.5	22.5
South Africa	12.9	19.9	20.1
Swaziland	18.5	25.2	33.4
Tanzania	9.4	8.1	7.8
Zambia	19.1	20.0	21.5
Zimbabwe	25.8	25.1	33.7

Source: UNAIDS, Reports on the Global HIV/AIDS Epidemic

HIV/AIDS pandemic is the time lag between infection with HIV and death from AIDS. A consequence of this is that even when HIV prevalence rates begin to fall, as they have in Uganda and Zambia, the number of people falling sick with AIDS and the number dying will continue to increase for some years.

Not only is HIV infection geographically uneven and constantly changing across Southern Africa: there are also geographical differences and differences relating to age and gender within each country. Although HIV/AIDS is now endemic throughout both Lesotho and Malawi, the urban areas experience considerably higher HIV prevalence than the rural areas. In Malawi, the southern part of the country (and in particular Blantyre) is worse affected than the northern or central regions. Most of those infected are adults - it is estimated that 92% of those infected in both countries are aged 15-49, most of the remainder being young children infected through mother-to-child-transmission. In both countries women suffer higher infection rates than men: around 55% of adult infections in Lesotho and 56% in Malawi are women. Women are also generally infected at a younger age than men. Seventy five percent of reported AIDS cases among 15-29 year olds in Lesotho, are women.

Those who are directly infected are not the only people affected by HIV/AIDS. In particular, many children are profoundly affected by the sickness and death of adults around them. In all SADC countries over 10% of children are now orphans (Table 2); a proportion considerably higher than would be the case in the absence of HIV/AIDS.[6] Furthermore, the number of orphans will continue to increase even after prevalence rates begin to fall. In both Malawi and Lesotho around 17% of children are already orphans; a proportion set to grow, in the case of Lesotho, to more than a quarter of all children.

A distinctive characteristic of orphanhood through HIV/AIDS is that the death of one parent is commonly followed by the death of the other. It is usual for the child's father to die before the mother, hence rates of paternal orphanhood exceed maternal orphanhood, although the difference narrows in the later stages of the epidemic (Table 3).[7] Ultimately HIV/AIDS produces an unprecedented proportion of double orphans.

It is important to note that children are affected by AIDS long before they become orphans and in some cases without themselves being orphaned. Children witness the sickness of adult household members, and may be called upon to provide care (either directly for the sick person, or to take on additional chores allowing others to provide care). AIDS also has serious economic consequences for households, in the form of diminished income and increased expenditure, which negatively affect children.

Table 2: Proportion of Children Aged 0-14 who are Orphans					
	1990	1995	2001	2005 est	2010 est
Angola	11.9	10.9	10.7	11.0	11.2
Botswana	5.9	8.3	15.1	20.8	21.6
Democratic Republic of Congo	10.7	10.8	10.6	10.1	9.4
Lesotho	10.6	10.3	17.0	23.6	25.5
Malawi	11.8	14.2	17.5	18.9	18.2
Mozambique	14.1	12.8	15.5	18.1	19.5
Namibia	9.4	8.8	12.4	16.4	18.3
South Africa	7.8	7.5	10.3	14.0	15.8
Swaziland	8.2	9.0	15.2	21.0	22.1
Tanzania	9.8	10.1	12.0	12.5	11.6
Zambia	10.9	13.8	17.6	19.4	18.4
Zimbabwe	7.9	11.9	17.6	22.1	21.4

Source: USAID/UNICEF/UNAIDS, Children on the Brink

Table 3: Maternal, Paternal and Double Orphanhood in Malawi and Lesotho						
	Malawi			Lesotho		
	Maternal	Paternal	Double	Maternal	Paternal	Double
1990	5.3	7.8	1.2	4.5	7.1	1.2
1995	6.5	9.4	1.8	4.1	7.0	0.9
2001	9.5	11.7	3.6	8.2	13.4	4.6
2005	10.8	12.2	4.1	14.7	18.6	9.7
2010	10.6	11.5	3.8	19.7	20.2	14.3

Sources: UNAIDS, Global HIV/AIDS Epidemic; A. Cliff and M. Smallman-Raynor, "The AIDS Pandemic: Global Geographical Patterns and Local Spatial Processes" The Geographical Journal 158 (2) (1992): 182-98; J. Caldwell, "The Nature and Limits of the Sub-Saharan African AIDS Epidemic: Evidence from Geographic and Other Patterns" Population and Development Review 19(4) (1993): 817-48

AIDS AND MIGRATION

The co-existence of high levels of both HIV/AIDS and migrancy in Southern Africa is not entirely surprising. Since the early years of the pandemic, the part played by migration in the spread of AIDS has been obvious.[8] Within a decade of its identification, HIV had spread to most parts of the globe. Apart from a tiny proportion accounted for by the movement of blood and blood products, this transmission took place through the movement of people. Unfortunately, the attention given to the role of migration in the pandemic's spread emphasizes migrants as carriers of disease. In some cases this was used to support the compulsory testing or even prohibition of immigrants to certain countries: practices that reflected xenophobia and stigmatized migrants.[8]

More recently, research and policy has turned to the vulnerability of migrants to infection, and the difficulties they face in accessing treatment and care. Migrants are recognised as more vulnerable to infection than people who do not move, because the situations they encounter expose them to risks.[9] Transit points such as truck stops, train and bus stations, market places, harbours and customs zones have been identified as 'high risk zones.' Some Southern African border posts, for example, have developed into thriving informal settlements where truckers can spend the night. These attract street vendors and sex workers, exposing not only travellers but also the local populations to heightened risk.[10]

It is not only in transit, however, that migrants risk infection. When they arrive at their destination they may be both poor and marginalized by the society they enter. In such situations, particularly when separated from the social control exercised by families, communities and wider social norms, people are more likely to engage in risky sexual behaviour.[11] Labour migration is often sex selective, separating couples for long periods of time; conditions in which people are more likely to engage in serial and high-risk sexual relationships.[12] Furthermore, if women are discriminated against in the local labour market, and unable to access regular employment, they may have no option but to engage in commercial sex work.[13] Not only are migrants at higher risk of contracting HIV/AIDS; they may also find it harder to access information and medical care, particularly when confronted by cultural and linguistic barriers.

In Southern Africa there has been a widespread assumption that wives of labour migrants who remain in rural areas are likely to be infected by their returning husbands. Migrants' wives risk infection not only from their husbands, but also because of risky sexual relationships

in their husbands' absence, in some cases as the only means of supporting themselves and their children.[14] Migrants' home communities are also rendered vulnerable if migrants return home suffering from AIDS. Sickness deprives households of income and imposes healthcare costs.

Another connection between AIDS and mobility is the migration that takes place as a result of the pandemic. People living with HIV/AIDS move for a variety of reasons: to access better medical care, to escape discrimination or prejudice, and to prevent acquaintances from learning about their illness.[15] In many parts of the world, they return to their parental home to seek support. The time lag between diagnosis with AIDS and eventual death allows people to move to a preferred place to die.[16]

> AIDS not only prompts migration by those directly infected by the disease. When a household member becomes sick or dies, this can lead to migration by other household members. In Southern Africa, migration has been used as a coping strategy by AIDS-affected households.[17] Adults may, for instance, migrate to find employment to provide income to cover medical costs, while others relocate between extended family households to reduce consumption, provide substitute labour or meet the need for care in affected households.[18] Ultimately, AIDS-affected households may dissolve entirely. In rural Tanzania, one study found that in 44% of cases where a household head died from AIDS, all the remaining household members moved away.[19] Such households included many children.

CHILDREN AND AIDS-RELATED MIGRATION

Children are a key vulnerable group in relation to HIV/AIDS. Significant numbers contract the disease from their mothers, at birth or during lactation. Older children may become infected through sexual activity, sometimes in the context of abusive relationships. Many more children are affected indirectly. Because those most at risk of contracting and dying from AIDS are of reproductive age, many children are orphaned. In Lesotho and Malawi, approximately 17% of children are estimated to have lost one or both parents, about half of them to AIDS, a situation which is set to deteriorate further over the coming decade.[20] Furthermore, because HIV is sexually transmitted, the death of one parent is often followed by the death of the other, giving rise to an unprecedented number of parentless children.

It is not only orphans who suffer the indirect impacts of HIV/AIDS. Also affected are those children whose families or households are impoverished because their income is reduced or costs increased because of the sickness or death of household members.[21] People with AIDS suffer debilitating illness over a period of months or years, which inevitably impacts on those around them. Children's nutritional status often suffers, and they may also undergo psychosocial distress, deteriorating healthcare, increased demands on their labour and reduced opportunities for schooling.[22] Many children are removed from school to earn an income or to provide support for their households. Girls in particular may be expected to undertake agricultural and domestic tasks as well as caring responsibilities including cleaning, feeding and administering medicine to their relatives.[23] Children may experience stigma associated with HIV/AIDS, lose their inheritance and even suffer forced migration and possibly homelessness.[24]

Southern African societies tend to be more mobile than most. Migration, including the movement of individuals into and out of households, contributes significantly to normal household survival.[25] Among these individuals are children, who have long engaged in unaccompanied migration between households of their extended families to contribute to the welfare of their kin. In Lesotho, for instance, it was commonplace for the eldest child to spend some years in early childhood living in the home of their maternal grandparents. Young boys are also often sent to herd animals. Girls may be sent to provide domestic help for other relatives whose own children are too young. Movements between households of an extended family are not usually viewed as migration, a concept normally reserved for movement of, or away from, the family.

In Southern Africa, there are conventional arrangements for the care of children whose parents die. In patrilineal, virilocal societies such as Lesotho (and in northern and central Malawi), children conventionally live in the village of their father's male ancestors, and would remain there if either or both parents died, raised in the home of their paternal grandparents or paternal uncle. By contrast, in matrilineal societies such as Southern Malawi, children traditionally grow up in the village of their mother's line. Again, if either or both parents died they would remain in the village, although if their mother died, their father would return to his own village and cease contact with the children.

Labour migration has led to the dispersal of families between more than one site. It is now relatively uncommon for children to spend their entire childhoods in the maternal or paternal village. Many children grow up in town, or near a parent's workplace, but may also spend time staying with grandparents on either the paternal or maternal side of

their family, or in other households of their extended families. Most households contain individuals who do not belong to a single nuclear family. In Lesotho in 1993, 22.4% of households had resident children who were not the offspring of the household head.[26] In Malawi, matrilineal practices have not been rigidly adhered to for many years.

The geographical dispersal of extended families gives rise to children's migration as a consequence of HIV/AIDS. In Uganda, orphans and foster children appear to migrate more frequently than other children.[27] In urban Zimbabwe, many orphans have moved from rural areas and are separated from their siblings.[28] Many urban children in Southern Africa now live in nuclear family units, and when their parents die, the household is dissolved, the children moving to live elsewhere. It can no longer be assumed that if their parents pass away there will be anyone in the home village who is able and willing to care for them. Occasionally, children remain in the home, either joined by an adult relative or remaining as a 'child-headed household'.[29] The needs of those who are sick with AIDS also entails migration by children. Households often rely on extended family networks to provide care for sick relatives. Many children providing care for relatives in urban Zimbabwe have moved there from rural areas.[30]

RESEARCH METHODS

The research project reported in this paper was undertaken with three key aims.

- To examine the nature and impacts of AIDS-related children's migration.
- To inform policy responses to the AIDS pandemic.
- To promote the voices of AIDS-affected children.

The research adopted a children-focused approach in order to examine: the forms of migration that young people affected by HIV/AIDS engage in; the difficulties they face; the coping strategies they employ and forms of support that are available to them; and the ways in which they might be better supported. Following an outline of the methods used, the remainder of this paper presents the research findings relating to these five questions.

The research employed children-centred qualitative and quantitative methods, drawing on methodologies developed by researchers exploring the impacts of migration on young people in other contexts.[31] There was a need to include a relatively extensive survey to determine the nature, extent and causes of migration among young people, as well as techniques that would allow in-depth insight into young people's responses and needs. In order to explore a wide range of migration experiences

the study was also comparative, contrasting urban and rural experiences, and comparing Malawi's relatively long-standing experience of dealing with HIV/AIDS with the more recent, but rapidly developing, situation in Lesotho.

Research was conducted over a period of five months in 2001 in four case study areas in the two countries. In Malawi, the urban location of Ndirande, a high-density township in Blantyre, the main commercial centre, was selected due to its large transient population seeking employment in the city. In contrast Mpando village area, located in Thyolo District in the Southern Region, has a much less mobile population, although migration into and out of the area still takes place. Mpando is located in one of the country's major tea growing areas, and therefore employment-related migration is not uncommon. In recent years migration has also occurred due to the food security crisis further south where flooding destroyed much of the maize crop. The locations selected in Lesotho also contained relatively transient populations. The capital city, Maseru, is located on the border with South Africa and is growing by 7% a year due to rapid rural-urban migration. The rural location, Tlali, is located about 60 km from Maseru, in the foothills of the Maluti Mountains. The population here is supported by subsistence agriculture combined with remittances from labour migration. More permanent migration also takes place, with migrants arriving from the more isolated highland areas or leaving to take up employment in urban areas.

Because school attendance is relatively high, even among orphans, it was decided that the best way to access large numbers of children was through schools. In Lesotho, children were randomly selected from Standards 5, 6 and 7 of the local primary schools and Form A of neighbouring secondary schools. In Malawi, where children remain at primary school a year longer, the children were in Standards 5-8 of primary school. Classes are not of uniform age, but while a wide range of ages was represented (the youngest was 10, the eldest 20), over 75% of participating children in each locality were aged 12-15. The vast majority conformed to the legal definition of a 'child' in both countries (i.e. they were under 18), but were old enough to be able to reflect on and articulate their migration experiences.

All of the schools selected were government schools catering for students from low-to-middle income homes. Wealthier households tend to educate their children in private schools and a minority of poor children drop out of primary school before reaching the upper primary classes. It was considered important not to exclude young migrants who were not attending school. In each country, groups of out-of-school children were identified in consultation with local leaders, while children in

institutional care and street children were accessed through local organisations.

A questionnaire was distributed to 822 school children proportionately representing each community. The questionnaire was used primarily as a preparatory exercise for identifying young AIDS migrants, and was subsequently triangulated with key informant interviews and in-depth qualitative methods. Further measures were put in place to ensure the children developed ownership of the exercise, which has been shown to increase true responses. Prior to undertaking the questionnaire children were invited to participate in discussions on migration and what it means to move house. Following this, children were involved in drafting and piloting the questionnaire. The children were also given the opportunity to draw or write about migration on the back of the form, in order to express their own thoughts and ideas more fully.

On the basis of the answers given in the questionnaires, children were selected for participation in further qualitative research, which involved three main methods: focus group discussions, migration storyboards, and migration mapping. These methods allowed the children to express their opinions and views freely and in detail. Approximately 50 children in each location were invited to take part in focus group discussions. These were children whose questionnaire responses revealed that they had moved home due to the sickness or death of a relative or had had children move into their household in such circumstances.

Following the discussions, smaller groups of approximately 10 to 15 children were invited to draw their experiences in storyboards and map children's migration patterns. The storyboards allowed the children to define the important aspects of their migration stories and to display these through drawing pictures. The storyboard then acted as catalysts for eliciting further oral description.[32] The mapping exercise was a further action-based method and involved the same children marking on a map of the country the places where children in their communities arrive from, and move to. Again this acted as a tool for discussing reasons for children's migration.

In order to investigate the extent and nature of children's migration, its relationship to AIDS-affliction among families and communities, and its impacts on other household members, 40 guardians were interviewed, drawn proportionately from the four communities, about their experiences of receiving children into their homes. Key government officials and NGO workers were also interviewed. Within each chosen community, teachers and local leaders were interviewed. These informants acted as aids in identifying guardians in the community who had received young migrants into their care.

For ethical and practical reasons, the research was not restricted to

children and families whose situations were demonstrably related to HIV/AIDS. Although cause of death was discussed, the stigma surrounding HIV/AIDS is such that deaths of relatives are almost never attributed to this cause. Research has demonstrated, however, that the parents of at least half the orphans in Lesotho and Malawi died of AIDS.[33] It is therefore likely that the majority of children involved in the research were indirectly affected by AIDS.

In 2003, return visits were made to the four communities in order to disseminate the results of the research. Dissemination workshops were held with migrant children (including some of the original participants who were still at primary school), and with the wider communities. These allowed the children and adults to find out about the research findings and to comment upon them, in particular suggesting how a range of actors from individual child migrants, other household members, schools, communities, NGOs and government might respond to them. Representatives of government ministries, NGOs and donor agencies were invited to participate in policy workshops that were also held in each country. These were used to develop policy recommendations and provide input into a web-based training manual for use with community workers in areas of high AIDS prevalence.

CHILDREN'S AIDS-RELATED MIGRATION IN LESOTHO AND MALAWI

The questionnaire survey revealed that about 50% of children had moved house at some time during their lives (Table 4): the proportion was highest (58%) in the Malawi communities, and lowest in rural Lesotho (31%). The questionnaire probably significantly underreported migration as many children were unable or unwilling to accept that moving to live with a relative was 'moving house.' The qualitative methods revealed considerably higher levels of migrancy than the questionnaires.

Table 4: The Extent of Children's Migration in Malawi and Lesotho

	Mpando		Ndirande		Tlali		Maseru	
	N	%	N	%	N	%	N	%
Moved once	110	59.0	130	58.0	62	31.0	97	50.0
Moved more than once	73	39.0	87	39.0	24	12.0	49	25.0

The reasons why children had moved home varied considerably from place to place, but the death or sickness of a parent or other relative figured significantly: between 3.9% (in urban Lesotho) and 19.7% (in rural Malawi) of child migrants reporting having moved for these reasons (Table 5). At least half the children in each sample had had people come to live in their households (Table 6), of whom between 6.1% (urban Lesotho) and 19.9% (urban Malawi) were children who had moved because their own parents or guardians were sick or had died (Table 7).

Table 5: Children's Reasons for Having Moved House

	Mpando		Ndirande		Tlali		Maseru	
	N	%	N	%	N	%	N	%
Parent/guardian died	16	15.0	11	8.6	1	1.6	2	2.6
Parent/guardian sick	0	0.0	1	0.8	1	1.6	0	0.0
Relative sick	5	4.7	0	0.0	2	3.3	1	1.3
To help relative	5	4.7	1	0.8	5	8.2	2	2.6
Told by relative	7	6.5	5	3.9	0	0.0	0	0.0
Parents working – sent to relative	0	0.0	0	0.0	3	4.9	1	1.3
Work/job moved	39	36.4	15	11.7	0	0.0	6	7.7
School	1	0.9	2	1.6	8	13.1	7	9.0
Urban advantages	0	0.0	0	0.0	0	0.0	2	2.6
Witchcraft	5	4.7	2	1.6	4	6.6	0	0.0
House destroyed	4	3.7	9	7.0	9	14.8	1	1.3
Newer/bigger/better home	4	3.7	45	35.2	0	0.0	4	5.1
Built house	1	0.9	12	9.4	1	1.6	16	20.5
Rent increases	0	0.0	7	5.5	0	0.0	0	0.0
Conflict with landlord/debt/expelled	0	0.0	0	0.0	0	0.0	7	9.0
Agriculture/land	6	5.6	1	0.8	2	3.3	0	0.0
Famine/disaster	8	7.5	2	1.6	0	0.0	0	0.0
Diseases	2	1.9	1	0.8	0	0.0	0	0.0
Other	2	1.9	0	0.0	9	14.8	13	16.7

Table 6: Children Who Have Had Others Move In to Live with Them

	Mpando		Ndirande		Tlali		Maseru	
	N	%	N	%	N	%	N	%
Yes	93	50.0	154	69.0	110	55.0	107	55.0
No	93	50.0	69	31.0	90	45.0	88	45.0

Table 7: Reasons Why Others Moved to Live with Children

	Mpando		Ndirande		Tlali		Maseru	
	N	%	N	%	N	%	N	%
Their guardian(s)/parent(s) sick	1	1.1	2	1.3	2	1.8	0	0.0
Their guardian(s)/parent(s) died	16	17.0	29	18.6	17	15.3	6	6.1
My guardian(s)/parent(s) sick	0	0.0	7	4.5	5	4.5	2	2.0
My guardian(s)/parent(s) died	1	1.1	3	1.9	5	4.5	2	2.0
Alone/old/sick/needed care	9	9.6	5	3.2	16	14.4	13	13.3
Spouse died	1	1.1	1	0.6	0	0.0	1	1.0
Their parents went away	4	4.3	1	0.6	0	0.0	4	4.1
To help at home	7	7.4	7	4.5	12	10.8	6	6.1
My parent(s) work away	0	0.0	2	1.3	12	10.8	6	6.1
Problems in their home/area	1	1.1	2	1.3	5	4.5	6	6.1
For school	10	10.6	42	26.9	3	2.7	8	8.2
Destitute/no home/home destroyed	10	10.6	12	7.7	19	17.1	12	12.2
For work	21	22.3	41	26.3	0	0.0	19	19.4
Don't know	9	9.6	1	0.6	5	4.5	0	0.0
Other	4	4.3	1	0.6	10	9.0	13	13.3

Table 8: Patterns of Children's Migration in Lesotho and Malawi (%)

	Lesotho		Malawi		Total
Migration type	Maseru	Tlali	Ndirande	Mpando	
Localised	43.2	13.5	79.3	17.3	43.2
Urban to rural		41.3		26.4	13.7
Rural to urban	39.8		16.0		14.9
Rural to rural		43.2		55.4	20.2
Urban to urban	12.8		3.9		4.4
From outside country	4.2	2.0	0.8	0.9	1.8
N	97	62	130	110	399

In general, slightly more children had moved to rural areas than to urban areas on account of the sickness or death of relatives (Table 8). The large discrepancy between Lesotho and Malawi may relate to the more recent impact of AIDS in Lesotho. In Malawi children are likely to have been orphans (or otherwise affected by AIDS) for longer, meaning that they are more likely to have engaged in AIDS-related migration. For the same reason, more of the orphans in Malawi will be old enough to have participated in the research. Other research suggests that even in Lesotho, children's migration has probably increased due to

AIDS: the years 1993 to 1999 saw the proportion of households accommodating children who were not the offspring of the household head increase from 22.4% to 32.8%.[34]

The trigger for children's AIDS-related migration was often a secondary consequence of sickness or death, again giving rise to underreporting on the questionnaire. The economic and social impacts of the disease are such that children move home because of their parents' or guardians' inability to pay rent, because school fees are lower elsewhere, to avoid gossipy neighbours, or 'witchcraft', which is often blamed for the symptoms of AIDS. Actual pattems of migration and their relationship with sickness/death were often highly complex. A seventeen-year-old boy in Maseru, for instance, reported that he had moved to live with his father for the first time at the age of twelve in order to care for him in the months prior to his death.

Children were found to engage in migration at local, national and international scales. In general, urban children were more likely to have moved from within the local area, whereas children moving to rural locations were from further afield. A large, though not overwhelming, proportion of the long-distance migration reported was from urban to rural locations, supporting the contention that children move back to their grandparents' villages to be cared for when their parents die.[35]

A sizeable proportion of young migrants had moved more than once (Table 4), demonstrating that migration is not always permanent. Both sequential and cyclical migration patterns were associated with HIV/AIDS. Cyclical migration generally meant children moving on a temporary basis to help a household under stress, whereas sequential migration patterns more often signalled the failure of the original migration, usually because the receiving household could no longer support incoming children emotionally or financially.[36]

The interviews conducted with guardians who had taken in children revealed that almost all were related to the children. Although there was not a consistent pattern (Table 9), most were grandparents and, contrary to Lesotho's patrilineal cultural conventions, most migrant children were residing with maternal relatives. The same was true in Malawi. Most guardians identified were women or couples.

Table 6 somewhat oversimplifies the situations of some children. A number of children could be described as resident in more than one household: some slept in one house but ate in another; some stayed at one place during the week, but another at weekends and during school holidays. The table also omits the significant number of children who live not with guardians but in institutional care or on the streets.

Table 9: Relatives with whom Orphaned Children Live			
Maseru		Blantyre	
Maternal grandparent(s)	4	Maternal grandmother	8
Maternal aunt	3	Maternal aunt	7
Paternal grandparent(s)	3	Grandmother	1
Paternal uncle	1		
Paternal relatives	1		
Aunts in-law	1		
Aunt	1		
Tlali		Mpando	
Maternal grandparent(s)	9	Maternal grandmother	3
Maternal aunt	2	Maternal uncle	2
Paternal aunt	1	Maternal aunt	2
		Maternal great-aunt	1
		Paternal grandparents	1
		Grandmother	1
		Sister	2
		Aunt	1

EXPLAINING CHILDREN'S MIGRATION

Much of the migration undertaken by children in response to HIV/AIDS is part of a household/family coping strategy. In the Southem African context it is important to extend consideration of household coping to the wider extended family, as many families are dispersed among several households whose individual membership is highly fluid. Actions taken in response to stresses such as HIV/AIDS take into account not only the needs and capacities of those who are (temporarily) co-resident, but also kin who are resident elsewhere.

Long-term sickness and high death rates are presenting Southern African families/households with numerous costs including medical and funeral expenses as well as the work of caring for the sick and emotional trauma of watching people die. Those who are sick are less able to earn an income or to contribute their labour to the sustenance of the household, including childcare, and their sickness may remove other individuals from productive or reproductive work in order to provide care. Death of adults is likely to further reduce income and, particularly relevant here, the ability of the household to care for children. In order to address these problems of loss of income and labour, families/households

employ children's (accompanied and unaccompanied) migration as a coping strategy.

The term 'coping strategy' is used here merely to refer to actions people take to address their own needs and those of their kin in situations of stress.[37] 'Coping' does not imply there are no costs involved or that actions are invariably successful; 'strategy' does not imply a carefully prepared plan. Furthermore, the particular issue of children's migration is complicated by two factors. First, actions taken with regard to where children live are never the product of purely rational decision-making, but are highly influenced by emotional attachment and sense of moral obligation. Second, children are not merely pawns, moved around at the will of adult decision-makers, but are themselves social actors exercising agency. Even where they are not formally involved in discussions concerning where they should live, they may have influence, and if dissatisfied they may migrate elsewhere of their own volition.[38]

There are three key sets of considerations that contribute to the decisions family members make conceming children's AIDS-related migration:

- who is responsible for the children;
- whether a particular household can meet the children's needs;
- whether a household might usefully employ the children's capacities.

These considerations are related both to the characteristics and needs of individual households and of children themselves. Children's age and gender play significant roles in determining what are thought to be their needs and capabilities.

RESPONSIBILITY FOR CHILDREN

Most people who take children into their homes feel that they have a responsibility to do so. This sense of responsibility is the product of a number of influences. Cultural conventions may be one such influence, but in practice, as Table 5 reveals, cultural edicts no longer dictate which relatives children live with, but only that they remain the responsibility of kin.

The fact that most orphans were found to be living with maternal relatives reflects a common sequence of events related to HIV/AIDS. Typically, the father pre-deceases the mother. A woman who (as in Lesotho) lives with her in-laws, may be forced to move away because she is blamed for her husband's death, or due to conflicts over property. Furthermore, if she herself becomes ill she is likely to move with her children to stay with her own parents. When she dies, the children are already resident with their maternal grandparents, and are by default

considered the responsibility of their maternal relatives, either the grandparents themselves or aunts/uncles. However, while co-residence may increase the sense of responsibility adults feel towards children, distance is seldom a significant factor and some children migrate long distances because a particular relative feels responsibility for them. The fact that most guardians are female suggests that women feel a greater sense of responsibility towards related children than do men, although this may also reflect the greater numbers of elderly women in both countries.

Some maternal grandparents explained that they were caring for children because their daughter would have wanted them to. In other cases it was affection or at least sympathy for the children that prompted guardians to provide a home. More often, relatives seek to divest themselves of the guardianship of children. The fact that nine of the forty guardians explained that they had taken in children because they "had nowhere else to go" demonstrates that not every relative is equally willing or able to accept AIDS-affected children. This may relate to the fear and stigma that is associated with AIDS, although that was not mentioned by guardians.

Sense of responsibility for children does not operate in a vacuum. Responsibility for care is considered to relate to capacity to provide care. An elderly and infirm individual is unlikely to be expected to accept young children unless those children are of an age that they can provide assistance. Equally, where there are a large number of siblings, they are likely to be shared between a number of households to reduce the cost to any one. Even where a parent is still alive, relatives may feel they should take the children into their own home if they are better able to care for them or pay school fees.

Sense of responsibility also relates to children's own preferences. Most child migrants interviewed for this study were not consulted about where they wanted to live, but a number of guardians said that they had responded to children's wishes and allowed them to stay with them. Children's agency is limited as they cannot choose to move to an unwilling household. If children are strongly opposed to the arrangements their relatives make for them, their only option may be to seek an alternative home on the streets.

PROVIDING FOR NEEDS

The second set of factors affecting decisions about where AIDS-affected children should live concerns household resources. Children's needs vary, as do the capacities of households to meet them. These needs include shelter, economic support, schooling, supervision and psychosocial support. The inability of a household to meet a child's needs may lead to their migration from that household.

Access to appropriate shelter is a key consideration in determining where AIDS-affected children are able to live. Access to housing is very sensitive to the impacts of HIV/AIDS. Where accommodation is rented, a household might have to move if a sick adult cannot work, or if a wage earner dies, as rent can no longer be paid. If all adults in a household die, it is highly unlikely that children will be able to remain in rented accommodation. Many families become divided when they have to leave a rented home.

The experiences of people living in their own homes are partly determined by inheritance laws and customs. In the absence of a written will, widows and minor children cannot generally inherit property in either Lesotho or Malawi. If a male household head dies, his relatives might claim the house, forcing his widow and children to leave. In Lesotho, this is common practice if the husband's family declares a marriage to have been invalid, for instance because insufficient bridewealth was paid.

If both parents die, children may be placed in an even more difficult situation. Although no guardians suggested that inheritance issues played a role in migration decisions, inheritance was mentioned by migrant children in nine of the thirty-one focus groups in Malawi. Some children had been forced to move when adult relatives 'grabbed' their homes. Even if instructions are left that children should inherit, some are reluctant to fight for their parents' property due to threats of witchcraft.[39]

Some orphans living in owner-occupied homes refuse to move in order to try and retain ownership of the property. Such orphan-headed households can survive, although lack of income and experience, particularly in caring for younger siblings, makes them very vulnerable and has implications for children's welfare. Many, however, fail to retain possession of their homes for long, and, regardless of whether their other material and social needs are met, they ultimately have to migrate, most being taken in by extended family members.

Households that take in children need to be able to provide for their economic needs in terms of food, clothing and school fees. In general,

comparatively affluent relatives are more likely to accept children than those who have few resources.

Usually, the economic resources must come from within the household. Only occasionally is reliable assistance available from people or organisations outside the home. Sometimes, neighbouring relatives share some of the costs. One woman in Maseru explained the arrangement by which both her sisters' orphaned children, and her own (11 in all) were cared for:

> These children have been divided: some live with me, some live with their grandmother and some live at home, but we collectively look after all their needs ... I used to care for them all when I had a job, but now the grandmother looks after us all as she is the only one with a job, but I keep an eye on all the children as she's not here.

Migration sometimes takes place because household economic circumstances change. Illness and death in a household may diminish the capacity to support fostered children who were not previously a significant burden on resources. Such situations may prompt carers to seek an alternative home for their charges. In other cases it is children themselves who decide to move on and seek a home elsewhere. Not all children give greatest priority to their own economic welfare, but in desperate situations, some decide that even living on the streets is preferable to extreme poverty at home. This also leaves more resources for those remaining.

In Southern Africa, a high value is attached to education, and even where it is technically free, school-related costs can be a substantial element of a household budget. The ability of households to provide for schooling can be a reason for children's migration. Schooling is often interrupted as a consequence of HIV/AIDS. Many children leave school when their parents become sick or die, and although some return to school when they move to stay with guardians, others drop out because their fees are no longer paid or they are required to undertake work during school time.

When it is known that children are not attending school, relatives sometimes intervene. Many uncles, for example, send for nieces or nephews to live with them (often in town), to ensure their attendance at school. Although fees may be paid by relatives resident elsewhere, this is uncommon. Usually the fee payer takes full charge of the child, sometimes requiring them to perform chores in exchange for their schooling:

> For us, only our father was working and mother wasn't working, so when he died we went back to the village and

> didn't have enough of everything like food. ... Then after two years I came here with my uncle to Ndirande. I came here to go to school, but in the village no one goes to school, so my uncle brought me here to go to a proper school.

If adults do not send children to school, the children themselves sometimes take the decision to move away, in some cases to the streets of Blantyre or Maseru. Stepparents were represented by children as particularly reluctant to fund their education.

Decisions concerning who is suited to care for AIDS-affected children take into account not only children's material needs but also their social and emotional well-being. Young children need fairly constant supervision by adults or older children to ensure their safety, help them learn and give emotional support. Households that are able to support children economically are not always the best equipped to offer supervision and provide for their psychosocial needs. Sometimes households are able to share in providing these functions. A Mosotho mother whose husband was sick and unable to work, for example, took her children to stay with their grandparents while she went to work in Johannesburg to earn money to provide for them. In most cases, however, a household has to attempt to meet all of a child's needs from within. A Mosotho grandmother explained:

> I'm paid little for my job so it makes it difficult for me to do all that (pay for clothes, food, school fees). I have to leave them alone at home because there is no one to look after them ... I feel bad about leaving them at home because they are young and it seems like I'm just neglecting them. They are alone because they have no parents and me leaving them adds to that ... The 10 year old boy takes care of them because he knows they are his siblings.

Very few guardians or children referred to children's needs for supervision and care, let alone their emotional needs. This might reflect an assumption that, unlike material needs, children's non-material needs can be met by any of the adults or older children who populate large Southern African households. Furthermore, quite young children are considered capable of spending long periods outside adult supervision.

Failure by guardians to acknowledge children's psychosocial needs has been noted in other research in Southern Africa.[40] Although the grandmother quoted above was clearly aware that orphaned children may have greater psychosocial needs than those whose parents are alive, some adults are reluctant to believe that children may suffer emotional problems, and many find it difficult to understand children's grief.[41]

Orphaned children commonly suffer anxiety and depression, which may be manifest in disruptive behaviour.[42] Children who feel their emotional needs are not met may seek a home elsewhere.

EMPLOYING CHILDREN'S CAPACITIES

Decisions concerning where children should live also take into account what they can contribute to a given household. Depending on, among other things, their age, children can contribute to household survival. In situations of stress, including that related to HIV/AIDS, many households take in children specifically to help in domestic and agricultural work and caring for sick family members. Households may also be more willing to take in otherwise homeless children if they believe they will make a useful contribution.

In Southern Africa, most children undertake some domestic work. Guardians, particularly grandparents, described how grateful they were for the work their charges contributed: only one guardian complained that a child in her care refused to work. Many children, some as young as 5 or 6, are sent to grandparents, uncles and aunts in order to help with housework.

When children are sent to fulfil a particular need, this may entail permanent migration or a shorter stay, staying with a needy relative only for weekends or school holidays. Although girls are often considered more attractive to families than boys, the research reported here found only slightly more girls being sent to perform day-to-day household chores.[43] The work is often gendered. In rural Lesotho, boys' services are demanded for herding, and in Malawi boys are sent to work in fields and gardens:

> When we were still at my father's village [after he'd died] my [maternal] uncle came to beg for one child to help reduce the number of children [that my mother was looking after], as ... my uncle's wife had passed away. I went with my uncle to Blantyre to help him. I wasn't really happy, but since it was the decision they made to reduce the number of children my mother had to care for I had to accept. ... I was ten years old when I came ... I have to cook for him, go to the maize mill and clean the place. He has five children but all are boys so they only help me cleaning the place.

Although being sent to help a relative is a common reason for children's migration, many decide to leave households where they feel they

are made to work too hard, or where work interferes with their schooling.

In the context of HIV/AIDS, there is growing need for people to perform caring roles. Caring is usually seen as work for adults, with children often regarded as the solution of last resort.[44] But increasing numbers of children are involved, and many are migrating in order to provide care for sick relatives. Caring work differs in several ways from other chores performed by children, and entails different forms of migration. Although it is often assumed that girls are more likely to be carers, in practice, boys are also involved, particularly but not exclusively where the care recipient is male.[45]

Caring work is distinctive in that it is usually temporary and, particularly in the case of AIDS-related illnesses, may terminate with the death of a relative. Migration associated with caring is therefore usually short term. As people's health may change very rapidly, it may also happen at short notice. Although caring-related migration is often temporary, AIDS-related illnesses may be episodic, and also commonly affect more than one family member. In such situations, children may engage in repeat migrations.

Where relatives do not, or cannot, provide the care children need or want, young people may move outside the extended family. This is itself a coping strategy on the part of adult relatives or of children themselves. Such a strategy may enable children's needs to be met, or at least reduce the costs to extended family households.

Movement outside the family can take a number of different forms. Some children are married early, a practice that in patrilineal societies brings economic rewards in the form of bridewealth to the girl's paternal relatives.[46] By marrying, a girl is likely to be assured of shelter, and her material welfare becomes the responsibility of another family. Usually, however, marriage signals an end to education. Alternatively, children may be taken by their relatives to institutions that provide shelter, food and schooling.

A minority of children leave their extended family households to earn an income, usually contributing their earnings to support the household. An aunt in Mpando, for instance, sent her 13-year-old daughter away to work as a housemaid. The money the girl earned supported the care of her younger cousins.

Other children decide to leave or are expelled from the household where they live, without having an alternative home to go to. Such children may turn to the streets. There are a number of NGOs that cater for street children, but in most cases their shelter, schooling and economic needs will not be adequately met. Some, nonetheless, perceive their situation to be preferable to remaining at home.

PROBLEMS FACED BY YOUNG MIGRANTS

While migration is often employed as a means of meeting children's needs, it is not without costs for the children involved. The complex migration experiences AIDS-affected young people engage in raise a number of difficulties for children who have to fit into 'new' families and 'new' communities.[47]

In contrast to situations where children are adopted by childless couples as a response to fertility problems, children who are adopted into a household through obligation are often treated differently from other children in the household, particularly if resources are scarce.[48] Although some children reported feeling welcomed by their new families, others were less enthusiastic about the way they were treated. Many felt discriminated against in the new family unit relative to the biological offspring of their guardians. Children explained that they were sometimes given different foods to eat, not adequately provided with clothing, beaten and overworked. Malawian children rated discrimination and ill treatment by foster families as the worst problems they faced.

Irrespective of how they are treated by their new guardians, rivalry between children also often characterises migrant children's experiences of their new homes. Divisions arise in the family, as biological children may not want to share their resources, both financial and emotional, with 'new' siblings, especially if they are coming to terms with parental death and need extra attention.

The converse of the difficulties children encounter in sharing with 'new' siblings is being separated from former siblings. Although sibling dispersal is seldom the preferred choice when deciding the future of orphans, in practice poverty often makes it difficult for a single household to accept a large sibling group. As a consequence, siblings are sometimes separated at funerals. Children are seldom involved in discussions as to where they will live and in some cases the distance between their new households makes contact difficult. Many children mentioned missing their siblings, and this is likely to be particularly acute where children have not come to terms with the recent loss of their parent(s). It is further exacerbated where there are disputes between the households that take in children and guardians are unwilling to facilitate (or even allow) contact.

However, other children are taken into the households of adult siblings, and this, too, creates difficulties. Such children are generally treated more as a younger sibling than an adopted child, and many stated that they felt they received inadequate care.

Maintaining contact with siblings and other family members was

particularly difficult for children living on the streets or in institutions. While some institutions found ways of promoting continued contact with families, others preferred their charges to make a clean break from abusive home situations.

Many children moving to a new home as a consequence of HIV/AIDS are expected to undertake more and different work from what they have been used to. In some cases this is because taking in children imposes additional costs, in time, energy and money, on families who may be poor or elderly, and can only be sustained if the children themselves share the burden. Children may perform domestic chores for the new household, undertake agricultural or other productive work, or they may be required to provide care for children or sick adults. Some young migrants are incorporated into households explicitly as workers in payment for their keep: either they migrate specifically in order to provide labour to another household or their acceptance into a household is conditional on their performance of domestic or productive chores. In either case this changes their relationship with the household, as they are not an member part of the new family. Children who are sent away from home to engage in wage labour to support AIDS-affected families are removed from their families and have to drop out of school.

Even where children are used to performing household chores, those expected of them in their new household may be unfamiliar, and may be physically challenging. Children sent to care for sick relatives may quickly have to learn new skills, and face not only physical and educational, but also emotional costs.

Place-related differences also shape the work experiences of those who move between urban and rural locations. Children migrating from urban to rural environments found it particularly difficult to adapt to agricultural chores. In Lesotho, urban boys found herding livestock boring, and got into trouble for failing to keep the animals away from farmers' fields. In Malawi children found working in the fields most difficult. This created tensions and often resulted in teasing, as rural children were seldom sympathetic to the plight of their urban cousins.

Children have been shown to suffer psychosocial difficulties including emotional distress, anxiety and depression related to the sickness or death of a parent from AIDS.[49] Many find themselves in "a social void, [lacking] a cohesive space in which one is located as a member of a stable family, a neighbourhood or a community."[50] These problems of isolation, anxiety, depression and poverty are exacerbated when AIDS-affected children engage in migration.

Those moving over long distances needed to develop new social contacts and many mentioned missing their friends. Intra-generational

friendship groups are important in children's lives, particularly in Southern Africa.[51] Friends are crucial not only socially, but also in the formation of identity.[52] Children commonly talked of missing their friends as one of the main drawbacks of migration, and described the isolation they felt. Many retreated indoors, spending their time doing schoolwork or watching television while other children were outside playing. The trauma of losing a parent makes social integration in a new community more difficult and guardians noted that newcomers were often withdrawn and found it difficult to engage with other children. This was exacerbated for those children who lacked competence in rural tasks, as work and play are often inter-related.[53] AIDS-related poverty is also problematic, as one way in which children commonly make new friends is through sharing resources. The trauma of losing a parent makes social integration in a new community more difficult and guardians noted that newcomers were often withdrawn and found it difficult to engage with other children. Further, the increasing association between orphanhood and AIDS makes integration into community life difficult. This was particularly the case in Lesotho where AIDS is more recent. Children who undertake repeated migration, as new guardians fall ill or can no longer support them, have particular difficulties in establishing social bonds.

For most children in Malawi and Lesotho, education, at least at the primary level, plays a prominent role in their lives. It is also an aspect of life that is often disrupted by migration, particularly where this takes place over medium or long distances so that children cannot continue to attend the same school. While children's schooling is sometimes a key consideration in deciding where they should live, many children drop out of school, or at least experience significant disruption, due to migration.

Migration-related educational disruption is likely to compound the absenteeism and school dropout rate related to HIV/AIDS. Where households are affected by HIV/AIDS, children are often withdrawn from school on a temporary or permanent basis, either because of loss of income to pay school fees and related costs or to care for those who are sick or engage in other tasks to assist the family. Parental death causes further difficulties such that orphans and foster children are less likely to attend school than children whose parents are living.

Most guardians expressed concern for the education of children in their care. However, although the cost of schooling is relatively low, many children talked of varying forms of disruption that migration caused to their education. In Lesotho, children ranked the disruption to education as the worst difficulty young migrants face.

Some children had been withdrawn from school when they moved

because there was no money in the new household to pay their fees and costs of uniforms, books and stationery. Very few children moving to the streets were able to attend school, but drop-out was also fairly common among children who returned to live with rural grandparents, and those attending secondary schools, which are much more expensive. Other children moved from private fee-paying schools in town to much cheaper rural schools.

Regardless of the relative status of the schools, moving school can be a difficult experience. In focus groups, children talked about the changes in curriculum, teaching methods and regulations as they moved between schools. Even the logistics of finding one's class can be difficult when, as in Ndirande, children arrive for the first time at a school with nearly 9000 students. Several children reported having been successful students at their previous schools, but finding themselves in a much lower class position having moved. The difficulties are at their most pronounced when migration takes place across national borders. In Lesotho several children had returned from schools in South Africa, and in Malawi some children had experienced the Mozambican and Zimbabwean education systems. For these children there were particular difficulties associated with language.

Irrespective of guardians' willingness to support their charges' education, migrant children often experience bureaucratic difficulties when changing school. These are especially problematic for those whose migration takes place with little notice. Many schools refuse to accept new students because all their places are full. They may also require a letter of introduction from the former head teacher - a letter that is not always easy to obtain, particularly if children were absent from school for a while prior to moving, as may be the case when their move is associated with the death of a parent. Children who move in the middle of the school year are often required to wait until the start of the new year to register, meaning they must restart the class they had already begun. Where children are at secondary school they may be required to restart the two- or three-year cycle.

Being relegated to a lower class, and struggling academically can be disillusioning for young people. Where children feel they stand out as different, because their clothes are older or less fashionable than those of other students, or they have no money to spend at lunch time, or they are stigmatised because of AIDS, there is an increased likelihood that they will play truant or drop out of school through their own decision.[54]

MULTIPLE MIGRATION

Of 65 children who depicted their migration experiences, one-third had moved more than once following the death of a parent or other guardian, and some had moved as many as five times. The story of Annie from Ndirande is illustrative. Annie's first move was undertaken in order to care for her sick grandmother. After her grandmother had recovered, her father fell ill, and she had to look after him. When her father died, she moved again, returning to stay with her mother. However, having lost the income from her father's employment, the family was impoverished, and Annie was sent to help her uncle with the housework, thereby relieving her mother's household of the cost of her upkeep. Although multiple migrations are not necessarily problematic, they do indicate that some children are facing repeated disruption to their education and social networks, and in many cases they signal the breakdown of the original fostering arrangement. There are two sets of reasons why migrations failed, both relating to household level factors: either children were very unhappy in their new homes and chose to leave or the circumstances of the household changed and they were required to leave.

The number of children who left their homes because they were unhappy was relatively small. The reasons were usually connected with feeling discriminated against or abused in their new home. Usually they resented the sense that their guardians did not care: that conditions could have been made better for them, but instead they were exploited. Most such stories of ill treatment related not to impoverished grandparents, but to aunts, uncles and especially stepparents whose affections were reserved for their own children. In such instances children undertook a second migration, either seeking out relatives who might be more sympathetic or, in more desperate cases, moving to the city streets.

Most repeat migrations were instigated not by children themselves, but were the outcome of changes in wider circumstances. Most often the explanation lay with the changing situation of the guardian(s). Given that AIDS tends to cluster in families, it is unsurprising that in some cases guardians became sick and were no longer able to provide adequate care. Some guardians died, making renewed migration inevitable. Some grandparents, too, suffered sickness or death, directly or indirectly requiring children to move on.

Another common change of circumstance that led to renewed migration among Malawian children was the remarriage of parents or other guardians. New spouses were sometimes reluctant to accept children into their homes.

Unemployment, too (which may relate to AIDS-related sickness),

can mean that a home that was once welcoming is no longer willing to support additional children. Sometimes this relates to the sudden scarcity of material resources; sometimes the family home is attached to the job. It is not always changes in a child's immediate household that provoke renewed migration. If circumstances change elsewhere, for instance when a relative falls sick, an orphan might be sent to provide assistance.

Given that grandparents are generally elderly, and that many adults in Lesotho and Malawi have AIDS, some migration associated with guardians' changing circumstances is unavoidable. It is noteworthy that where grandparents take in orphans the arrangement was found to be three times more likely to last than where children enter the homes of aunts or uncles. This suggests that where guardians are motivated to care for children, and do not have competing loyalties to reconcile, they are more likely to provide a long-term home.

POLICY IMPLICATIONS

Policy contexts differ considerably between Lesotho and Malawi, although neither country's government has taken the implications of children's migration in response to AIDS on board. Lesotho has no specific policy on children affected by AIDS.[55] Despite a detailed report by UNICEF in 1999, the National AIDS Strategic Plan focuses almost exclusively on prevention, and has little to say in relation to the impacts of AIDS on children or adults.[56] Although one of the 'strategic aims' expressed in the Plan is for '50% of orphans, due to AIDS, [to be] cared for by March 2003', it is unclear what this means or how it was to be achieved. Of the nineteen 'strategic objectives', none relates specifically to AIDS-affected children. The government Policy Framework on HIV/AIDS Prevention, Control and Management contains only a few lines referring to caring for orphans.[57] Although individual government ministries as well as NGOs, CBOs and faith-based organisations are taking a variety of actions in relation to the impacts of AIDS on children, there is no national mechanism for the coordination of such policy responses.[58]

By contrast, Malawi's National HIV/AIDS Strategic Framework includes three pages on orphans, widows and widowers, recommending strategies relating to the modification of laws and policies; improved care and support; and the provision of life skills training.[59] The Ministry of Gender, Youth and Community Service has been involved in developing a National Policy on Orphans and Vulnerable Children which encompasses policy development in a range of areas of govemment activity.[60]

When relating these policy documents to the needs of migrant children, two major issues emerge. First, the policy documents (and policy solutions) consider only the needs of orphans, and neglect children who are otherwise affected by AIDS. For Malawi's National Policy on Orphans and Vulnerable Children, a 'vulnerable child' is taken to mean 'a child who has no parents or able guardians, staying with elderly grandparents or in a sibling headed household.'[61] This definition excludes, for instance, children sent to care for sick aunts, uncles or perform work for stepparents.

The second problem with respect to policy responses to HIV/AIDS, is that they commonly advocate 'community-based care.'[62] UNICEF's report on programming for families and children affected by AIDS in Lesotho, for instance, states that "it is assumed that community based approaches are the only viable and sustainable alternative for providing care and protection for children made vulnerable by the HIV/AIDS epidemic."[63] However, such documents do not use the term 'community-based care' in a consistent and uniform way. It is used variously to refer to care in the community (i.e. not in institutions); care organised at the community level (for instance through coordination of service provisions through Community AIDS Committees); or care by the community (where individuals or groups devote time or money to the care of children). In all three usages it is assumed that there is an identifiable and static community to which orphaned children and their guardians belong. In practice, however, the prevalence of migration among children affected by AIDS means that many orphaned children are newcomers to their communities.

Children in both Lesotho and Malawi are considered the responsibility of their kin, and not the wider community. Children who were unhappy with the support offered in a particular household did not look to unrelated community members for assistance, but left the community to seek help from relatives elsewhere, or to make a life on the streets. This is not to suggest that communities have no role to play in supporting the family care of AIDS-affected children, but that policies should recognise that in highly migrant societies families and communities play very distinct roles. Static support mechanisms need to be supplemented by measures that recognise the fluidity of AIDS-affected communities.

Policy responses are needed to diminish the problems associated with migration, tackling both the causes of the problems and the capacities of those involved to address difficulties, as well as diminishing the need for children to undertake (repeated) migration.[64] Ways are needed to facilitate children's incorporation into new households, new communities and new schools. Since young AIDS migrants are supported mainly through the extended family, support needs to be channelled in ways

that, first, support the children themselves, and second, support the families that receive them. There are clear roles for government in relation to social welfare, finance and education.

Although social welfare departments in both Lesotho and Malawi are poorly resourced, there are many NGOs and CBOs working with people in their communities who could play a role in helping families to find ways to make migration easier for children. Given that some of the key difficulties faced by young AIDS migrants concern making social contacts, learning environment-specific chores and fitting into new households, children are likely to find migration less traumatic if they are familiar with the people and place in advance of having to move home. Where children had regularly visited their new families and homes prior to moving, they faced fewer problems. By contrast, the children who found migration most difficult were those who had been apprehensive about moving to an unfamiliar place. Policy interventions might support transition strategies to ease the migration process. By promoting preliminary visits and the developing of contacts with potential guardians, some of the anxieties that surround moving might be reduced.

Anxiety was exacerbated in situations where children had not been told to expect the death of a parent, and where the cause of sickness was not discussed. Stigma associated with HIV/AIDS, as well as a general reluctance to talk about impending death, means that children are seldom well informed about the course of a relative's illness. For many children, the death of a parent was unexpected, a situation that made adjustment difficult. In many cases, decisions conceming where children should live took place immediately after the funeral. Children were not involved in discussions but simply told whom they would live with. In these situations children felt powerless: they were aware that adults were the decision-makers and that they had no choice.

Children would find it easier to cope with new situations if they were included in discussions concerning where they should live, and in some cases this might avoid breakdown of fostering arrangements. Although children do not expect to be consulted by those making such decisions, many state they would like to have a say. Although the realistic options are often very limited, discussions with children would at least enable them to voice their opinions and to understand the reasoning behind the decisions that are made.

It is not only important to prepare children for migration and to develop relationships in advance; children also benefit from maintaining ties with kin once they have moved. There are a number of means by which children's connection to their former lives - both the places and the people that populated them - might be kept alive. This might

be achieved through visits to the former home and relatives (including to those who themselves have moved elsewhere). If this is not possible other strategies might be pursued. Family trees can be drawn to demonstrate to children who they are related to and to enable them to learn something about their kin. These might assist children to feel more socially and culturally rooted. Memory books or memory boxes have been used to assist children in remembering deceased parents. These include photographs, stories and memorabilia conceming the parent, ideally put together while they are still alive. This is an idea that can be extended to include memories of a place - of a former school, friends and relatives from a child's former home. Maintaining memories and contacts in this way is particularly important for children who are cut off from family life by being placed in institutions or living on the streets. Ensuring that children do not become too distanced from their family and cultural background would provide them with a greater range of options in their future lives.

Economic considerations are also of great significance in relation to children's migration, and here there is a potential role for finance ministries. Many of the difficulties young migrants face, including competing with other children for resources, dropping out of school and having to work, relate to the costs of caring for children in situations of poverty. These conditions also prompt families to choose guardians for children on the basis of economic expediency, rather than taking into account the full range of children's needs and interests. Where guardians are selected for reasons of short-term economic viability they may prove inadequate care-givers, or be unwilling to continue as guardians should their circumstances change. It is therefore desirable that policies enable children to be cared for by guardians who are able and willing to provide sustainable long-term homes.

Grandparents often offer more sustainable homes for AIDS-affected children than other relatives. As the ratio of orphaned children to healthy adults increases, however, aging relatives are struggling to provide financial and physical resources to care for growing numbers of children. Grandparents are sometimes unable to accept children on account of poverty, and when children leave the homes of grandparents the reason usually relates to poverty. The most effective way of supporting grandparents (or other committed relatives) in caring for AIDS-affected children would be to reduce the costs involved and facilitate access to material resources. Any reduction in the costs to a household of caring for children is likely to facilitate their incorporation into new homes, and acceptance by new siblings. Given that children's migration is usually triggered by economic factors, rather than directly by AIDS, reducing costs could diminish the need for repeated migrations. Free

primary education in Malawi, for instance, means fewer children there migrate for reasons related to the cost of schooling than in Lesotho, where education was free only in Standards One and Two. Accelerating the roll-out of free primary education, as has been mooted by the Lesotho government, would bring widespread benefits.[65] Old age pensions would also assist many grandparents to care for children. Other possible ways of reducing costs to households include feeding schemes, income generation projects, and the provision of pre-schools that would allow guardians to work and generate an income.

The education sector, too, has a clear role to play in improving conditions for migrant children. Children's movement between schools is hampered by bureaucratic procedures and the rigidity of curricula. Governments are beginning to consider the value of introducing more flexibility into education systems, which would allow for periods of absence from school to fulfil caring responsibilities and would also enable children to move between schools with less disruption. Schools may also operate as focal places for addressing the needs of vulnerable children.[66]

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