HIV/AIDS Orphans and Vulnerable Children On-line Toolkit: draft introductory texts

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2.2 Doing the Work

This section provides practical tips for organizations carrying out activities aimed at providing support to orphans and other vulnerable children. It focuses particularly on the type of activities which might form part of a community-based, 'orphan' visiting programme.

Other sections look at related issues, such as how such programmes might **get started** (Hyperlink Section: 'Getting Started') or **be improved** (Hyperlink Section: 'Improving the Work'). Others examine specific issues related to doing the work in more detail, for example **local advocacy** (Hyperlink Subsection: 'Local Advocacy'), **working with volunteers** (Hyperlink Subsection: 'Working with Volunteers') and **running an organization** (Hyperlink Subsection: 'Running an Organization').

Key points about doing the work are:

1. Activities are most effective when they are carried out by individuals or groups who are part of the local community. External organizations, such as NGOs, need to play a facilitating role only.

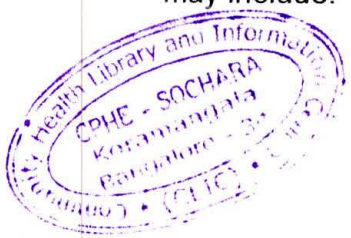
2. **Volunteers** drawn from the local community constitute the most important human resource in such programmes. Training, supporting and motivating this group of people is an important part of any programme. (Hyperlink Subsection: 'Working with Volunteers').

3. Projects will need to have a way of keeping records which helps **monitor** activities of the programme as a whole and the situation of individual children (Hyperlink Subsection: 'Monitoring and Evaluation').

4. In situations of poverty, material support may be required by particular children. However, there are many risks involved with this. Experience has shown that material support is best provided through community groups once they have demonstrated that they are able to prioritise children in greatest needs and monitor activities, including the provision of material support.

Visiting Orphans and Vulnerable Children

Many of the **projects** (Hyperlink Subsection: 'Project Case Studies') which work with orphans and vulnerable children have some kind of visiting programme at their core. These usually work through a group of **volunteers/mentors** (Hyperlink Subsection: 'Working with Volunteers') who are selected from local community members. These volunteers carry out a range of activities, which may include:



- Practical tasks, such as cleaning, washing, collection of firewood.
- **'Counselling'** (Hyperlink Subsection: 'Counselling') – on issues including bereavement and growing up
- Teaching of skills, for example in home management
- **Psychosocial Support** (Hyperlink Heading: 'Psychosocial Support'), including showing love, spiritual support and teaching about culture and traditions
- Assessment of **health and nutritional status** (Hyperlink Heading: 'Health and Nutrition'), including checking on immunizations, health card and accompanying to clinic when ill
- Ensuring that children attend **school** (Hyperlink Section: 'School Age Children') and that barriers to this are overcome
- Providing support to **caregivers** (Hyperlink Section: 'Carers')
- Prevention and detection of **abuse** (Hyperlink Section: 'Protection from abuse etc.')

Some organizations have developed frameworks for volunteers to operate within. One of these is referred to as LEPO. It involves **l**istening, **e**ncouraging, **p**roblem-solving and identifying **o**ther resources.

Some organizations conduct activities in addition to visiting orphans and vulnerable children. In some situations, these activities are not linked to visiting orphans and vulnerable children. These activities include:

- **Economic strengthening** (Hyperlink Heading: 'Economic Strengthening')
- **Psychosocial support** (Hyperlink Heading: 'Psychosocial Support')
- **Local advocacy** (Hyperlink Subsection: 'Local Advocacy')
- **Protection from abuse** (Hyperlink Section: 'Protection from abuse etc.')

2.2.1 Local Advocacy

This section explores practical ways in which NGOs and CBOs might get involved in advocating for children, particularly at local level. It also looks at the issue of advocacy more broadly and briefly considers ways in which locally-focused NGOs and CBOs can get involved in advocacy at national and international levels.

Other sections looking at related issues include **doing the work** (Hyperlink Section: 'Doing the Work'), **working with volunteers** (Hyperlink Subsection: 'Working with Volunteers') and **running an organization** (Hyperlink Subsection: 'Running an Organization').

Key points about local advocacy are:

1. Advocacy can be defined as pleading in support of others or speaking for those who are powerless to speak for themselves.

2. The **Convention on the Rights of the Child** provides a powerful basis for advocacy efforts at all levels (Hyperlink Heading: 'Children's Rights').

3. Many NGOs/CBOs find 'advocacy' difficult. However, local advocacy can be started in a number of small practical ways, which are often simply an extension of existing activities.

4. Locally-based NGOs/CBOs can often engage most effectively with advocacy issues at national/international levels through involvement with networks and coalitions.

What is Local Advocacy?

Advocacy has been defined as pleading in support of others or speaking for those who are powerless to speak for themselves. Advocacy for orphans and vulnerable children at local level might take a number of forms including:

- Providing training about the **rights of children** (Hyperlink Heading: 'Children's Rights'), in general and the Convention on the Rights of the Child, in particular. This training might be provided to community-based volunteers working with orphans and vulnerable children and the children themselves.

- Being aware of and focusing on children at particular risk.

- Being careful to avoid **terms** (Hyperlink Section: 'Terminology') which reinforce **stigma** (Hyperlink Section: 'Stigma and Discrimination'), such as AIDS orphans.

- Using the law to protect the rights of children, for example on **inheritance** (Hyperlink Subsection: 'Inheritance') of property.

- Assisting children to get important documents, such as **birth certificates** (Hyperlink Subsection: 'Birth Registration').

- Representing children's interests in a variety of ways, including to social workers, the police, courts, community leaders and to schools.

- Assisting in a variety of ways to ensure that children gain access to important services, such as **health** (Hyperlink Subsection: 'Access to Health Care') and **education** (Hyperlink Subsection: 'Access to Education').

- Using the media to disseminate information.

- Linking to networks to participate in national and international advocacy.

2.2.2 Working with Volunteers

This section explores issues relating to ways in which NGOs and CBOs work with community-based volunteers. Such people are often the key group in **doing work** (Hyperlink Section: 'Doing the Work') with orphans and vulnerable children at community level. It looks at how these people are selected, trained and supported.

Other sections looking at related issues include **doing the work** (Hyperlink Section: 'Doing the Work'), **local advocacy** (Hyperlink Subsection: 'Local Advocacy') and **running an organization** (Hyperlink Subsection: 'Running an Organization').

Key points about working with community volunteers are:

1. These volunteers should be selected by members of the local community using a process and criteria agreed by the community.

2. Training should be relevant to the activities the volunteer is expected to carry out and should be ongoing.

3. Ways need to be found to provide ongoing support and encouragement for community-based volunteers. Initial training only is unlikely to be sufficient to achieve this. Clear policies on 'incentives' for volunteers may need to be developed.

4. In many projects, volunteers are mainly women. Ways need to be found to mobilize men into these roles and to share the burden of care more equitably.

Visiting Orphans and Vulnerable Children

Many NGOs that work with orphans and vulnerable children do so by supporting **visiting programmes** (Hyperlink Section: 'Doing the Work') which operate through community-based volunteers. To **get these programmes started** (Hyperlink Section: 'Getting Started'), such volunteers need to be selected. This should be done by the local community using a process and criteria developed by them. Examples of criteria for volunteers developed by one programme include leading from the heart, people skills, ability to manage community change, ability to be a role model and a sense of humour.

Training Volunteers

Many programmes conduct initial training for their community-based volunteers. The precise content of this training varies but is likely to include training for what the volunteer may need to do during a visit, sources of additional support and

record-keeping systems. Experience has shown that initial training alone is unlikely to be sufficient, and that training needs to be ongoing.

Ongoing Support to Volunteers

A key element of working with volunteers involves supporting them in their work on an ongoing basis. This support may take many forms and may include:

- Ongoing training – this may include workshops, training elements in support meetings and also exchange visits to other programmes
- Support/supervision meetings
- Feedback on individual and programme performance. This feedback may come from various sources, including from inside and outside the local community
- Visits to the programme. These may be motivational, in that they give recognition to the volunteers and the work they are doing. However, they can be problematic particularly if the number of visits becomes excessive
- Counselling and other supports to overcome problems of stress and burnout
- Allowing volunteers to actively participate in programme development
- Ensuring realistic workload, given that volunteers carry out programme activities as volunteers, in addition to other responsibilities
- Group identity – many volunteers gain support from religious bodies they belong to
- Material incentives – such as food, soap, T-shirts, shoes etc. This element is potentially problematic because of the risk of creating dependency. Clear guidelines may be helpful in this regard.

In many programmes, the majority of volunteers visiting orphans and vulnerable children are women. This emphasizes the point that the burden of care which results from HIV/AIDS is falling mainly on women.

2.2.3 Running an Organisation

In many cases community-based activities with orphans and vulnerable children have not been started by an established organization but by an informal community group or perhaps a church. In those cases, the people involved need to learn a variety of skills, not only those specific to working with orphans and vulnerable children, but also more general skills related to running a project, and setting up an organization. Although this section contains some resources which refer to these issues, many more resources are available in the International HIV/AIDS Alliance's **NGO/CBO Support Toolkit** (Hyperlink Toolkit).

Other sections looking at related issues include **doing the work** (Hyperlink Section: 'Doing the Work'), **local advocacy** (Hyperlink Subsection: 'Local Advocacy') and **working with volunteers** (Hyperlink Subsection: 'Working with Volunteers').

2.3 Improving the Work

This section looks at ways in which activities being carried out with orphans and vulnerable children can be improved and strengthened. This is an essential part of **running a programme** (Hyperlink Heading: 'Running a Programme') once it has been **started** (Hyperlink Section: 'Getting Started') and some **work is already being done** (Hyperlink Subsection: 'Doing the Work'). Three essential elements are considered here, namely **monitoring and evaluation** (Hyperlink Subsection: 'Monitoring and Evaluation'), **working with others** (Hyperlink Subsection: 'Working with Others') and **setting standards** (Hyperlink Subsection: 'Setting Standards').

Key points about improving the work are:

1. **Monitoring and evaluation** (Hyperlink Subsection: 'Monitoring and Evaluation') of a project helps establish what has been achieved, including what has worked well and what could be better. Learning from such activities can be valuable in improving work.

2. NGOs can **work with others** (Hyperlink Subsection: 'Doing the Work') in a variety of ways, including through formal and informal networks and with implementing joint projects. This contact with other organizations, locally, nationally and internationally can be a useful way of learning about other approaches which can be used to improve activities.

3. **Setting standards** (Hyperlink Subsection: 'Setting Standards') to be reached in the provision of care for children can be useful for **monitoring and evaluation** (Hyperlink Subsection: 'Monitoring and Evaluation') purposes, and for comparing different projects and approaches. Such standards can be used by organizations as targets to aim for. This is likely to improve the quality of work being carried out.

2.3.1 Monitoring and Evaluation

This section looks at the monitoring and evaluation of programmes. This is an essential part of **improving work** (Hyperlink Section: 'Improving the Work'). Related sections include **working with others** (Hyperlink Subsection: 'Working with Others') and **setting standards** (Hyperlink Subsection: 'Setting Standards').

Key points about monitoring and evaluation are:

1. Both monitoring and evaluation are processes used to assess project progress.

2. 'Monitoring' refers to an ongoing system used to keep the project 'on track'.

3. 'Evaluation' refers to a one-off event conducted to account for resources used and/or to document lessons learned.

4. There are two main approaches to evaluations. Scientific approaches emphasise the importance of objective facts/evidence. Interpretive approaches emphasis the views and perspectives of people affected by/involved with the project. These people are termed 'stakeholders'.

5. Many approaches to evaluation now emphasise the active participation of stakeholders, particularly children and young people. Different stakeholders may have very different levels of power within a project.

6. Indicators are things which are used to measure or assess progress made by a project. They may be expressed as numbers (quantitative) or descriptive words (qualitative). They may be internationally or locally-defined and can be used to measure project activities at different levels, for example processes/activities and outcomes/impacts

7. Good monitoring systems and evaluation approaches collect and compare information from a variety of different sources using different methods. This is termed triangulation.

Defining Monitoring and Evaluation

Resources in this section contain a number of definitions of the terms 'monitoring' and 'evaluation'. These two processes both seek to examine and analyse the progress of a particular project. They differ from each other in three main ways:

1. **Nature:** The term monitoring is used to describe a system of collecting and analyzing information about the work of the project. On the other hand, the term evaluation is usually used to describe a specific event.

2. **Timing:** Monitoring is a regular and ongoing process which takes place throughout the life of a project. An evaluation usually occurs at a particular time, for example midway through a project or at the end.

3. **Purpose:** The purpose of monitoring is relatively narrow, in that it usually focuses on keeping a project 'on track'. This involves measuring what the project has done and comparing this with its plans. Evaluation may have broader purposes, for example assessing what has been learned as a result of project activities.

Purpose of Evaluation

Two main purposes can be identified for conducting an evaluation. First, an evaluation can be conducted to hold a project accountable for what it has done and achieved. In such cases, actual project activities and achievements will be compared with what was planned. Such evaluations are often required by donor organizations that provide funds for a project. The receipt of further funds may depend on achieving a satisfactory outcome to such an evaluation. Secondly, an evaluation may seek to learn lessons from project activities. This is likely to include an assessment of what worked well and what didn't. Things that have worked well may be referred to as 'good', 'effective' or 'best' practice. There is a tension between these two purposes. For example, this may explain the reason why 'negative' findings, that is what didn't work, are rarely recorded in evaluation reports. Although such findings are very useful for the purpose of learning, they are problematic in terms of accountability, because donors are unlikely to be willing to fund activities shown to be ineffective. Consequently, organizations may not wish to publicise findings of this nature.

Ways of Conducting Evaluations.

There are a variety of ways of conducting evaluations. These can be divided into two main types. The 'scientific' approach seeks to compare a group of people receiving a particular intervention or service with a comparable group who do not receive it. The purest form of this is referred to as a randomized, controlled trial. It places strong emphasis on objective facts/evidence. On the other hand, the 'interpretive' approach places much greater emphasis on trying to understand the views and perspectives of different individuals and groups associated with the project.

Stakeholders

People associated with the project can be referred to as 'stakeholders'. Many different stakeholder groups can be identified for a particular project, including the children and young people who are intended to benefit from it. These stakeholders may have very different expectations of a project evaluation. Two key issues relating to stakeholders and evaluation are:

1. **Power:** There may be power imbalances between different groups of stakeholders. For example, donor views may be given greater weight within an evaluation because they control project funds.

2. **Participation:** Interpretive approaches to evaluation place great emphasis on the active participation of project stakeholders, particularly children and young people, in an evaluation.

Indicators

Indicators are widely used in both monitoring and evaluation. Essentially, they are things which can be measured or assessed to see the progress being made by a project. They may be expressed in numbers (quantitative) or through descriptive words (qualitative). They may form part of an international set of core indicators or may be developed locally for a specific project. They may measure different 'levels' of a project. These levels include:

- **Inputs** – that is the things needed for the project to occur. An example of an indicator of project inputs is project cost.

- **Processes** – that is the activities of a project. In general, these are relatively easy to measure and process indicators often form the bulk of monitoring systems. An example of a process indicator would be the number of orphans and vulnerable children visited by volunteers. In some situations, these figures are expressed as the percentage of people who need a service who actually receive it. This is termed 'coverage'.

- **Outputs** – that is things produced by the project, for example an upgraded health facility.

- **Impact/Outcome** – these are longer-term changes produced as a result of the project. In many cases, it may be difficult to show clearly that these changes have occurred as a result of the project because they are affected by many other things. An example of an impact indicator might be children's nutritional status.

Some examples of process and outcome indicators used by programmes working with orphans and vulnerable children are presented in the table below.

Process Indicators	Outcome Indicators

Number of children assisted by the programme Number of **community-based volunteers** (Hyperlink Subsection: 'Working with Volunteers') within a programme Production of **community-generated financial and material resources** (Hyperlink Heading: 'Economic Strengthening') Number of volunteer training sessions Number of supervisory visits carried out by senior staff	Prevalence of abandoned children/**street children** (Hyperlink Subsection: 'The Street')/**child-headed households** (Hyperlink Subsection: 'Child-headed Households') Stunting and wasting Dietary intake profile School enrolment/drop-out Immunisation status Proportion of sibling separation Primary carer income Household land cultivation

Monitoring and Evaluation Methods

Monitoring and evaluation may use a variety or different methods for collecting information. Primary methods are those used by the people doing the monitoring/evaluation. Primary methods may include questionnaires, surveys, focuse group discussions, direct observation and interviews with key informants. Secondary methods involve looking at work done by other people, usually through reviewing project and other documents. Good quality monitoring and evaluation uses information from a variety of different sources, collected using different methods to cross-check its validity. This is called triangulation.

2.3.2 Setting Standards

This section looks at setting standards for activities which seek to provide care and support for orphans and vulnerable children. It is part of **improving work** (Hyperlink Section: 'Improving the Work'). Related sections include **working with others** (Hyperlink Subsection: 'Working with Others') and **monitoring and evaluation** (Hyperlink Subsection: 'Monitoring and Evaluation').

Key points about setting standards are:

1. Standards can be used by an individual project/programme to assess their own achievements and to have something to aim for

2. Standards can be used to compare different approaches. This may be particularly important when trying to assess costs.

3. Standards can be set in a number of areas where children have needs/rights. These include survival, security, socialization and self-actualisation.

Why are Standards Needed?

Organizations have very varied ways of working with orphans and other vulnerable children. It may be extremely difficult to assess the relative effectiveness of these approaches unless there are agreed standards for the kind of care that needs to be provided. Such standards may be useful for individual projects who can use them to assess how they are doing and as targets for improved activities in the future. Also, such standards can allow comparisons to be made between different project approaches. However, many of the standards are affected by poverty in general. It may be necessary for communities to adapt these standards so that they are appropriate for local settings.

Areas in which Standards are Useful

One approach is to identify four areas in which standards are needed. These are:

1. **Survival**: This area covers a number of basic physical needs that children have in order to survive. These include food, clothing, home environment, hygiene/infection control, treatment and health care. It is possible to set standards in each of these areas. For example, in South Africa under 'food', two standards were adopted, namely that children should receive three meals per day and should be involved in food preparation and choice.

2. **Security:** This area covers a child's need for both protection and affection. Areas in which children need protection include from **abuse** (Hyperlink Section: 'Protection from abuse...'), **stigma and discrimination** (Hyperlink Section: 'Stigma and Discrimination') and from **loss of parental assets** (Hyperlink Subsection: 'Inheritance').

3. **Socialisation:** This covers a range of needs and rights children have in relation to interaction with others. These areas include the right to their own identity,; **education**/schooling (Hyperlink Heading: 'Education') ; **participation** (Hyperlink Section: 'Participation'); understanding, information and communication and **counseling**/supportive services (Hyperlink Subsection: 'Counseling').

4. **Self-actualisation**: This area covers a child's need for recreation/idleness and freedom of expression.

2.3.3 Working with Others

This section looks at ways in which organisations can work with other groups conducting activities aimed at orphans and vulnerable children. It is part of **improving work** (Hyperlink Section: 'Improving the Work'). Related sections include **working with volunteers** (Hyperlink Subsection: 'Working with Volunteers') and **monitoring and evaluation** (Hyperlink Subsection: 'Monitoring and Evaluation').

Key points about working with others are:

1. Links to other organisations can be very useful in learning about what others are doing. This can be extremely helpful in improving practice.

2. Working with others may take many forms. It may consist of informal linkages, official networks and formal partnerships

Reasons for Working with Others

Organisations often find it useful to develop linkages with other organizations. Reasons for this vary. First, it provides organisations with ways of sharing information about what they are doing and learning about what others are doing. This may be done in a number of different ways including electronic and print media, meetings and site visits. Such learning can be helpful in improving an organisation's work. In addition, such linkages provide encouragement for staff and volunteers in organizations who often feel they are working in isolation. They also provide opportunity for organisations to work constructively together. Such joint working may result in improved services for orphans and vulnerable children.

Types of Relationships between Organisations

Relationships between organisations take many forms. These include:

- Informal links – such as exchange visits for staff and volunteers
- Formal networks – such as the Children in Need Network (CHIN) in Zambia
- Formal partnerships – where two or more organisations agree to work together on a particular activity

3. Health and Nutrition

This section looks at the health and nutrition of orphans and vulnerable children. It looks at ways in which the effects of HIV/AIDS on the health and nutrition of children can be measured and the ways in which HIV/AIDS causes its effects on the health and nutrition of orphans and vulnerable children. It also looks at what **rights** (Hyperlink Heading: 'Children's Rights') orphans and vulnerable children have regarding health and nutrition and what actions can be taken to improve their health and nutrition. Other sections look in more detail at health and nutrition of **orphans and vulnerable children, in general**, (Hyperlink section: 'All Children') and **children living with HIV/AIDS** (Hyperlink Section: 'Children living with HIV/AIDS'), in particular.

Key points about health and nutrition are:

1. HIV/AIDS is having severe effects on the health and nutrition of children. In countries with severe HIV/AIDS epidemics, this is seen in increasing rates of under 5 mortality.

2. HIV/AIDS affects the health of children directly and indirectly.

3. It is possible to approach this issue by considering the **rights** (Hyperlink Heading: 'Children's Rights') that children have regarding health, and examining how these rights are abused in relation to HIV/AIDS.

4. Ways in which the effects of HIV/AIDS on the health of children can be reduced include effective HIV prevention; health education for children and caregivers; strengthening **nutrition** (Hyperlink Subsection: 'Nutrition and Access to Food') and food production; and improving **access to health services** (Hyperlink Subsection: 'Access to Health Care') in general and **antiretrovirals** (Hyperlink Subsection: 'Access to Treatment'), in particular.

Effects of HIV/AIDS

HIV/AIDS is having severe effects on the health and nutrition of children. In countries with severe HIV/AIDS epidemics, this is seen in increasing rates of under 5 mortality. In some other countries, with lower rates of infection, under 5 mortality rates have either not risen or fallen as a result of other factors.

HIV/AIDS affects the health of children in a number of different ways including:

- Directly, when **children themselves are infected with HIV** (Hyperlink Section: 'Children living with HIV/AIDS').

- By making children more vulnerable to other infections. For example, children, in general, are more vulnerable to tuberculosis as a result of

HIV/AIDS because of greater exposure to the disease. Children living with HIV/AIDS are more vulnerable to tuberculosis because of reduced immunity.

- Through the impoverishing effects of HIV/AIDS. One of the **impacts** of HIV/AIDS on children, their families and communities is worsening poverty (Hyperlink Section: 'Situation'). This affects the health and nutrition of children in a number of ways. Families are less able to afford health care and other measures to prevent disease, such as the purchase of mosquito nets. In addition, poor people often have poorer nutrition, housing, hygiene and water. All these have effects on the health of children.

- Orphans and vulnerable children are more likely to be involved in work. Such **child labour** (Hyperlink Section: 'Child Labour') is often unregulated and may expose them to a variety of hazards, including chemicals and pesticides.

- Orphans and vulnerable children may be less able to **access health care** (Hyperlink Section: 'Access to Health Care') than other children due to a variety of reasons.

- HIV/AIDS has reduced the ability of health systems to cope and deliver services. This is because of the increased demand for services as a result of HIV/AIDS and the reduced ability to deliver services because of illness and death of health personnel.

- HIV/AIDS has negative effects on the growth and development of children. Causes of this include poverty and illness of the parent and/or the child.

Children's Health Rights

The **Convention on the Rights of the Child** (Hyperlink Heading: 'Children's Rights') includes specific rights regarding health. Examples of these include the right to medical confidentiality, the right to informed consent and the right to access to basic health care services. In many situations, orphans and vulnerable children do not enjoy the benefits of these rights.

Reducing the Effects of HIV/AIDS on Children's Health

There are many different ways in which the effects of HIV/AIDS on the health of children can be reduced. These include:

- By promoting effective methods to prevent the further spread of HIV/AIDS.

- Through health education of children and their caregivers.

- Through a variety of measures which **make health services more accessible** (Hyperlink Section: 'Access to Health Care') and appropriate for

children. Provision of effective health services for children's caregivers will also have effects on the health of children.

- Improving **access to treatment** with antiretroviral drugs (Hyperlink Subsection: 'Access to Treatment').

- Steps to improve children's nutrition, including initiatives to strengthen household food production.

3.1. All Children

This section looks at issues which affect the **health and nutrition** (3) of all orphans and vulnerable children. This is distinct from issues affecting **children living with HIV/AIDS** (3.2). More details are available in other sections on **nutrition** (3.1.1) and **access to health care** (3.1.2).

Key points about **health and nutrition** (3) are:

1. HIV/AIDS is having severe effects on the health and nutrition of children. In countries with severe HIV/AIDS epidemics, this is seen in increasing rates of under 5 mortality.

2. HIV/AIDS affects the health of children directly and indirectly.

3. It is possible to approach this issue by considering the **rights** (Hyperlink Heading: 'Children's Rights') that children have regarding health, and examining how these rights are abused in relation to HIV/AIDS.

4. Ways in which the effects of HIV/AIDS on the health of children can be reduced include effective HIV prevention; health education for children and caregivers; strengthening **nutrition** (Hyperlink Subsection: 'Nutrition and Access to Food') and food production; and improving **access to health services** (Hyperlink Subsection: 'Access to Health Care') in general and **antiretrovirals** (Hyperlink Subsection: 'Access to Treatment'), in particular.

More details on these key points are available in the section on **health and nutrition** (3).

Research from Zambia has shown that some children orphaned by HIV/AIDS are more at risk of problems with health and nutrition than others:

- Younger children are more at risk than older children.

- Children living in large families in rural areas are more at risk than those in smaller families. This may not be true in urban areas.

- Children in poor families are more at risk.

- Paternal orphans living with their mother are more at risk of health problems than maternal orphans living with their father. This stresses the need to consider **paternal orphans** (1.1) when working with orphans and vulnerable children.

3.1.1 Nutrition and Access to Food

This section looks at issues which affect the nutrition of orphans and vulnerable children and their access to food. Other sections cover general issues of **health and nutrition** (3.1) and details of **access to health care** (3.1.2).

Key points about nutrition are:

8. Good nutrition is essential for the physical growth and development of children. It is also necessary for full development of their immune system.

9. Certain groups of children are particularly vulnerable to nutrition problems. These include **young children** (3.1) and **children living with HIV/AIDS** (3.2).

10. Children's need for good nutrition starts before they are born. Children of different ages have different nutritional needs.

11. HIV is known to be transmitted from mother to child through breastfeeding. However, children are more at risk of other infections if they do not breast feed. Things to consider when a woman decides how to feed her baby include whether or not she knows her HIV status and whether or not she is able to safely feed her baby in another way.

Good nutrition is essential for the physical growth and development of children. It is also necessary for full development of their immune system.

Certain groups of children are particularly vulnerable to nutrition problems. These include **young children** (3.1) and **children living with HIV/AIDS** (3.2).

Children's need for good nutrition starts before they are born. Children of different ages have different nutritional needs. Young children are particularly at risk of problems with nutrition. For this reason, many of the documents focus on the nutrition of children under the age of five years. These children can also be broken down into groups, 0-6 months, 6-11 months, 12-23 months and 24 months to 5 years.

Issues to consider in the nutrition of children under the age of 5 include:

- **The role of breastfeeding**. It is well-known that breastfeeding is very good for children. It protects them against many diseases and greatly increases their chances of survival. However, it is known that breast milk can transmit HIV. Deciding on how to feed an infant can be very difficult for women because of HIV. This choice will depend on whether the woman knows if she is HIV positive and whether or not she can safely feed her baby in another

way. **Policy principles on infant feeding** (0000175e00) were agreed by leading UN agencies in 2002. Approaches to infant feeding form an important part of measures to prevent mother to child transmission (PMTCT) of HIV. However, there are other important steps which need to be taken, including preventing HIV infection in women, preventing unintended pregnancy and providing long-term support to women.

- **Other foods.** Children need other foods apart from breast milk from the age of 3-6 months. There is some evidence that exclusive breastfeeding before that time reduces the risk of transmission of HIV from an HIV positive mother. Children need a range of nutrients including those which provide energy and a range of 'micronutrients'. Important micronutrients include vitamin A, iron and vitamin C.

- **Feeding practices** can affect whether or not a child is well-nourished. A child should be provided with food they can digest on their own plate. Good hygiene is very important when preparing food for children. Particular care is needed to ensure that a child continues to receive nutrients when they are ill.

- **Access to food.** Many documents which talk about nutrition of children overlook a key problem. Many families do not have enough food throughout the year. They do not always have the right kinds of food. Ensuring children and families have enough food is important to ensure that orphans and vulnerable children are well-nourished. Community grain banks are one way in which communities can provide 'safety nets' for vulnerable children.

3.1.2 Access to Health Care

This section looks at issues which affect the access of orphans and vulnerable children to health care. Other sections cover general issues of **health and nutrition** (3.1) and details of **nutrition and access to food** (3.1.1). Many of the barriers to accessing health care are the same as those which prevent children from **accessing education** (4.2.1).

Key barriers to access to health care for orphans and vulnerable children are:

1. Lack of money
2. Distance to the health facility and availability of transport
3. Lack of time to seek health care
4. Negative attitudes and limited skills of some health workers
5. Lack of a family care giver
6. Lack of health knowledge among children and care givers

Money

Lack of money is a major reason why children fail to receive the health care they need. Money is often needed to pay to see a health worker, to get medicines and for transport to the health facility. Children and their care givers may lose income if they spend time seeking health care.

Distance to Health Facilities

Distance to the health facility affects access to health care. Children will need to spend more money and time on getting health care if their home is far away from the health facility. Availability of transport affects the degree to which distance is a barrier.

Time

Children and their care givers may lack the time they need to seek health care. This is particularly true if the child is acting as a care giver within the home. Adult care givers may have commitments to work, agriculture or the home which stop them taking a child to the health centre.

Health Workers

Children and their care givers may not use health services because they fear they will not be treated well by health workers. This may be because of negative attitudes among health workers. Health workers may also lack skills to deal effectively with orphans and vulnerable children. In some cases, people with HIV are not given treatment or are given a lower standard of treatment. There may also be fears that information about health will not remain confidential or that they will have to explain frequent trips for health care.

Care Givers

There may be other reasons why a parent or other adult care giver is unable to take a child for health care. For example, they may be ill themselves and unable to do this. Children in **child-headed households** (7.1.2) may have no adult to take them for health care. In some cases, adults may feel it is not worth spending time and resources on health care for children, particularly if they have HIV. Also, some adult guardians may prioritise the needs of their own child rather than others that they care for.

Knowledge

Care givers may lack the skills and knowledge on health issues. For example, they may not know when to take a child to a health centre. This may be a particular problem when the care giver is a grandparent or older child because much health education about children is targeted at mothers.

3.2 Children Living with HIV/AIDS

This section looks at health and nutrition issues which particularly affect children living with HIV/AIDS. More general issues of **health and nutrition** (3) and how they affect **all orphans and vulnerable children** (3.1) are covered in other sections. Other sections give more details on access to **antiretroviral treatment** (3.2.1) in children, **which drugs to use** (3.2.2) in children and **practical tips** (3.2.3) on how to give such treatment in children.

Key points about the health and nutrition of children living with HIV/AIDS are:

1. UNAIDS estimates that 1500 children per day are being infected with HIV globally.

2. Most HIV infection in children occurs through mother to child transmission (MTCT). Other routes of infection include through sexual activity and unsafe health practices.

3. It is difficult to test children under the age of 15-18 months for HIV. Children born to HIV positive women have HIV antibodies from their mother in their blood until this age.

4. HIV has serious effects on the health of children. They often grow poorly and are more at risk of infectious diseases. These are often more severe than in other children.

5. Without treatment, 60-75% of children with HIV die before the age of five years. With effective antiretroviral treatment, this figure can be reduced below 20%.

6. Children with HIV have a range of health needs in addition to access to antiretroviral treatment. These include immunization and prevention and early treatment of all infections.

In this section, the term children living with HIV/AIDS is used to mean HIV positive children. However, some documents use the term more broadly to describe **all children** (3.1) who are affected by HIV/AIDS.

UNAIDS estimates that 1500 children per day are being infected with HIV globally.

Routes of Transmission

Most HIV infection in children occurs through mother to child transmission (MTCT). This can occur during pregnancy, at the time of birth or through

breastfeeding (3.1.1). In developing countries, approximately one in every three children born to an HIV positive mother is themselves infected with HIV. In developed countries, less than one child in fifty born to an HIV positive mother is themselves infected. This is because of health practices including delivery by Caesarean Section, treatment with antiretroviral drugs and safe alternatives to breastfeeding. Children may also be infected with HIV through sex and unsafe health practices. **Sexual spread of HIV** (4.2.2) is most common in older children but can occur in younger children through **sexual abuse** (8.3). Unsafe health practices include use of non-sterile needles and unsafe blood products. These practices may also occur in the traditional health sector and include activities such as circumcision and ear piercing.

HIV Testing in Children

It is difficult to test children under the age of 15-18 months for HIV. Standard HIV tests detect antibodies to HIV. Children born to HIV positive women have HIV antibodies from their mother in their blood until this age. These are called maternal antibodies. In some cases, these maternal antibodies are found in the blood of children aged more than 18 months. It is possible to detect HIV directly. However, these tests are very expensive and not widely available in developing countries. The test used is the HIV DNA polymerase chain reaction (PCR). In the United States, children born to HIV positive mothers receive PCR tests at birth and again at 1-2 months and at 4-6 months. Two positive tests are taken as evidence of HIV infection. Two negative tests are evidence that the child does not have HIV infection. This can be confirmed using standard HIV antibody tests, which become negative after the age of about 18 months.

There are many issues to consider before testing a child for HIV:

- HIV testing should only be carried out if it brings some clear benefit to the child. For example, this might be if it results in better care and support.
- Counselling needs to be provided for children and their care givers. The counseling provided should be appropriate for the age of the child.
- HIV testing needs to be carried out in a way which ensures that results are kept confidential.

It is also possible to decide how severe a child's HIV infection is. This is done by assessing two factors:

- **Symptoms:** The presence and severity of symptoms can be used to assess how severe a child's infection is.
- **CD4 count:** CD4 cells are a particular type of white blood cell. They form part of the body's immune system. Tests which count these can show how well

the immune system is working. In children, age-adjusted tables need to be used for assessing CD4 counts. This is because there are more CD4 cells in the body at birth. These levels fall during childhood to reach adult levels at about 13 years of age.

Effects of HIV Infection on Children

HIV infection affects children in a number of ways:

- Children with HIV infection often fail to grow properly. This is sometimes referred to as failure to thrive.
- Children with HIV infection are more frequently affected by infectious diseases. These are often more severe than in other children.
- Without treatment, 60-75% of children with HIV die before the age of 5 years. With treatment with **antiretroviral drugs** (3.2.1), this figure can be reduced to about 20%.
- Children with HIV often face **stigma and discrimination** (8.2) as a result of their infection.

Other routes of infection include through sexual activity and unsafe health practices.

Health Needs of Children Living with HIV

Children with HIV have a variety of health needs. These include:

- **Treatment** (3.2.1) of their HIV infection.
- Medicines which can prevent common infections occurring. This is called prophylaxis.
- Early and effective treatment of common infections.
- Immunisation. Children with HIV/AIDS should receive immunizations in the same way as other children. These help protect the child against infectious diseases.
- Good nutrition
- Good hygiene
- A balance between exercise and rest

- **Psychosocial Support** (5) including care, comfort and counselling

3.2.1 Access to Treatment

This section looks at issues concerning the access of **children with HIV** (3.2) to effective treatment. Other sections look at **which antiretroviral drugs** (3.2.2) should be used and provide **practical treatment tips** (3.2.3).

Key points about access to treatment for HIV are:

1. Effective antiretroviral drugs have been available since 1996. Using several of these drugs together in combination has greatly increased survival of people with HIV in developed countries.

2. It is estimated that more than 6 million people in developing countries need antiretroviral treatment. However, only around 230 000 people receive this treatment.

3. One of the main barriers to treatment has been its cost. This has been particularly high because of the high costs of the drugs and the fact that a person needs to take several of these over a long period. However, prices of antiretroviral drugs have fallen dramatically since 2000.

4. There are other barriers to treatment in developing countries. These include the lack of sufficient health infrastructure, lack of sufficient trained staff and lack of national policies which promote antiretroviral treatment from a public health approach.

Access to Antiretroviral Drugs

Effective antiretroviral drugs have been available since 1996. Using several of these drugs together in combination has greatly increased survival of people with HIV in developed countries. These drugs do not 'cure' HIV. They do control the disease which means that people living with HIV live longer and have a better quality of life. They do have to be taken for life and can have severe side-effects.

Unfortunately, very few people in developing countries currently receive these drugs. It is estimated that more than 6 million people in developing countries need antiretroviral treatment. However, only around 230 000 people receive this treatment. Most of these live in one country, Brazil. The World Health Organisation has set a target that more than 3 million people in developing countries should be receiving these drugs by 2005.

Barriers to Access - Cost

The main barrier to access to this treatment has been its cost. This was estimated at $10-15 000 per year. This was not only because of the high cost of

the drugs but also because a person needs to take more than one drug for a long period. However, drug prices have fallen dramatically since 2000. Treatment may now cost as little as $350 per year. This has occurred for several reasons. These include:

- **Generic Production** – Many of the antiretroviral drugs that are available are produced by drug companies. These companies seek to protect their new drugs through a system of 'patents'. These patents are laws which prevent other companies 'copying' the drug. Drugs protected by patents are sometimes called proprietary drugs. Drugs that are not protected by patents are called 'generic'. Some countries (Brazil, India, Thailand) have produced 'generic' versions of antiretroviral drugs at much lower prices than the proprietary drugs. As a result of this competition, drug companies have greatly reduced prices of their proprietary drugs.

- **Differential Pricing/Discounting** – This involves companies selling their drugs at a lower price in developing countries than in developed ones. This only works if the markets can be kept separate. It relies on the good will of drug companies. They may only agree to this if countries agree to stricter rules on patents and other forms of 'intellectual protection'.

- **TRIPS Safeguards** – TRIPS (Trade-related aspects of Intellectual Property Rights) is one of the rules of the World Trade Organisation (WTO). Its aim is to ensure that rules on intellectual property rights are applied throughout the world. Many countries are currently able to produce and use generic antiretroviral drugs because their national laws do not recognise patents on these drugs. There is international pressure for countries to adopt the provisions of TRIPS which would make these patents apply in all countries. However, TRIPS allows for countries to overrule these patents when it is needed to promote 'public health'. This can be done through 'compulsory licencing' which allows a country to make or buy a generic version of a proprietary drug when it is needed for public health reasons. Buying such a generic drug from another country is called 'parallel importing'.

- **Regional/International Procurement** – Drug costs can be reduced when they are purchased in bulk. This can be done where countries purchase jointly with other countries in their region. International arrangements have been used for other medicines, such as vaccines. Currently, there is no international system for purchasing antiretroviral drugs.

- **Local Production through Voluntary Licencing** – This involves a country and a drug company agreeing to allow the drug to be manufactured in that country. This will require the transfer of technology from the drug company to the country.

- **Drug Donations** – These may improve short-term access to a drug. However, they may hinder changes needed to ensure these drugs remain available over time. They may stop countries producing their own medicines. In addition, such donations usually only benefit a few people in a few countries.

Other Barriers to Access

Other major barriers to access to antiretroviral drugs include the lack of health infrastructure and adequately trained staff in developing countries. This is particularly important with antiretroviral drugs because they are complex and difficult to take, it is difficult to select and monitor patients and there is a risk of resistance developing.

One major part of health infrastructure is the availability of laboratory facilities. The World Health Organisation has identified four levels of such facilities – minimum, basic, desirable and optional. The minimum level requires the ability to measure haemoglobin and to test for HIV antibodies. Currently, only the minimum level is required to be able to start antiretroviral treatment programmes.

Expanding Access to Treatment

The following steps will be helpful in expanding treatment with antiretroviral drugs:

- Starting small and gradually expanding.
- Securing additional resources so that funds are not diverted away from other parts of the health service.
- Adopting national policies which have a public health approach. These include having an agreed, simplified first line treatment regime and ensuring a continuous drug supply.
- Training health staff at all levels in how to provide this treatment.
- Ensuring that work is carried out in both public and private sectors.
- Developing a national system for monitoring drug resistance.

3.2.2 Which Drugs?

This section looks at issues affecting the choice of antiretroviral drugs to treat **children with HIV** (3.2). Other sections look at general issues regarding **access to treatment** (3.2.1) and provide **practical treatment tips** (3.2.3).

Key points about choosing antiretroviral drugs in children are:

1. There are many differences between children and adults regarding HIV infection and its treatment. Evidence is unclear about whether treatment of HIV in children is as effective as in adults.

2. Recommendations about when to start treatment differ between the United States and Europe. World Health Organisation guidelines for developing countries broadly follow European guidelines.

3. There are very many different antiretroviral drugs available. They are in three main categories – Nucleoside Reverse Transcriptase Inhibitors (NRTIs), Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) and Protease Inhibitors (PIs).

4. All treatment plans now use a combination of at least three drugs. These usually include two NRTIs and one from another group.

5. A wide range of issues need to be considered when deciding which drugs to use. Some of these are general while others apply particularly to children. It is helpful if a country has one combination of drugs which it uses for first treating people with HIV. This is called the primary regime. Other drug combinations may be needed for people who experience side-effects or do not respond to the primary treatment. These combinations are called secondary regimes.

6. Dosages for children are calculated either based on the surface area of a child or its weight. Special formulations of drugs are needed for children. Breaking tablets for children is not recommended.

7. Children who have TB should usually complete their TB treatment before starting treatment with antiretroviral drugs.

8. Cotrimoxazole should be given to all children born to HIV positive mothers in the first 6-12 months of life. This is to prevent pneumocystis pneumonia.

Differences between Adults and Children

There are many differences between children and adults regarding HIV infection and its treatment. Diagnosis of HIV infection is difficult in children under 18

months of age. This is because they still have **antibodies from their mother** (3.2) in their blood. It may be more difficult to measure disease progress in children using laboratory tests. This is because levels of viral load and CD4 cells are very different in children as compared to adults. Some studies have suggested that treatment of HIV in children is less effective than in adults. Other studies have shown that treatment of children is just as effective as in adults. This means that the current position is unclear.

When to Start Treatment

Recommendations about when to start treatment differ between the United States and Europe. World Health Organisation guidelines for developing countries broadly follow European guidelines. These are shown in the table below:

Child under 18 months of age who has had HIV infection confirmed by laboratory test (PCR)	WHO stage III disease OR WHO stage I or II disease with a CD4 percentage <20%
Child under 18 months of age who has not had HIV infection confirmed by laboratory test (PCR)	WHO stage III disease and CD4 percentage <20%
Child over the age of 18 months who has a positive HIV antibody test	WHO stage III disease OR WHO stage I or II disease with a CD4 percentage <15%

WHO Staging System

Stage I – Asymptomatic or generalised lymphadenopathy

Stage II – Unexplained, chronic diarrhea; severe or persistent candidiasis outside the neonatal period; weight loss or failure to thrive; persistent fever or recurrent severe bacterial infections

Stage III – AIDS-defining opportunistic infections, severe failure to thrive, progressive encephalopathy, malignancy or recurrent septicaemia/meningitis

In practice, this means that different approaches are needed depending on whether the child is over the age of 18 months. Under that age, it will probably not be possible to be sure that the child has HIV infection. In that case, treatment is only recommended for those who are very ill (stage III) and have evidence of damage to their immune system (CD4percentage <20%). If the child is over the age of 18 months, treatment should only be given to children who have had a positive antibody test. It can then be given to all those who are very ill (stage III)

and those who are less ill (stages I and II) but have evidence of a damaged immune system (CD4 percentage <15%).

Drug Types and Names

There are so many different antiretroviral drugs available that it can be very difficult to understand articles which describe ways in which they are use. Antiretroviral drugs have a variety of names:

- **Trade or Proprietary Name:** This is the name given to a particular version of a drug produced by a particular company. These names should not be used when describing or prescribing drugs. Some tablets contain more than one active drug. These drugs are often known by their trade names but it is better to describe them using their generic names or abbreviations.

- **Generic Name:** This is the name of the drug which is used by everyone that makes it. This is the name that should be used when describing the drug.

- **Abbreviations:** The generic names of most antiretroviral drugs are very long. This makes them hard to remember and use. Most of them have been given abbreviations which are made up of three letters or numbers. Some have more than one abbreviation. For example, AZT and ZDV both refer to Zidovudine.

Antiretroviral drugs can be grouped into three main types according to how they work. There are Nucleoside Reverse Transcriptase Inhibitors (NRTIs), Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) and Protease Inhibitors (PIs). A table showing the names of drugs in these categories is shown below:

NRTIs	Zidovudine (AZT/ZDV) Didanosine (ddI) Stavudine (d4T) Lamivudine (3TC) Zalcitabine (ddC)
Pis	Ritonavir Nelfinavir (NFV) Amprenavir Lopinavir (LPV) Indinavir (IDV) Saquinavir (SQV)
NNRTIs	Nevirapine (NVP) Efavirenz (EFZ) Abacavir (ABC) (In some papers this is grouped with NRTIs) Delavirdine

Combination Therapies

All treatment plans now use a combination of at least three drugs. These usually include two NRTIs and one from another group. There is now no place for treatment with one or two drugs only. Countries should develop their own policies on which drugs to use in primary and secondary treatment regimes. Where these exist they should be followed.

Factors to be considered in choosing drugs for the primary treatment regime include:

- Potency – that is the effectiveness or power of the drugs. For example, NNRTIs are not effective against HIV2.
- Side-effects
- Interactions with other drugs – for example Zidovudine and Stavudine can not be used together
- Potential for future treatment options
- Adherence – some drugs require precise timings and large numbers of tablets to be taken.
- Coexistent conditions
- Risks in children and pregnant women – for example, Efavirenz can not be taken in pregnancy or by children under the age of 3
- Risk of resistance
- Cost and other access issues
- Suitability of each drug for use in areas of limited health infrastructure
- Ease of transport – some drugs require storage in glass containers and/or refrigeration
- The existence of different groups and sub-types of HIV
- The availability of formulations suitable for small children, such as liquids. It is not recommended to break adult tablets for children.
- In the case of children, whether or not mothers have received antiretrovirals during pregnancy. Current evidence suggests that this does not need to be taken into account when choosing drug regimes

One primary treatment regime suggested by WHO is Zildovudine, Lamividine and Abacavir. Secondary treatment regimes usually use two different NRTIs and a drug from a different category. This would mean that if a PI is used in the primary treatment regime, an NNRTI would be used in the secondary regime. Secondary regimes are required for people whose disease does not respond to the primary regime and those who experience side effects from the primary regime.

Dosage of Antiretroviral Drugs in Children

It is important to calculate the dose of antiretroviral drugs accurately for children. Many documents advise doing this on the basis of surface area. However, it is not possible to measure a child's surface area directly. This has to be calculated from measurements of height and weight using formulae or charts. In some cases, dosages can be calculated from a child's weight. 'Drug tables' can assist with these calculations and help to avoid errors.

Other Issues

A few general issues are considered here:

- Children who have TB should usually complete their TB treatment before starting treatment with antiretroviral drugs. This is because of the risk of harmful interactions with the TB drug, Rifampicin.

- Cotrimoxazole can be used to prevent children with HIV becoming ill with pneumocystis pneumonia (PCP). This is called PCP prophylaxis. It is recommended in all children born to HIV positive mothers for 6-12 months.

- Work is currently being undertaken to integrate issues relating to HIV into the approach to childhood illness currently recommended by the World Health Organisation. This is called the integrated management of childhood illnesses (IMCI).

3.2.3 Practical Treatment Tips

This section looks at ways in which **children with HIV** (3.2) can be assisted to take their antiretroviral drugs properly. Other sections cover issues regarding **access to treatment** (3.2.1) and provide which **antiretroviral drugs** to use (3.2.3).

Key points about treatment with antiretroviral drugs in children in practice are:

1. If antiretroviral drugs are to work properly they need to be taken regularly and in certain ways. Taking drugs in the required way is called 'adherence' or 'compliance'.

2. There are many reasons why people fail to adhere to the treatment schedules.

3. There are a number of practical ways in which children can be helped to adhere to treatment schedules.

4. In addition to their medicines, sick children and adults require a great deal of care and comfort. Much of this is provided by family members in the home.

Why is Treatment Adherence so Important?

If antiretroviral drugs are to work properly they need to be taken regularly and in certain ways. Taking drugs in the required way is called 'adherence' or 'compliance'.

Problems with Taking Antiretroviral Medicines

There are many reasons why people fail to adhere to the treatment schedules. These include:

- Some medicines, such as Stavudine, Didanosine and Ritonavir need to be stored in a refrigerator.

- Some medicines need to be taken on an empty stomach. This means taking them either one hour before food or two hours after. These include Indinavir and Didanosine. In addition, these two drugs need to be taken one hour apart from each other. Some medicines need to be taken with food. These include Nelfinavir, Saquianvir and Lopinavir.

- Some medicines interact with each other. One may stop the other from working. They may also make side-effects more likely.

- Some medicines taste bad. Their taste can be improved by mixing with food, such as milk. Examples include Nelfinavir and Ritonavir.

- Some capsules are very large and difficult to swallow.

- It is difficult to remember to take a medicine several times a day every day. It may be difficult to fit this into schedules, such as going to school. Children may not wish to take medicines in public.

- Some medicines cause side-effects which make the child feel ill. They may not wish to take the medicine for this reason.

- It is difficult to calculate dosages based on surface area. It is easier to use weight. Dosages need to be increased as the child grows.

Some projects have lists of questions that adults can answer to check that a child is taking their medicines correctly.

Practical Ways of Improving Adherence

There are several practical ways of helping a child stick to their treatment schedule. These include:

- Producing a schedule for taking all the medicines. This should fit in with the family's schedule, including mealtimes.

- Finding ways of reminding children and their care givers when doses are due. This may include sticking the schedule somewhere that it can be easily seen. Alarm clocks and watches can be used to remind when doses are due.

- Having a way of recording when each dose has been given. This may include a version of the schedule with boxes that can be ticked.

- Coloured bottles to show which medicine is which.

- Special dosing cups, measuring spoons or oral syringes to help ensure that the right dose is given.

- Packing drugs into packages sufficient for one week. It is then possible to check at the end of the week that all medicines have been taken.

- Being positive and encouraging in dealing with the child.

- Ensuring that an adult is involved with the child in taking the medicine. This is particularly important for measuring the amount to be taken by small children.

Adults should also check that children have swallowed the medicine they have been given.

- Finding ways of improving the taste of some medicines. This may include mixing the medicine with something or taking something with a better taste after the medicine. Chilling a medicine may make it taste better.

- Involving the child in taking their own medicines. This is particularly important as the child gets older.

- Using medicines which can be given once per day rather than those that have to be given more often.

- Using dosage tables which show how to calculate the dosage of medicines from the weight of the child.

- Discussing any possible side-effects of the medicines with health staff.

- Informing health staff of any problems in taking the medicines. This includes informing them of any missed doses.

Care and Comfort

In addition to their medicines, sick children and adults require a great deal of care and comfort. Much of this is provided by family members in the home. Elements of care and comfort include:

- Listening, talking and touching
- Dealing with past concerns
- Planning for the future
- Providing water and food
- Washing
- Changing the person's position in bed. Rubbing Vaseline on the skin
- Encouraging rest and exercise
- Avoiding getting or spreading any infections
- Treatment of common diseases, such as diarrhoea
- Taking to a clinic

- Buying medicines and assisting the person to take them

4 Education

This section looks at education issues which affect orphans and vulnerable children. Other sections look in more detail at issues relating to **early childhood development** (4.1) and **school age children** (4.2).

Key points about education and orphans and vulnerable children are:

1. Education is vital to the development of children in a number of ways.

2. HIV/AIDS is having serious effects on the education sector. Many teachers are sick or have died. The cost of education is also increasing because of the need to train more teachers.

3. Orphans and vulnerable children, particularly girls, may miss out on educational opportunities. They may also not perform to their full educational potential. They may also face **stigma and discrimination** (8.2) in school.

4. The **Convention on the Rights of the Child** (8) has many implications for education. Relevant rights include the rights to equality, basic education, privacy, an environment that promoted health and access to information.

Importance of Education

Education is vital to the development of children in a number of ways. It aids their psychosocial development. It is vital for their future opportunities. It helps reduce their risks and vulnerabilities. For example, it can contribute to reducing their risks of contracting HIV infection.

Effects of HIV/AIDS on the Education Sector

Documents in this section do not all agree on the effects of HIV on the education sector. Some claim that it is having severe effects. The effects that are claimed occur because of the level of HIV infection among teachers. This leads to increased absenteeism through ill-health and attending funerals. This affects the quality of education provided. As teachers die of AIDS, this reduces the number of teachers available. It also increases the cost of education because of the need to train more staff to replace those that have died. Some argue that teachers should be a priority for receiving treatment with antiretroviral drugs because of the important role they play in providing education to children.

Others claim that there is little real evidence of these effects in studies which have been done to document the consequences of HIV/AIDS on the education sector. They argue that the number of teachers needed is declining because of a decline in the number of learners in school.

Effects of HIV/AIDS on Children's Education

Orphans and vulnerable children, particularly girls, may miss out on educational opportunities. Reasons for this are considered in more detail in a section which explores issues of **access to education** (4.2.1). They may also not perform to their full educational potential. They may also face **stigma and discrimination** (8.2) in school.

Children's Education Rights

The **Convention on the Rights of the Child** (8) has many implications for education. Relevant rights include the rights to equality, basic education, privacy, an environment that promoted health and access to information.

4.1 Early Childhood Development

This section looks at issues related to HIV/AIDS that affect early childhood development. Another section looks in general at issues relating to **education** (4). Another section looks in more detail at issues relating to **school age children** (4.2).

Early childhood is a period during which children learn and develop extremely rapidly. This development depends on a number of key factors including health, education, stimulation and interaction. Interventions at this stage have been shown to have great benefits for children including:

- Higher intelligence scores
- Higher and timelier school enrollment
- Less grade repetition and lower dropout rates
- Higher school completion rates
- Improved nutrition and health status
- Improved social and emotional behavior
- Improved parent-child relationship
- Increased earning potential and economic self-sufficiency as an adult
- Increased female labor force participation

At a conference on Early Childhood Development in 2001, it was agreed that HIV/AIDS was having serious effects on young children's development. However, it was agreed that relatively little was known about this because of the tendency to focus on children between 0-18 years of age as one group.

4.2 School Age Children

This section looks at the **education** (4) of orphans and vulnerable children of school age. Anther sections looks at issues affecting **younger children** (4.1). Other sections look in detail at **access to education** (4.2.1), **HIV/AIDS and life skills education** (4.2.2) and the **role of schools** (4.2.3).

Key points about education and orphans and vulnerable children are:

1. Education is vital to the development of children in a number of ways.

2. HIV/AIDS is having serious effects on the education sector. Many teachers are sick or have died. The cost of education is also increasing because of the need to train more teachers.

3. Orphans and vulnerable children, particularly girls, may miss out on educational opportunities. They may also not perform to their full educational potential. They may also face **stigma and discrimination** (8.2) in school.

4. The **Convention on the Rights of the Child** (8) has many implications for education. Relevant rights include the rights to equality, basic education, privacy, an environment that promoted health and access to information.

More details on these key points are available in the section on **education** (4).

4.2.1 Access to Education

This section looks at issues which affect the access of orphans and vulnerable children to **education** (4). Issues of access particularly affect **school age children** (4.2). Other sections cover issues regarding **HIV/AIDS and life skills education** (4.2.2) and the **role of schools** (4.2.3). Many of the barriers to accessing education are the same as those which prevent children from **accessing health care** (3.1.2).

Key points about the access of orphans and vulnerable children to education are:

1. Barriers to education are similar those which prevent **access to health care**. They include lack of money, involvement of children in household duties, **stigma and discrimination** (8.2), reduced education provision and quality, low value placed on education by some families and the fear of infection.

2. There are a wide range of initiatives which have been tried to improve the access of orphans and vulnerable children to education. These include reducing costs, changing the way education is provided, increasing access to education in other ways and improving educational quality.

3. A number of key principles have been established regarding access to education. These are based on lessons learned from practical experience.

Barriers to Access to Education

Things which prevent orphans and vulnerable children gaining access to education include:

- **Cost of Education** – Many poor families are unable to send their children to school because of the costs involved. These may be direct costs, such as school fees. They may also be indirect expenses, such as cost of uniform, school supplies, transport and food.

- **Household Duties** – Many orphans and vulnerable children are expected to spend considerable time in household duties. This may involve care for sick adults and younger children. It may also involve contributions to household livelihood. For example, this might involve agricultural or wage labour. In some cases, children may be withdrawn from school to do such duties. This withdrawal may be short or long-term. Girls are affected more than boys.

- **Stigma and Discrimination** (8.2) – Orphans and other vulnerable children may experience stigma and discrimination in school. This may result in them not attending school.

- **Reduced Education Quality and Provision** – HIV/AIDS is seriously affecting the **education sector** (4) in severely-affected countries. Some teachers are ill and dying from AIDS. This may be reducing the number of teachers available to school and the quality of education provided by those schools.

- **Some Families do not Value Education** – Some families may not see education as a priority, particularly for girls and children with HIV. In many cases, this is because they see survival needs as of higher priority.

- **Fear of infection** – This is particularly the case for children with HIV/AIDS. However, children with HIV/AIDS are able to attend school normally.

Action to Improve Access to Education

Many activities have been introduced which seek to try to improve the access of orphans and vulnerable children to education. These include:

- **Reducing school-related costs** – There are various ways of doing this. These include eliminating school fees or meeting them in a different way. They also include subsidising other expenses or providing in-kind support to schools that admit orphans and vulnerable children. An example of such in-kind support would be providing World Food Programme rations to children through school.

- **Changing the way education is provided** through community schools, interactive radio education and vocational training centres.

- **Increasing access indirectly** – This might involve **strengthening the economic position** (6) of orphans and vulnerable children through **microfinance** (6.1.3). This would make them more able to pay. Other indirect methods include **local advocacy** (2.2.1) and building the capacity of community care coalitions.

- **Improving Educational Quality** – This might involve adapting curricula to make them more relevant to orphans and vulnerable children, training teachers in meeting children's **psychosocial needs** (5) and in using community-based volunteers to support the work of teachers.

Key Principles

Key principles for increasing access to education include:

- Targeting all vulnerable children in an area, not just those affected by AIDS.
- Creating affordable schooling.
- Giving priority to non-formal education as well as formal education.

- Activities which are based on community need and community participation.
- Increasing management capacity at both national and community level.
- Linking short-term relief to longer-term policies.
- Ensuring safety at school for girls.
- Ensuring that increasing access to education also increases quality.
- Evaluating what works and what doesn't and sharing this information.

4.2.2 HIV/AIDS Awareness and Life Skills

This section looks at HIV/AIDS education for orphans and vulnerable children. This includes raising awareness about HIV/AIDS and practical training in life skills. Other sections focus in general on **education** (4) and **school age children** (4.2). Other sections cover issues regarding **access to education** (4.2.1) and the **role of schools** (4.2.3).

Key points about HIV/AIDS awareness and life skills for orphans and vulnerable children are:

1. Education about HIV/AIDS may take place in schools in several ways. It may be included in the curriculum or in extra-curricular activities, such as AIDS prevention clubs.

2. Information about HIV/AIDS is useful to children and young people. However, information alone is not enough to overcome the risk of HIV infection. Children and young people need to gain certain skills as well. These are called life skills.

3. Life skills training in schools can be seen as part of a range of activities which promote the health of children and young people.

4. A wide range of other activities may be used in schools to reduce vulnerability to HIV infection. Some of these reduce vulnerability indirectly.

HIV/AIDS Education in Schools

Education about HIV/AIDS may take place in schools in several ways. It may be included in the curriculum or in extra-curricular activities, such as AIDS prevention clubs. This education needs to start before children become sexually active. This means that it needs to start in primary school. Such education needs to be appropriate for the age of the child. Teachers require training in order to provide this education. This training needs to include use of participatory methods. Children also learn a great deal from each other. Approaches which use 'peer education' methods are based on this fact.

Life Skills

Information about HIV/AIDS is useful to children and young people. However, information alone is not enough to overcome the risk of HIV infection. Children and young people need to gain certain skills as well. These are called life skills. Training in life skills usually involves participatory ways of learning, such as using games. The aim of such training is to modify behaviour, not just to give knowledge. Areas covered in life skills training include negotiation skills,

assertiveness, coping with peer pressure, compassion, self-esteem, tolerance and social norms.

Health Promotion

Life skills training in schools can be seen as part of a range of activities which promote the health of children and young people. These include provision of health services, policy on health, nutrition, hygiene and sanitation, teaching and learning and a focus on using the school to promote health within the wider community.

School health promotion is defined as all means a school uses to become healthier and to spread health to those who attend and work in it and to their families and communities. It includes health education but is more than just this. It also includes:

- A safe and healthy environment
- Good nutrition practices
- Good school health services
- Joint health action between the school and the community

Other Measures

A wide range of other activities may be used in schools to reduce vulnerability to HIV infection. Some of these reduce vulnerability indirectly. These activities include:

- Education itself. Children who receive at least nine years of education are less vulnerable to sexual exploitation and HIV infection.
- Ensuring the quality of education and that it is relevant to local needs.
- Ensuring that girls have the same educational opportunities as boys.
- Making counselling available to children. Such counselling should be broader than HIV/AIDS and sexual health. It should include issues relating to problems in families and finding employment.
- Providing recreational and social services.
- Establishing monitoring systems to detect problems within schools. These problems include sexual abuse and the coercion of children and young people into commercial sex activities.

- Developing supportive policies, such as those which promote **children's rights** (8).

4.2.3 Strengthening Roles of Schools

This section looks at the various roles schools can play for orphans and vulnerable children. Other sections focus in general on **education** (4) and **school age children** (4.2). Other sections cover detailed issues regarding **access to education** (4.2.1) and **HIV/AIDS awareness and life skills** (4.2.2).

Key roles which schools can play include:

1. Providing children with **education** (4) in general.

2. Providing children with education about HIV/AIDS in particular and training in **life skills** (4.2.2).

3. Developing **resiliency** (5.1.2) in children. Schools have been identified as a key place where this happens.

4. Activities which promote **health** (3).

5. Promoting and modeling a supportive and caring environment for orphans and vulnerable children. This involves, in particular, tackling **stigma and discrimination** (8.2).

6. Providing practical support for orphans and vulnerable children. Schools are well-placed to do this because of their daily contact with children who attend. Teachers and other school staff need to be aware of sources of further support for children.

7. Exerting influence in the local community. In many situations, teachers occupy a position of great respect in a community. This gives them influence to promote education and health within the community.

8. As a workplace for teachers. Many businesses are carrying out activities to prevent the spread of HIV/AIDS among their work force. This can also be done in schools.

5 Psychosocial Support

This section looks at general issues regarding psychosocial support for orphans and vulnerable children. Other sections look in more detail at the **psychosocial effects of HIV/AIDS** (5.1) and various **responses** (5.2) to these.

Key points about psychosocial support for orphans and vulnerable children are:

1. Activities that support orphans and vulnerable children need to do more than simply meet their physical needs. They also need to address their psychological needs and needs for social interaction. These are termed psychosocial needs.

2. HIV/AIDS has a wide range of **psychosocial effects** (5.1) on children.

3. There are several **important principles** (5.2) for responding effectively to the psychosocial needs of orphans and vulnerable children. These have been identified from practical experience.

4. One of the most important of these principles is that children are best cared for in their own communities. **Institutions** (7.3.3) are particularly poor at providing for children's psychosocial needs.

5. **Children living with HIV/AIDS** (3.2) may have particular psychosocial needs. Adults who provide care for orphans and vulnerable children also have psychosocial needs.

What is Psychosocial Support?

Psychosocial support has been defined as an ongoing process of meeting physical, emotional, social, mental and spiritual needs, all of which are considered essential elements of meaningful and positive human development. It goes beyond simply meeting children's physical needs. It places great emphasis on children's psychological and emotional needs, and their need for social interaction. Many programmes of support for orphans and vulnerable children have focused almost completely on their physical needs only. Programmes which aim to meet the psychosocial and physical needs of a child are called holistic.

Orphans and vulnerable children require psychosocial support because of the trauma and stress they have experienced. Trauma is an emotional shock that produces long-lasting, harmful effects on the individual. Parental illness and death are causes of emotional trauma for children. Stress is an emotional condition, experienced or felt when an individual has to cope with unsettling, frustrating or harmful situations. It is a disturbing sense of helplessness, which is uncomfortable and creates uncertainty and self-doubt. Psychosocial support aims to help children cope with emotional trauma and stress.

5.1 Psychosocial Effects of HIV/AIDS

This section looks at the psychosocial effects of HIV/AIDS on orphans and vulnerable children. Other sections look in general at the issue of **psychosocial support** (5), in more detail at the issue of **grief and bereavement** (5.1.1) and at the **resilience** (5.1.2) that many children have to cope with even the most difficult of circumstances.

Key psychosocial effects of HIV/AIDS on children are:

7. The effects of stress. Stress is an emotional condition, experienced or felt when an individual has to cope with unsettling, frustrating or harmful situations. It is a disturbing sense of helplessness, which is uncomfortable and creates uncertainty and self-doubt.

8. The effects of **parental death** (5.1.1).

9. Poor sense of identity. This particularly affects those children who are in **institutions** (7.3.3). They have no parent or adult relative who can help them develop their own identity, within their own culture.

10. Behavioral problems. Some children react to stress by becoming aggressive, withdrawing, taking drugs or drinking alcohol. These may be the way in which these children cope with the stress they are facing. These have been called 'negative defence mechanisms'.

11. Poor management of change. Parents assist their children to cope with changes that occur in their lives. Children without parents may lack this support, particularly if they have little contact with family or community members. This is particularly a problem for children living in **institutions** (7.3.3).

Stress

Stress is an emotional condition, experienced or felt when an individual has to cope with unsettling, frustrating or harmful situations. It is a disturbing sense of helplessness, which is uncomfortable and creates uncertainty and self-doubt. Different things cause stress. Some of them are called 'primary stress factors'. These include death or sickness of a parent. These may be made worse by other factors, such as loss of home, worsening poverty, dropping out of **school** (4), **stigma and discrimination** (8.2) and separation from brothers and sisters. These are called 'secondary stress factors'. Children who are stressed often feel anxious and lacking in confidence. They may have a low opinion of themselves. In some situations, children may become depressed. Depression is a deep sadness with long-term, harmful effects on a child's health and development.

Parental Death

In many societies, people believe that children should be protected from death because they are too young to understand what has happened. They may also believe that children quickly forget about their parents. Although children do react differently to the death of a parent, there are some feelings which children commonly experience. These include:

- Guilt – the child feels responsible for the parent's death
- Anger – this may be directed at the parent who died or a person who the child believes caused the death
- Sadness – this is a normal and natural reaction to the death of a parent

Effects on Other People

In addition to the psychosocial effects of HIV/AIDS on children, there are also effects on their **carers** (7.1). Adult carers may experience the feelings described above. **Children with HIV** (3.2) may be particularly vulnerable to psychosocial problems because of the additional stresses they face.

5.1.1 Grief and Bereavement

This section looks at issues relating to the grief and bereavement that children experience, particularly when a parent dies. This is one of the main **psychosocial effects of HIV/AIDS** (5.1) on children. Another section looks at the **resilience** (5.1.2) that many children have to cope with even the most difficult of circumstances.

Key points regarding grief and bereavement in children are:

1. Grief is the emotional response/feelings to an event that affects a person, usually the loss of a person, thing or idea. Grief is a normal emotional response to loss.

2. Children may experience a wide range of feelings as part of their grief. These include anxiety, fear and guilt. Initially, they may not accept or understand the permanence of the loss. The feelings involved with grief may cause physical problems for the child, such as feeling physical pain.

3. The ways children respond to loss and express their grief varies depending on age.

4. There are many ways of assisting a child who is grieving. These need to be appropriate for the age of the child.

Accompanying a Grieving Child

An adult who seeks to accompany a child through their grief needs to have understood the way they feel themselves about grief and loss in their own lives. They need to be able to listen and speak to children in a way which is appropriate for the age of the child. It is helpful for children to be able to talk about the loss they have experienced. This will involve talking about death in situations where a parent has died. Children should be allowed to express emotions in these situations. Creative media, such as drawing, writing, telling stories, games, drama, music and sports are all useful ways of expressing feelings. Children may be better able to deal with their grief if they are prepared for the death of their parent and if they are allowed to participate in rituals related to death, such as funerals.

5.1.2 Resiliency

This section looks at issues relating to resiliency in children. Other sections look at the **psychosocial effects of HIV/AIDS** (5.1) on children and the specific issue of **grief and bereavement** (5.1.1).

Key points regarding resiliency in children:

1. Resiliency is the ability to cope with adversity. Children are naturally extremely resilient and able to cope with very difficult circumstances.

2. Resilient children have the ability to understand an adverse event. They believe they can cope because they have some control over what happens. They are able to give deeper meaning to the adverse event.

3. Resiliency comes from what the child has, who the child is and what the child can do. The first of these is called external resources. The second and third are internal resources.

4. It is possible to build resiliency in children in a number of different ways. These either increase a child's internal or external resources.

5. Key places where a child develops resiliency are in the family and at **school** (4.2.3).

What is Resiliency?

Resiliency has been described as...

... the human capacity to face, overcome and be strengthened by or even transformed by the adversities of life
... the universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity
... the ability to bounce back
... the ability to cope with life's adversities

In many ways, it is the opposite of vulnerable. Vulnerable children are less able to cope with problems they face in life. Resilient children are more able to cope.

Resilient children understand adverse events. They believe they can cope because they have some control over what happens. They are able to give deeper meaning to the adverse event.

Where does Resiliency Come From?

Resiliency comes from a child's external and internal resources. Their external resources consist of what they have. Their internal resources consist of who they are and what they can do.

A child has:

- People that they trust.
- Structures and boundaries for their safety.
- People who set examples of how to behave. These are called role models.
- Encouragement to do things on their own. This is called being autonomous.
- **Access to health** (3.1.2), **education** (4.2.1) and social welfare services.

A child has a sense of who they are from how they are treated by other people. A child is more likely to be resilient if they:

- See themselves as lovable and appealing.
- Are able to do kind things for others and show concern.
- Are proud of themselves.
- Are able to take responsibility for what they do.
- Are filled with hope, faith and trust.

A child is more likely to be resilient if they can:

- Communicate.
- Solve problems.
- Manage feelings and impulses.
- Understand how other people are feeling.
- Establish trusting relationships.

Building Resiliency

Steps can be taken which actively build a child's resiliency. This is done by increasing the internal and external resources available to them. This may involve:

- Providing a safe, nurturing environment
- Spending time listening to and playing with the child
- Teaching a child how to communicate
- Allowing a child to make mistakes
- Involving the child in day to day activities and routines
- Praying with the child
- Trusting and valuing the child
- Using experiential learning in schools

The key places where children develop resiliency are in the family and at **school** (4 2 3).

5.2 Psychosocial Responses

This section looks at responses which can be taken to provide **psychosocial support** (5) to orphans and vulnerable children. Other sections look in detail at **counseling** (5.2.1), **succession planning** (5.2.2), **training in psychosocial support** (5.2.3) and **examples of psychosocial responses** (5.2.4).

Key principles in responding to the psychosocial needs of orphans and vulnerable children are:

1. All responses should be guided by the **UN Convention on the Rights of the Child** (8).

2. All responses should treat all children equally without **discrimination** (8.2).

3. Communications with children should be based on openness and truth.

4. Children need to be prepared for the death of a parent. This helps them understand what is happening. This means they can then cope better with **grief** (5.1.1) and loss.

5. Children are individuals. They respond differently and have individual psychosocial needs.

6. Early responses can prevent more serious problems occurring later.

7. Children should be allowed to **participate** (8.1) in decisions which affect their future.

8. Care of children is best provided in families and communities. **Institutions** (7.3.3) are very poor at meeting the psychosocial needs of children.

9. Responses need to focus on families as well as on individual children.

10. The community is an essential source of psychosocial support, Community members need to be involved in any response.

11. Monitoring of programmes is needed to see what works best. Research is also needed into the impact of HIV/AIDS on children and how children cope.

12. Responses need to focus on all children's needs, not only the physical. Such programmes are called holistic.

5.2.1 Counselling

This section looks at counselling orphans and vulnerable children. General principles to guide **psychosocial responses** (5.2) for these children are contained in another section. Other sections look in detail at **succession planning** (5.2.2), **training in psychosocial support** (5.2.3) and **examples of psychosocial responses** (5.2.4).

Key points about counselling children are:

1. The basic principles of counselling are the same as for counselling an adult. 8).

2. Counselling may be provided to children individually or as part of family counseling. Common situations which mean children need counseling include HIV testing, disclosure of HIV test results, death of a family member and **sexual abuse** (8.3).

3. Counselling a child requires a relationship to be established between the child and the counsellor. This is called 'joining'. Methods to do this depend on the age of the child.

4. Counselling children requires skills in talking and listening to children.

5. There are many tools which can be used to help communicate with children. These include drawing, telling stories, play and drama.

Principles of Counselling

Counselling aims to help people cope better with situations they are facing. This is true for counselling children too. This involves helping the child to cope with their emotions and feelings and to help them make positive choices and decisions. Doing this involves:

- Establishing a relationship with the child
- Helping the child tell their story
- Listening carefully
- Providing correct information
- Helping the child make informed decisions
- Helping the child recognise and build on their strengths
- Helping the child develop a positive attitude to life

It does not involve:

- Making decisions for the child

- Judging, interrogating, blaming, preaching, lecturing or arguing
- Making promises that you can not keep
- Imposing beliefs on a child

Types of Counselling

Counselling may be provided to children as individuals. This is called one-to-one counselling. Counselling may also be provided to a child as part of a family. This family counselling is a form of group counselling. Particular situations in which a child may need counseling include:

- When HIV testing of a child is being considered.
- When deciding who to tell about the result of an HIV test. Telling someone else the result of a test is called 'disclosure'. This happens particularly when an adult has had a positive HIV test. The adult needs to decide if they are going to tell their children the result. If they do so, they need to decide how best to do this.
- When someone close to the child is dying or has died.
- When it is suspected or known that a child has suffered **sexual abuse** (8.3).

Counselling Skills

If an adult wishes to counsel a child, they first need to establish a relationship with the child. This is called 'joining'. Methods for doing this depend on the age of the child. They are very different from methods used with adults. For example, for a child under 5 years of age, this may involve getting on the floor to play a game that they like.

Similarly, talking with and listening to children requires special skills and approaches. Other tools may be particularly useful in counselling children. These include telling stories, drawing, drama and games.

Other Issues

Adults providing counselling for children need to be aware of their own feelings towards issues which might come up in counselling a child. In addition, they should be aware of their own beliefs on culture, tradition, religion and gender. They should avoid imposing these on the child. They also need to be clear of rules regarding confidentiality. These should be made clear to the child in a way appropriate for their age. In many cases, counselling may reveal issues which require action. The counsellor may need to act on behalf of the child on some of these issues. This is a form of **local advocacy** (2.2.1).

5.2.2 Succession Planning

This section looks at the issue of succession planning. Succession planning is planning for what will happen to children after their parents have died. Other sections look in detail at **counselling** (5.2.1), **training in psychosocial support** (5.2.3) and **examples of psychosocial responses** (5.2.4).

Key points about succession planning are:

1. There are many problems when a parent dies. These are worse if there has been no planning.

2. There are many reasons why succession planning does not happen in developing countries.

3. Responses which focus on encouraging succession planning use a variety of methods, including the use of memory books and boxes.

4. Benefits of succession planning projects include increased appointment of guardians, improved disclosure of positive HIV test results to children and increased use of wills.

Problems of Poor Planning

There are many problems when a parent dies. These are worse if there has been no planning. These problems include:

- Children not understanding what has happened.

- Adults being unclear as to who will care for the children and act as their guardian

- Property being taken by relatives and others

Barriers to Succession Planning

There are many reasons why succession planning does not happen in developing countries. For example, wills can be a key tool in this planning. However, people rarely write wills in some developing countries. Reasons for this include:

- Belief that writing wills and preparing for death can cause death.

- The tradition that property is only distributed after death by senior people within the extended family.

- The tradition that women and young children can not inherit property.
- The tradition that wills are verbal not written.
- Limited knowledge and enforcement of laws.
- Limited literacy.
- Limited experience with legal issues among NGOs in rural areas.

Responses to Encourage Succession Planning

Projects may seek to encourage succession planning in a number of different ways, including:

- **Counselling** (5.2.1) HIV positive parents regarding telling their children about their test results.
- Creating memory books or boxes. These consist of a book or box which describes and remembers a person's life. They may focus on specific events or periods within a person's life. These are called 'windows'. These windows may be organized around a particular theme or 'plot'. Memory boxes may be used to hold important documents, such as birth certificates and wills.
- Support to appoint a standby guardian. This person will take on the responsibilities of a parent for a child if the parent is no longer able to do this.
- Training of guardians.
- Education on legal matters including practical support to write wills.
- Assistance with school fees and supplies.
- Training in ways of **generating income** (6.1) and funds to get activities started.
- Community sensitization on needs of AIDS-affected children. This forms part of the activities described under **local advocacy** (2.2.1).

Benefits

Projects which promote succession planning have had several benefits. These include:

- An increase in the number of guardians appointed before a parent dies

- An increase in the number of parents who tell their children the results of their HIV test. This is particularly true where children are over the age of 12 years.

- An increase in the number of wills written. However, in a project in Uganda the number of people who wrote wills remained very low, although it rose considerably from the level when the project started.

Experience has shown that a project has benefits beyond the area in which it operates. This is because people within the project area share the benefits with those outside the area.

5.2.3 Training in Psychosocial Support

This section looks at the issue of training people in how to provide **psychosocial support** (5) to orphans and vulnerable children. Another section looks in general at principles for responding to children's psychosocial needs. Other sections look in detail at **counselling** (5.2.1), **succession planning** 5.2.3) and **examples of psychosocial responses** (5.2.4).

Key points about training in this area are:

1. Training in providing psychosocial support is needed because psychosocial need is often overlooked by people working with orphans and vulnerable children. In addition, specific knowledge and skills are needed to work in this area.

2. Many different groups of people need this training. These include teachers, people who work with NGOs, people who work in communities and religious leaders.

3. Training in this area is best provided using participatory learning methods.

Training Content

The areas which need to be covered in such a training course include:

- Why psychosocial support is needed.
- Different meanings of what it means to be a child.
- How children experience **grief** (5.1.1).
- Important ideas and words used when describing psychosocial support. These include risk, vulnerability, stress, trauma, coping and **resilience** (5.1.2).
- Responses and the **principles** (5.2) underlying them.
- Facilitation of learning.
- **Monitoring and evaluation** (2.3.1).

5.2.4 Examples of Psychosocial Responses

This section presents examples of projects which are **responding to the psychosocial needs** (5.2) or orphans and vulnerable children. Other sections look in more detail at issues of **counselling** (5.2.1), **succession planning** (5.2.2) and **training in psychosocial support** (5.2.3). They are arranged by alphabetical order of name by which the project is commonly known. Another section has examples of **projects working with orphans and vulnerable children** (1.3.1) in other ways.

A variety of documents are included. They are of two main types:

- **Project descriptions** are used to explain what the project does and to promote its work. They may be written by someone from within the project or outside. They may include some analysis.

- **Reports of evaluations/reviews** are usually longer and more detailed documents. They are usually written by someone from outside the project and include considerable analysis, including a review of project strengths and weaknesses.

There are links to websites which give more detail of the work of particular projects or organisations.

6 Economic Strengthening

This section looks at ways in which the economic position of orphans and vulnerable children and their families can be strengthened. Details of specific **responses** (6.1) are presented in another section. Children are extremely **resilient** (5.1.2). They are able to cope with a wide range of difficult circumstances. However, in some situations, these efforts to cope may produce problems. Some of the **problems** (6.2) which may occur as a result of efforts to cope with the economic impact of HIV/AIDS are considered in another section.

The key point underlying the need for **responses focused on economic strengthening** (6.1) of orphans and vulnerable children is that HIV/AIDS increases poverty. It does this at several levels:

- National
- Community
- Private Sector
- Family

National

HIV/AIDS increases poverty at national level. This is seen in falling gross domestic product (GDP) and slower rises in human development index (HDI).

Community

HIV/AIDS fuels community poverty in different ways. It increases community expenses, for example on contributing to funeral costs. These and other community mechanisms which support families at times of difficult are called 'community safety nets'. These are being placed under strain by HIV/AIDS. HIV/AIDS is also causing other social changes. For example, illness and death of teachers and health workers is reducing access to these services. In addition, HIV/AIDS may be reducing the number of people who are available for wage labour. HIV/AIDS may also reduce the number of employers looking for this kind of worker.

Private Sector

HIV/AIDS is affecting private companies in a number of ways. It is increasing their costs and reducing their profitability. An example of increased costs includes the amount paid for funeral costs. The rate of absenteeism is high. Costs of training new staff have increased overall costs.

Family

HIV/AIDS affects the economic **situation of children** (1.2.1) in many ways. These ways include:

- Reducing income.
- Increasing family size. As the extended family absorbs more orphans, the size of family increases. This increases the financial burden on the family.
- Increasing costs, for example of medicines and funerals
- Sale of assets.

There are three general ways in which families try to respond to the economic trauma of death of a parent. First, they seek to respond in a way which is purely reversible. Secondly, they use methods which are more difficult to reverse, for example sale of assets. Finally, their actions become irreversible. This is termed destitution.

6.1 Economic Responses

This section looks at specific responses which can be used to improve the **economic situation** (6) of orphans and vulnerable children. Other sections look in more detail at **skills and vocational training** (6.1.1), **financial services for the very poor** (6.1.2), **agriculture** (6.1.3) and **specific examples of projects** (6.1.4).

The key points about responses to strengthen the economic situation of orphans and vulnerable children are:

1. It is important to be clear of the purpose of any activity before it is started. This means that the right tool can be used.

2. Some projects seek to strengthen household resources. This may be done in preparation for or after a crisis. **Financial services aimed at the very poor** (6.1.2) can be extremely useful in these situations.

3. Other projects seek to provide relief to households at times of crisis. Financial services aimed at the very poor are not appropriate in this situation. Community 'safety nets' are needed. These can be established in a variety of ways including community fundraising, mobilisation of savings and joint **agricultural activities** (6.1.3).

4. Providing financial services to the very poor requires special skills. It also requires a business-like approach. For these reasons, AIDS NGOs are often not able to run these services effectively. Partnerships with specialist microfinance institutions are more likely to be effective.

Why are Economic Strengthening Activities Needed?

It may seem obvious that such activities are needed because of the extreme poverty faced by many orphans and vulnerable children, their families and their communities. However, there are several reasons why such activities are needed. It is important to be clear about the purpose of a particular activity so that appropriate tools can be used. Reasons include:

- To strengthen the economic resources of a household. This may be needed after a crisis or to prepare for a crisis that might occur. This is called 'emergency preparedness'. **Financial services aimed at the very poor** (6.1.2) can be extremely helpful in these situations.

- To provide relief to the most vulnerable households at times of crisis. Financial services are not appropriate in this situation. This is because these

families are focused only on survival needs. They would not be able to use a loan, for example, for business services. Community 'safety nets' are needed.

- To assist communities to create funds which can be used as 'safety nets' for individuals at times of crisis. NGOs often try to establish group-run income generating activities for this purpose. These rarely succeed. More effective approaches are community fundraising and group saving schemes. **Communal agriculture activities** (6.1.3) may work, particularly where these have existed traditionally.

AIDS NGOs and Financial Services for the Very Poor

It has proved very difficult for AIDS NGOs to run **financial services for the very poor** (6.1.2). Reasons for this include:

- AIDS NGOs are mostly involved in social projects. These have very different aims and approaches from projects which provide financial services, which are based on business principles.

- The confusion which occurs if organisations give money or goods to people as grants and then try to introduce loans.

- The different skills which are required for social projects and financial services.

- Group-based income generating activities favoured by AIDS NGOs are rarely effective.

AIDS NGOs do have a useful role in activities which strengthen the economic situation of orphans and vulnerable children. This may include supporting community savings schemes, providing training and encouraging activities which build community solidarity as this is essential if community safety nets' are to work effectively. However, AIDS NGOs that wish to introduce financial services for the poor may wish to do this in partnership with an organisation with expertise in this area.

6.1.1 Skills and Vocational Training

This section looks at skills and vocational training for orphans and vulnerable children. Another section looks in general at **ways of responding** (6.1) to the economic problems faced by orphans and vulnerable children. Other sections look in more detail at other ways of responding, including **financial services for the very poor** (6.1.2) and **agriculture** (6.1.3). Another section gives **examples of various projects** (6.1.4).

The key points about skills and vocational training are:

1. There are many examples of projects in which NGOs are seeking to provide skills and vocational training for orphans and vulnerable children.

2. The purpose of such training should be very clear. If the intention is to prepare children and young people for work, the training must be appropriate for the market needs in the local area.

3. Training should be practical in nature and should ensure that people who complete the course are able to produce high quality products.

4. NGOs need to assess carefully whether providing such training is a priority for them and if they have the skills to do this well. In some cases, it may be better for NGOs working on HIV/AIDS to partner other organizations with more expertise in this area.

Project Examples

There are many examples of projects in which NGOs are seeking to provide skills and vocational training for orphans and vulnerable children. In many cases, these are a small part of overall activities which are often strongly focused on HIV/AIDS. Examples of areas where skills training might be provided include tailoring, brick laying, cobbling, carpentry, catering, art and design, adult literacy and computer skills.

Purpose of Training

Skills training many be offered for different reasons. For example, **life skills training** (4.2.2) is often strongly focused on HIV prevention. In general, vocational training aims to enable young people to find jobs or to gain income by running a small business. Often, these small businesses operate in the informal sector. However, these aims are often not clearly stated in the project documents. There may be a mixture of social and financial targets which makes it difficult to assess the success of the project.

Can AIDS NGOs Provide this Training?

AIDS NGOs are often very skilled at providing practical, participatory training which is very appropriate in this setting. However, they may lack the technical skills needed. This may result in people completing training without being able to produce quality products in the chosen field. In addition, AIDS NGOs often offer vocational training without assessing local markets. If such training is aimed at providing livelihoods for orphans and vulnerable children, it is essential that they either gain employment or can operate a small business on completing the course. This will only be possible if there is a gap in the market for the skills they have. In addition, to operate a small business they will need essential business skills. Vocational courses offered by AIDS NGOs may be lacking in this area. In addition, vocational training courses may be offered by AIDS NGOs but may not be their highest priority. This may mean they do not always get the attention they require.

Before starting courses of this nature, it may be worth asking the following questions:

- Are the skills being developed in this course needed? Are there other skills that are needed more?
- Will the training be of a high technical standard?
- Will people who complete the course be able to get jobs or run their own businesses?
- Will the course give them all the skills they need? (This may include 'how to apply for a job' or 'how to run a small business'.)
- Does the NGO have the skills to run this kind of training well?
- Is this training a priority to the NGO? Is it part of their mission?
- Are there other organizations who have more skills in this area who the AIDS NGO could work with?

6.1.2 Financial Services for the Very Poor

This section looks at the provision of financial services to the very poor. Another section looks in general at different **economic responses** (6.1) to benefit orphans and vulnerable children. Other sections look in detail at **skills and vocational training** (6.1.1), **agriculture** (6.1.3) and **specific examples of projects** (6.1.4).

The key points about providing financial services for the very poor are:

1. Experience has shown that financial services can be of immense benefit to poor people. These services can be run effectively and sustainably. Poor people are able to run small, informal businesses and to repay loans with interest.

2. A wide range of terms are used to describe these services. One of the commonest is 'microfinance'. Although this is often seen as mainly the provision of small loans ('microcredit'), it also includes activities which promote saving.

3. Providing financial services to the very poor requires special skills. It also requires a business-like approach. For these reasons, AIDS NGOs are often not able to run these services effectively. Partnerships with specialist microfinance institutions are more likely to be effective.

4. There are several questions which may need to be asked before starting to offer microfinance services. Checklists can be useful for this purpose.

Features of Financial Services for the Very Poor

Many poor people are engaged in activities to generate household income. These are in effect small businesses. They are usually highly informal in nature. They are sometimes called 'microenterprises' or 'income-generating activities'. Financial services for the very poor aim to strengthen these activities. This is in turn intended to improve their standard of living and to enable them to withstand financial shocks.

Experience of providing these financial services comes from many countries, including Bangladesh and Bolivia. These financial services include promotion of savings and provision of small loans. They are delivered near to where poor people live. This makes them accessible. They often benefit women in particular. They are usually run by specialist organisations. These bring together experience from NGOs and commercial banking. They are called 'microfinance institutions' or 'MFIs'.

One of the key activities of MFIs has been the provision of small loans to poor people ('microcredit'). MFIs charge interest on these loans. Interest rates are often higher than market rates. MFIs require 'security' on such loans. However, the types of security they will accept are quite varied. These include physical property, such as goats and chickens and monies saved. Security may also be provided by a group for loans to individual members. MFIs focus very strongly on ensuring high rates of loan repayment. They have incentives to ensure loans are repaid in full and on time. They have penalties for late payment.

Defining Terms

It is sometimes confusing reading documents about financial services for the very poor because of the number of different terms used. The most commonly used term is 'microfinance'. This has been defined as 'financial services for the very poor over the long-term through the establishment of self-sustaining indigenous institutions'. Other terms include:

- **Microenterprise Development** – This includes microfinance and activities to support business development. This includes training in running a business and establishing market linkages.

- **Microenterprises** – These are small, informal businesses. They may be operated by an individual or a group. They are also sometimes called income-generating activities.

- **Income-generating activities** – In the broadest sense, these are the same as microenterprises. However, amongst NGOs the term is widely used for activities which are aimed to increase the income of the organisation's target group. These activities may be run by individuals or, more commonly, by groups. Such group-based income-generating activities are rarely successful. Reasons include failure to clearly define objectives, lack of business skills, lack of market research, insufficient client base and problems of running income-generating activities as a group. Also, these activities are often targeted at people who are experiencing a financial crisis. This is an inappropriate approach.

- **Microfinance** – This has been defined above. These financial services have two main elements. These are savings and provision of small loans. Savings may be voluntary or compulsory. Compulsory saving means that people have to save a fixed amount per month to be part of a scheme. Some microfinance institutions also offer insurance services. These may provide money to clients in case of death or illness. They may also repay a loan if a person fails to pay the loan back.

- **Microcredit** – This is the credit element of microfinance only, that is, it does not include savings. Some documents refer to this element alone as microfinance. Level of loans vary from $50 to $50 000.

- **Rotating Savings and Credit Associations** – These are community groups which encourage group members to save regularly. Funds generated through saving may then be loaned to individual members. NGOs often encourage the formation of these groups. Although they make credit available within the group, this does not involve taking loans from microcredit associations.

Principles

Experience of providing financial services to the very poor has resulted in a number of key principles being identified. These are:

- Microfinance is not a universal solution in all settings.

- Microfinance will only work in areas where there is sufficient cash-based, market activity. This means that it may not work in some areas, where people live on what they grow and buy very little.

- Successful microfinance institutions run on business principles. They do not mix grants and loans. They expect loans to be repaid. AIDS NGOs are not good at doing this work. However, they can be involved through partnerships with microfinance institutions.

- Microfinance requires a large client base. This means that it will rarely work if it is limited to the clients of a particular NGO, for example, people living with HIV/AIDS. It is better to offer these services to all people in a community. In areas with a high prevalence of HIV, this will mean that people with HIV are involved.

- People who are running microenterprises require basic business skills. For example, they should be able to calculate the price to charge for goods they produce. Training may be required. This is part of microenterprise development.

- Group borrowing for group projects rarely succeeds.

- Lending for production of agricultural crops is very risky. Crops may fail or be eaten rather than sold. Many communities have previous experience which raises expectations that funds supplied for crops are grants that do not need to be repaid.

Checklist

It may be helpful to ask the following questions before starting to offer financial services in an area:

- Is the area's cash economy sufficient to support microcredit?
- Is the area stable? Wars or natural disaster increase the risk of loans not being repaid.
- Does the area have enough physical resources and access to market?
- Can all the things needed for the microenterprise be obtained easily?
- Are there enough clients? (600 has been suggested as a minimum.)
- Does local culture and tradition support this kind of activity, particularly by women?
- Can people who will be clients travel to market and for other reasons as needed?
- Can microfinance staff live there? Could they get to a bank easily? Would they be accepted by the community? Would a man be accepted to work with female clients?
- What else is currently happening for poor people in the area?
- Does the local leadership support the introduction of microfinance activities? Will they support measures to pursue bad debts?
- Are there sufficient community and household 'safety nets'? These are important to help people with loan repayments in case of unforeseen problems.
- Are potential clients able to meet their survival needs? If not, there is a risk of loans being used for these.
- Is sufficient labour available for the planned activities? Will this be the case if the key person is ill?
- Do the clients have sufficient skills to run a small business?
- Are clients clear of the difference between loans and gifts?

6.1.3 Agriculture

This section looks at issues relating to agriculture and orphans and vulnerable children/. Another section looks in general at **responses** (6.1) which can be used to improve the economic situation of orphans and vulnerable children. Other sections look in more detail at **skills and vocational training** (6.1.1), **financial services for the very poor** (6.1.2) and **specific examples of projects** (6.1.4).

The key points about agriculture and orphans and vulnerable children are:

1. HIV/AIDS is having serious effects on agriculture in severely-affected areas. These effects include loss of cash crops, increased reliance on subsistence farming and sale of assets.

2. Responses which prevent or reverse these changes can have significant economic benefits for households.

3. Ministries of Agriculture have a key role in supporting such responses.

Effects of HIV/AIDS on Agriculture

HIV/AIDS is having serious effects on agriculture in severely-affected areas. Families affected by HIV/AIDS commonly switch their agricultural efforts away from producing cash crops. They focus all their efforts on producing crops that they consume themselves. These crops are essential for survival. This type of agriculture is called 'subsistence farming'. If the situation worsens, they may seek to meet short-term economic needs by selling agricultural assets, such as livestock and farming tools.

Agricultural Responses to HIV/AIDS

These changes may enable a family to survive. However, they push the family into poverty and make it less able to cope with any further financial shocks. Responses which can prevent these changes from taking place or can reverse them when they have happened can strengthen families' economic situation.

Ministries of Agriculture

Most countries have a Ministry of Agriculture. However, very few of these ministries have been very involved in HIV/AIDS issues until recently. Reasons for this include:

- Failure to include Ministries of Agriculture in National AIDS Committees.

- Efforts by Ministries of Health to involve Ministry of Agriculture staff as extension health workers.

- The widespread view within Ministries of Agriculture that HIV/AIDS is a health issue.

However, these views are changing. This is because HIV/AIDS has affected Ministry of Agriculture staff directly and has also disrupted Ministry of Agriculture activities. Ministries of Agriculture are having to adjust to environments which have been severely affected by HIV/AIDS. For example, HIV/AIDS has reduced the availability and quality of agricultural labour.

6.1.4 Examples of Economic Strengthening Projects

This section presents examples of projects which are seeking to strengthen the economic situation of orphans and vulnerable children. Another section gives general information about **responses** (6.1) to the economic situation of orphans and vulnerable children. Other sections look in more detail at **skills and vocational training** (6.1.1), **financial services for the very poor** (6.1.2), and **agriculture** (6.1.3).

The documents included are mainly project descriptions. These describe what the project does and they promote its work. They may be written by someone from within the project or outside. They may include some analysis.

6.2 Problems of Economic Responses

This section looks at problems which orphans and vulnerable children may face because of **responses** (6.1) they make to cope with the **economic situation** (6) they face. Other sections look in more detail at the specific problems of **child labour** (6.2.1) and **economic and sexual exploitation** (6.2.2).

HIV/AIDS affects the economic position of children and their families. Parental illness and death reduces family income. Families spend more on **health** care (3). These changes make children and their families poorer. Children and their families respond to these changes in a number of ways. Some of these ways help to meet immediate, survival needs, such as for food but increase vulnerability in the long-term. Children without adult care are particularly affected. Examples of responses which increase children's long-term vulnerability include:

- Change in **farming practices** (6.1.3). These include the shift away from cash crops and sale of farm-related assets.
- Removal of children from **school** (4) to save money.
- Involvement of children in **child labour** (6.2.1).
- **Economic and sexual exploitation of children** (6.2.2).
- Children who seek to live and earn a living on the **street** (7.2.3).

6.2.1 Child Labour

This section looks at the issue of child labour and its links with HIV/AIDS. Children are being forced to work more as a result of HIV/AIDS. This is one of the **problems** (6.2) which occur as result of responses to the economic problems faced by orphans and vulnerable children. Another situation looks in detail at issues of **economic and sexual exploitation** (6.2.2).

Key points about child labour are:

1. Most societies expect children to do some form of work. This is particularly the case in developing countries. Children are expected to play a part in family work from an early age. Some tasks, such as herding of livestock are done almost exclusively by children.

2. The extent to which children are expected to work appears to be increasing in developing countries. Poverty, disasters and HIV/AIDS all increase the number of children working. Working children are also more vulnerable to being infected with HIV.

3. Some documents distinguish between child labour, which harms the child and child work, which does not.

4. Children carry out a wide-variety of work. Working children are vulnerable to exploitation and abuse. However, there are also benefits to children from working.

5. Worst forms of child labour include prostitution, slavery, trafficking of children, debt bondage and forced labour.

6. Effective responses will seek to empower children and to protect them from abuse and exploitation.

Child Work and Child Labour

Most societies expect children to do some form of work. This is particularly the case in developing countries. Children are expected to play a part in family work from an early age. Some tasks, such as herding of livestock are done almost exclusively by children.

Some documents, such as the **UN Convention on the Rights of the Child** (8), distinguish between child work and child labour. Child work is seen as activities which do not harm the child, whereas child labour does. However, other documents see both as forms of child labour. This section uses the term child labour to mean all forms of child work, not necessarily those that are harmful.

Much of the focus on the problems of child labour has been on paid work. However, this may not be helpful because unpaid child labour may harm the child. In fact, unpaid child labour may be more exploitative than paid labour.

HIV/AIDS and Child Labour

Until recently, there had been little direct research into the linkages between child labour and HIV/AIDS. However, this has been studied intensively in several countries in recent years. These studies show that the economic effects of HIV/AIDS are resulting in more children working. This is particularly true of children who have no adult to care for them. Other factors, such as poverty and disasters also increase child labour. Working children are also more vulnerable to contracting HIV infection.

Types of Child Labour

Children work in a wide variety of different areas. These include:

- Providing care within a family, for example to a sick adult relative.
- Domestic work – This may be paid or unpaid and provided wither to a relative or non-relative. This is sometimes referred to as a hidden form of child labour. This is because it is not easily visible and is rarely covered by campaigns on child labour. Most of the children involved in domestic work are girls.
- Different forms of **agriculture** (6.1.3) – including both commercial and subsistence farming.
- Selling items on the **street** (7.2.3).
- Transportation of goods.
- Work in warehouses and factories.
- Work in the fishing industry.
- Mining.
- Work in the military.
- Selling sex. This may involve very young children, for example from the age of 9 years.

Some forms of child labour may not always be harmful to a child, such as domestic work or agriculture. Whether or not harm occurs will depend on the

conditions the child works under. However, other forms of child labour such as working as a soldier or selling sex always risk harm to the child.

Harmful Effects of Child Labour

There are many harmful effects of child labour. These include:

- **Low pay**. Children are often paid much less for work done than adults, for example they may only receive one quarter of adult wages. There is also evidence that increased use of child labour reduces adult wages. This is because child labour increases competition for jobs directly and indirectly by enabling more women to work.

- **Long hours**. Some children are expected to work excessive hours, for example, up to 12-16 hours per day.

- **Loss of educational opportunities**. Many children who work either withdraw from school or find that their educational performance declines because of the work they are doing.

- **Physical harm**. Working children may experience physical harm in a number of ways. These include:
    - Increased risk of accidents – children often work in unregulated environments where little attention is paid to safety.
    - Assault – working children often experience violence in the workplace from adult staff and managers. Children working in the **street** (7.2.3) are also at risk of physical violence from police officers and other authority figures.
    - Violent theft – this is also a risk faced by street vendors.
    - Risk of illness from poor hygiene and exposure to bad weather.
    - Harmful effects of pesticides.

- **Sexual abuse**. This includes rape. Effects include unwanted pregnancy, sexually-transmitted infections and HIV infection. In one study in Kenya, one fifth of all girls, aged 6-8 years who were working reported having been sexually abused.

- **Extreme forms of abuse and exploitation**. These include prostitution, slavery, trafficking, debt bondage and forced labour.

In general, girls are more vulnerable to the harmful effects of child labour than boys.

Responses to Child Labour

Many of the responses to child labour have focused on introducing laws to make child labour illegal. Sanctions have then sometimes been applied to companies which break those laws. However, there are problems with this approach. These problems include:

- Failing to clearly distinguish between harmful and non-harmful forms of child labour.

- Failing to recognise the benefits to children and their families of working. These benefits include:
    - The financial contribution made by the child to individual and family livelihoods. These can be essential for survival.
    - Learning important skills for living and earning.
    - Improving education opportunities. This may be by making funds available or by working in a place where education is provided.
    - The pride and self-esteem felt by children because of the work they do.

- Failing to recognise the harmful effects of children not working, particularly in situations of extreme poverty.

- Rules and regulations are usually only able to be enforced in formal employment. This forces children to work in informal, unregulated work where they are more vulnerable. For example, children are not allowed to work in the formal mining sector. However, many children work in informal mines in appalling conditions.

- Laws which prevent children from working can be used by people in authority, such as the police, to harass and physically assault children who are working.

Consequently, it may be more effective to work in ways which recognise that children do work in most societies and that this is an essential survival mechanism in situations of poverty. Actions could then focus on:

- Targeting the most abusive and exploitative forms of child labour, such as child prostitution.

- Training children and finding other ways of protecting them from risk.

- Finding new ways of educating children who are working other than traditional schools.

- Supporting working children to speak and act for themselves through the formation of their own organisations and movements.

6.2.2 Economic and Sexual Exploitation of Children

This section looks at the issue of economic and sexual exploitation of children. This can be considered as one of the **problems** (6.2) which occur as a result of responses to the economic problems faced by orphans and vulnerable children. Another situation looks in detail at issues of **child labour** (6.2 1).

Key points about economic and social exploitation of children are:

1. Many forms of **child labour** (6.2.1) involve the economic exploitation of children. Some people regard all child labour as exploitative.

2. Sexual exploitation of children involves sexual abuse of children and payment of money to them or a third party.

3. Forms of sexual exploitation include sex tourism, child prostitution, child pornography, trafficking and early marriage.

4. Many factors make children more vulnerable to sexual exploitation. These include poverty, lack of education, low status of women, weak legislation, poor governance, HIV/AIDS, some cultures and traditions, demand for sexual services, the youth of much of the population in developing countries and increasing urbanisation.

7 Living Environments

This section looks at the different environments in which orphans and vulnerable children live. Other sections look in detail at **who provides care** (7.1) for these children, **particularly difficult situations** (7.2) in which they might live and **alternatives to care** (7.3) within the community/extended family.

Key points about the living environments for orphans and vulnerable children are:

1. Most orphans and vulnerable children in developing countries live in the local community with their extended families.

2. The capacity of the extended family to cope is being severely tested by HIV/AIDS. Signs of this include increasing numbers of children living and working on the **streets** (7.2.3) and the emergence of **child-headed households** (7.1.2).

The Extended Family

Most orphans and vulnerable children in developing countries live in the local community with their extended families. The way in which this is done varies from place to place. For example, in some places this is the responsibility of the father's family and in other places the mother's. It may vary depending on precise circumstances. In some situations, this care involves remarriage within the extended family.

There are many reasons why children may be cared for by their extended family rather than by their parents. Although parental illness and death is one of them, others include parents working, particularly as migrant labourers.

Strains on the Extended Family

HIV/AIDS is placing an increasing strain on the extended family in many communities. This is because:

- The number of children requiring care and support from the extended family has increased.

- HIV/AIDS increases poverty. Poverty makes extended families less able to cope with caring for additional children.

- The number of available adults to take on caring responsibilities has been reduced through illness and death. Much of the burden of care has always fallen on women. It is now particularly falling on the **very young** (7.1.2) and the **old** (7.1.1).

Some people argue that extended family structures are not as strong as they once were in many communities. Reasons for this include:

- Increasing adoption of 'Western' lifestyles, including the 'nuclear' family.
- The increasing number of people in developing countries living in cities.
- An increasing reliance on cash to buy things that are needed by the family.

Evidence for this is provided by the increasing number of children who are being cared for outside the extended family. This includes children living and working on the **street** (7.2.3) and those living in **child-headed households** (7.1.2).

Issues about Living Environments

Particular issues about living environments are:

- **Who provides care** (7.1) for orphans and vulnerable children in those environments?
- Some **children do not live with their extended family** (7.2) in a local community. The environments faced by these children can be very different and challenging. They include **commercial farms and other places of work** (7.2.1), **prisons and detention centres** (7.2.2), the **street** (7.2.3) and **situations of conflict** (7.2.4).
- Most countries have laws which allow the state to take over responsibility for the care of a child in particular situations. In these situations, the state may arrange for the child to be cared for outside of the extended family. These **alternate forms of care** (7.3) include **placement with another family** (7.3.1), **day centres and night shelters** (7.3.2) and **residential care** (7.3.3).

7.1 Carers

This section looks at issues relating to people who provide care for orphans and vulnerable children. It looks at who these people are and examines, in particular, the problems of stress and burnout. Other sections look, in general, at **environments in which children live** (7) and in detail at issues facing **older carers** (7.1.1) and **child-headed households** (7.1.2).

Key points about carers of orphans and vulnerable children are:

1. Most orphans and vulnerable children in developing countries are cared for by family members in the local community. These family members include surviving parents, **grandparents** (7.1.1), other adults and **brothers/sisters** (7.1.2). These people are a child's primary care givers.

2. Although men are often identified as a child's formal guardian, the burden of care falls mainly on women.

3. Primary care givers may receive support from a number of sources. These include **community-based volunteers** (2.2.2), professional staff and traditional healers.

4. Care givers may experience stress for a variety of reasons. In some situations, this stress gradually builds up until a person can no longer cope. Their physical and mental health, personal relationships and standards of care may all suffer. This is referred to as 'burnout'.

Carers of Orphans and Vulnerable Children

Most orphans and vulnerable children in developing countries are cared for by family members in the local community. These family members include surviving parents, **grandparents** (7.1.1), other adults and **brothers/sisters** (7.1.2). These people are a child's primary care givers.

A study in Uganda showed that orphans received care from a surviving parent in 50% of situations. Other carers were grandparents (35%), aunts/uncles (11%) and brothers/sisters (3%). Most of the brothers and sisters providing care were aged over 18 years but there was one situation where **care was being provided by a child** (7.1.2) under the age of 18 years.

Although many children are cared for by surviving parents, this is not automatically the case when one parent dies. Reasons why this might not be the case include:

- Cultural practices which lead to children being 'inherited' by one side of the family (often the father's) rather than by the surviving parent (usually the mother).

- The surviving parent remarrying and the new partner being unwilling to take on responsibility for the children. This is strongly influenced by cultural norms and practices.

- Better economic prospects for the child with the extended family.

- The surviving parent being unable to care for the children. A common reason for this relates to the parent's need to work.

Although men are often identified as a child's formal guardian, the burden of care falls mainly on women.

Primary care givers may receive support from a number of sources. These include **community-based volunteers** (2.2.2), professional staff and traditional healers.

Stress and Burnout

Care givers may experience stress for a variety of reasons. In some situations, this stress gradually builds up until a person can no longer cope. Their physical and mental health, personal relationships and standards of care may all suffer. This is referred to as 'burnout'. Primary care givers may experience stress and burnout, as well as volunteers and professional staff.

Signs of stress include:

- Physical symptoms, such as inability to sleep and bowel disturbances.

- Emotional problems including feelings of inadequacy, helplessness and guilt.

- Withdrawing from other people.

- Reduced quality of care.

- Worsening relationships with other people.

Stress is caused by a number of factors including:

- Poverty and its effects, including lack of resources to meet survival needs of both the child and carer. This includes lack of food and medicines.

- Interpersonal and family conflict. This is common within families affected by HIV/AIDS because the virus spreads mainly through sex. This often leads to people being blamed for 'bringing the virus into' the family.

- Isolation and fear for the future.

- Excessive workload.

- **Stigma and discrimination** (8.2) relating to HIV/AIDS.

- Excessive personal involvement in issues relating to the child.

- Poor organizational arrangements. This applies particularly to secondary care givers. Issues include lacking a voice in the way things are done, inadequate support and lack of clarity over roles.

Stress and burnout can be managed by developing personal coping mechanisms and organisational strategies. Religious faith may be important as part of personal coping mechanisms. Organisational strategies include:

- Recognising that caring is stressful and that stress and burnout are complex.

- Ways of dealing with problems that carers can not deal with.

- Finding ways of showing that carers are valued.

- Providing carers with training.

- Relieving poverty and ensuring that activities are reliably funded.

- Effective stress management measures including regular time off, realistic workload, team meetings and participation in decision-making.

7.1.1 Older Carers

This section looks at issues relating to older people who provide care for orphans and vulnerable children. Other sections look, in general, at issues facing **carers** (7.1) and in detail at **child-headed households** (7.1.2).

Key points about older people and HIV/AIDS are:

1. Older people are sexually active and vulnerable to being infected with HIV. They also take on much of the burden of caring for children and sick adults. Much of this burden falls on women.

2. Poverty is the main problem facing most older carers. Their income is often declining because of age. Their caring responsibilities mean they have less time available to generate income.

Older People and HIV/AIDS

Older people are sexually active and vulnerable to being infected with HIV. They also take on much of the burden of caring for children and sick adults. Much of this burden falls on women.

Poverty and Older Carers

Poverty is the main problem facing most older carers. Their income is often declining because of age. Their caring responsibilities mean they have less time available to generate income.

Other Issues

Other issues affecting older carers include:

- **Stigma and discrimination** (8.2) associated with HIV/AIDS. In some situations, older people have been accused of witchcraft because of this.

- Older people may be denied their rights. These rights include access to information and health care. They also involve being treated equally and fairly.

- Information about HIV/AIDS is rarely focused on older people.

- Research into HIV/AIDS and its effects often excludes older people.

7.1.2 Child-Headed Households

This section looks at issues relating to child-headed households. Other sections look, in general, at issues facing **carers** (7.1) and in detail at issues facing **older carers** (7.1.1).

Key points about child-headed households are:

1. A child-headed household is one which is led by a child under the age of 18. This child takes on responsibilities usually carried out by parents, including providing care to other children.

2. Child-headed households have been observed in parts of Africa which have been badly affected by AIDS. They are a new thing in those areas. The main cause of this change is the large number of young adults dying from AIDS.

3. Some documents state that child-headed households are evidence that the extended family system is collapsing and failing to cope. Evidence shows that most child-headed households receive support from their extended families. Child-headed households are one way in which the extended family is adapting to cope with problems produced by HIV/AIDS.

4. Child-headed households face a wide range of issues. The most pressing relate to survival needs and poverty.

5. Child-headed households can be helped to cope more effectively with modest levels of support. Effective support mechanisms include visits from community volunteers, modest levels of material support and training in effective parenting.

What are Child-Headed Households?

A child-headed household is one which is led by a child under the age of 18. This child takes on responsibilities usually carried out by parents, including providing care to other children. Children as young as 8 act as heads of such households.

The main event that leads to establishment of a child-headed household is the death of both parents. However, in some cases, one or both parents are still alive. Other events include parental illness or disability. In some cases, one or both parents have left the family home for some reason. The term is usually applied to households where the person heading it is not the parent. Although there are many documents about teenage pregnancy, this does not appear to have been identified as a factor in causing the establishment of child-headed households.

In many cases, the child-headed household was not established immediately at the time of parental death. Often, the children were cared for initially by a relative, often a grandparent. Only another event, such as the death of that care giver resulted in a child-headed household being established.

Child-headed households have mainly been observed in rural areas. This may be due to higher cost of living in urban areas and the more stable community structures in rural areas. Children do live unaccompanied by adults in urban areas but this is often not in any formal shelter. Such children are often referred to as **street children** (7.2.3).

In some cases, adults do live within households which are child-headed. However, they play no part in providing care for the household and do not contribute to its livelihood. This may be due, for example, to disability or illness. Such households are called 'accompanied' child-headed households. This is distinct from 'unaccompanied' households which have no adults in them.

Similarly, some authors identify 'adolescent-headed households'. These are defined as households headed by a person aged 18-24 years, who is not the biological parent. In many cases, child-headed households become adolescent-headed once the primary caregiver reaches 18 years of age.

Child-Headed Households and HIV/AIDS

Child-headed households have been observed in parts of Africa which have been badly affected by AIDS. They are a new thing in those areas. Most child-headed households are composed of families where both parents have died. Cause of death is not always known but HIV/AIDS is likely to be the cause in most cases.

It is widely stated that the creation of child-headed households is evidence that the extended family system is unable to cope with situations created by HIV/AIDS. However, evidence suggests that this might not be the case. Rather, child-headed households may be a mechanism used by extended families to cope with the situation. Evidence for this includes the following:

- Many child-headed households live close to their extended families. They are often visited by them. They may receive limited amounts of material support.

- In some situations, younger children (under 5 years) are taken to live with the extended family. The older children are kept together within a child-headed households.

Various reasons are given for children living in a child-headed household rather than with the extended family. This may be because no relative could be identified to take them. Alternatively, it may reflect the wishes of the parent and/or the children. Many parents and children prefer to live as a child-headed

household rather than to risk loss of the family home and other property. In addition, children often wish to stay together. This is not always possible if care of children is taken on by extended family members.

Issues faced by Child-Headed Households

Child-headed households face a wide range of issues. The most pressing relate to survival needs and poverty. Children in child-headed households need to work hard to care for each other and to earn a living. They may miss out on **education** (4) and **health care** (3). They have to cope with **grief** (5.1.1), **stigma and discrimination** (8.2) and may receive little support from the community.

Helpful Responses

Child-headed households can be helped to cope more effectively with modest levels of support. Effective support mechanisms include visits from community volunteers, modest levels of material support and training in effective parenting. Training in effective parenting involves learning:

- Skills in caring for sick people.
- About growing-up, including issues relating to sex, drugs and alcohol.
- Household management.
- Nutrition and cooking.
- First Aid.
- About laws and **human rights** (8).
- How to deal with conflict in families.
- How to record memories.
- How to encourage children to play.

7.2 Children Living Outside of Family Care

This section looks at situations where children are living outside the care of their extended family. Most children orphaned by HIV/AIDS live with their **extended family** (7). In this situation, **care** (7.1) is provided by a relative of one type or another.

However, some children live outside the care of their extended family. These include:

- Children living on **commercial farms** and at other workplaces (7.2.1).
- Children living in **prisons** and detention centres (7.2.2).
- Children living on **the street** (7.2.3).
- Children living in **situations of conflict** (7.2.4)

In addition, in some situations, responsibility for the care of children is taken on by the state. They may then be provided with **alternative forms of care** (7.3).

7.2.1 Commercial Farms and Other Workplaces

This section looks at the situation facing orphans and vulnerable children living on commercial farms. The experience is based largely on the work of Farm Orphans Support Trust (FOST) in Zimbabwe but lessons learned would be relevant to other workplaces which involve workers living at the workplace. Another section looks in general at issues facing children **living outside of family care** (7.2). Other sections look in detail at children living in **prisons** (7.2.2), on the **street** (7.2.3) and in **situations of conflict** (7.2.4).

Key points about orphans and vulnerable children living on commercial farms are:

1. Much of the experience comes from Zimbabwe, in general, and the work of Family Orphans Support Trust (FOST), in particular.

2. The nature of the 'community' of workers living and working on commercial farms makes children living there particularly vulnerable.

3. Orphans and vulnerable children on commercial farms face many of the same problems faced by other vulnerable children. However, they rarely have supportive contact with extended family members. This means they often lack the family and community safety nets available to other vulnerable children.

4. There are a range of appropriate responses which avoid the use of **institutions** (7.3.3). These include the use of farm-based volunteers and **non-relative foster carers** (7.3.1).

Communities of Farm Workers on Commercial Farms

There are many examples of forms of work which require large numbers of people and require them to live and work at the same place. One example of this which has been widely studied relates to commercial agriculture in Zimbabwe. Communities of workers on commercial farms have certain characteristics. These include:

- **Lack of sense of community** – workers on commercial farms lack a shared sense of history and belonging which is seen in other communities. They rarely have community structures for decision-making. This results in low levels of social organization.

- **Isolation** – because of distance and poor communications. Consequently, farm workers may be marginalized from political processes.

- **High mobility** – workers move from one farm to another.
- **Lack of extended family structures** – many workers originate from other countries originally and have lost links with their extended family.
- **Lack of personal identification documents** – such as **birth certificates** (8.4.1).
- **Unstable family groups** – are a feature of casual, temporary work. Informal and casual sexual relationships and early marriage are all features of farm life.
- **Poor access to facilities** for recreation, **health** (3.1.2) and **education** (4.2.1).

Orphans and Vulnerable Children on Commercial Farms

Orphans and vulnerable children on commercial farms face many of the same problems faced by other vulnerable children. However, they rarely have supportive contact with extended family members. This means they often lack the family and community safety nets available to other vulnerable children.

Problems which affect orphans and vulnerable children on commercial farms include:

- **Food insecurity** (3.1.1).
- Lack of **access to education** (4.2.1).
- The struggle to meet material needs.
- Lack of **psychosocial support** (5).
- Poor **life skills** (4.2.2) and knowledge.
- **Abuse and exploitation** (8.3).
- Lack of extended family network.
- Poor housing.
- Lack of secure tenure of housing. This means they do not own their house and can be asked to leave by the farm owner.
- Lack of **access to health care** (3.1.2).

- Lack of **birth certificates** (8.4.1).

- Involvement in **work** (6.2.2).

Appropriate Responses

In general, responses aimed at orphans and vulnerable children are broadly similar to responses in other settings. They are based on the same **principles** (2.2). This means that establishing **institutions** (7.3.3) is almost never appropriate. Because of the particular nature of communities on commercial farms, new and imaginative responses may be needed. Examples include:

- Working constructively with the farm owner.

- Seeking to establish community development structures on farms, such as farm development committees (FADCOs).

- Providing short-term material support to compensate for absent 'safety nets'. This may include provision of food and funds for school fees.

- Providing training in **psychosocial support** (5).

- Identifying and training volunteers from among farm workers. This may include using existing people, such as farm health workers (FHWs).

- **'Fostering'** children with non-related farm workers (7.3.1). There are often cultural taboos regarding taking responsibility for unrelated children. However, this can be overcome by regarding the children as household 'guests'.

- **Income-generating activities** (6).

- **Advocacy** (2.2.1) at local and national levels.

- **Succession planning** (5.2.2) and other activities focused on preparing for death.

7.2.2 Prisons and Detention Centres

This section looks at the situation facing orphans and vulnerable children living in prisons and detention centres. Another section looks in general at issues facing children **living outside of family care** (7.2). Other sections look in detail at children living on **commercial farms** (7.2.1), on the **street** (7.2.3) and in **situations of conflict** (7.2.4).

Although a great deal has been written about prisons and HIV/AIDS, relatively little appears to have been written specifically about children in this setting. Orphans and vulnerable children may be more likely to engage in illegal activities. In some cases, children carry out these activities to survive or generate a livelihood. This means that orphans and vulnerable children may be more likely to end up in prisons or detention centres.

Children in prison are particularly vulnerable. Children may live in a prison environment for a number of reasons. Young children may be there because their mother is in prison. Older children may be there because of offences they have committed themselves. Children in prison are vulnerable to **physical and sexual abuse** (8.3), particularly where facilities to keep them separate from adult prisoners are inadequate.

7.2.3 The Street

This section looks at issues relating to children living on the street. Another section looks in general at issues facing children **living outside of family care** (7.2). Other sections look in detail at children living on **commercial farms** (7.2.1), in **prisons** (7.2.2) and in **situations of conflict** (7.2.4).

Key points about 'street children' are:

- They are defined by the United Nations as children for whom the street has become their home and/or source of livelihood, and who are inadequately protected or supervised by responsible adults.
- They are mostly boys. Girls are more likely to become involved in domestic work or selling sex.
- There are 'push' and 'pull' factors which cause children to be on the street. Parental death due to HIV/AIDS is an increasingly important 'push' factor.
- Street children are vulnerable to many problems. They are particularly vulnerable to HIV infection as a result of survival and commercial sex.
- There are many examples of programmes which are working effectively with street children. Key principles have been developed from that work.

Street Children: Who are They?

The United Nations defines street children as girls and boys for whom the street has become their home and/or source of livelihood, and who are inadequately protected or supervised by responsible adults. This is a broad definition. It includes homeless children who live on the street. It also includes children who earn their livelihood by working on the streets. It does not include children who live on the street with their families.

The number of street children are increasing in many cities around the world. They are mainly seen in cities and are said to be one feature of the increasing number of people moving to cities from rural areas.

Most street children are boys. Girls are also affected by the same things that cause boys to move to the streets. However, they are more likely to become domestic workers or commercial sex workers. In many cases, both these kinds of work amount to a type of slavery. Girls working as domestic workers are often sexually abused. Girls living and working on the street are particularly vulnerable to sexual abuse.

Why do Children Move to the Street?

In many cases, children choose to move from a rural area to the city and then find themselves living on the street because they are unable to live elsewhere. Reasons for such rural-urban movement can be categorised as 'push' and 'pull' factors.

Factors which 'push' children away from the rural areas include:

- Poverty and lack of economic opportunity.
- Rural underdevelopment.
- Hardships and uncertainties of subsistence farming.
- Abuse, violence and family break-up. Many children report problems with step-mothers as a major factor in their decision to leave home.
- Parental death – many children living on the street are 'double orphans'. In some cases, these children were first taken in by an adult relative who then themselves died. This reason and others provide a link between street children in cities and **child-headed households** (7.1.2) in rural areas. Factors causing children to live on the street in cities are also causing them to live as child-headed households in rural areas.

Factors which pull children towards cities include:

- Improved job opportunities.
- Leisure and entertainment.
- Reports from peers of positive experiences.
- A sense of adventure.

Problems of the Street

Street children face a wide range of problems on the street. These include:

- Work-related problems – long hours, low pay and dangerous conditions.
- Poor diet.
- Lack of shelter – poor hygiene and overcrowding.
- Poor **access to health care** (3.1.2) and **education** (4.2.1).

- Harassment from the authorities, adults and other children. Street children are often in conflict with the law. They risk arrest and imprisonment.

- Sexual abuse. They may engage in sexual activities for money or simply to survive. They are vulnerable to sexually transmitted infections, including HIV.

- Substance use – including glue sniffing, illegal drugs and alcohol.

Appropriate Responses

Programmes which aim to work with street children should be focused on the child's 'best interests'. This means starting working with them where they are and not trying to force them to leave the streets. In some places, authorities have introduced activities which are focused strongly on children leaving the street. These are usually motivated by factors other than the best interest of the child, such as civic/political pressure to 'clean up' the streets.

Appropriate activities may assist them to find alternatives to life on the street. Equally, they may assist them to remain safe while on the street. Key features of appropriate activities for children living on the street include:

- Establishing a sense of trust with the children. Many street children mistrust adults, particularly those in authority. Overcoming this mistrust is essential for an effective programme and for the children to be more integrated in the community.

- Building skills which enable children to earn a living or enter the labour market.

- Imaginative ways of providing **education** (4) and **health care** (3) for street children.

- Advocating on behalf of street children with those in authority. This may be done at national level. However, it is particularly needed at **local level** (2.2.1). For example, programmes working with street children will need to engage with police officers in the area to try to encourage a more supportive approach to street children.

- Ensuring that street children **participate** (8.1) in design of programmes. They should also participate in decisions which affect them.

- Reducing their vulnerability and risk to sexual abuse and its consequences.

- Working with families, the community and other organisations.

- Seeking to address the reasons why children move to the streets.

7.2.4 Situations of Conflict

This section looks at issues relating to children living in situations of conflict. Another section looks in general at issues facing children **living outside of family care** (7.2). Other sections look in detail at children living on **commercial farms** (7.2.1), in **prisons** (7.2.2) and on the **street** (7.2.3).

Key points about children living in situations of conflict are:

- Conflict and HIV/AIDS have been called a double emergency for children. When they occur together, they increase children's vulnerability through causing parental death and by damaging families and communities that protect and care for children.
- Conflict increases vulnerability to the spread of HIV/AIDS.
- Effective responses require training of armed forces and humanitarian staff in how to deal more constructively with children and how to prevent the spread of HIV/AIDS.
- Efforts to provide care for children should focus on reuniting families and rebuilding communities and not on establishing **institutions** (7.3.3).

HIV/AIDS and Conflict – A Double Emergency

Conflict and HIV/AIDS have been called a double emergency for children. When they occur together, they increase children's vulnerability through causing parental death and by damaging families and communities that protect and care for children. Of the 17 countries with more than 100 000 children orphaned by HIV/AIDS, 13 are affected by conflict.

War Spreads HIV

People living in areas affected by conflict are more vulnerable to HIV. Reasons for this include:

- Community disintegration.
- Displacement of people.
- Disruption of families. Children may be separated from their parents.
- Destruction of services including **health** (3) and **education** (4). In addition, activities to prevent the spread of HIV/AIDS are more difficult in conflict situations. Measures that are needed to monitor the way in which HIV is spreading are often not in place.

- Increase in sexual violence against women, including rape. Rape is used as a weapon of war and is particularly common in refugee camps.
- Many women sell sex in order to survive in situations of conflict.

People living in refugee camps may be particularly vulnerable to the spread of HIV. Social structures, norms and values may all be affected in camps.

Armed forces may contribute to the spread of HIV. They may encourage local women to trade sex in exchange for protection. They may also engage in casual and commercial sex in areas where they are based for prolonged periods.

Responses

Effective responses require training of armed forces and humanitarian staff in how to deal more constructively with children and how to prevent the spread of HIV/AIDS.

Efforts to provide care for children should focus on reuniting families and rebuilding communities and not on establishing **institutions** (7.3.3).

7.3 Alternates to Community Care in Extended Families

This section looks at alternate forms of care for children apart from **care within the extended family** (7). Other sections look at issues facing **carers** (7.1) and situations in which **children live outside of family care** (7.2). Other sections look in detail at **placing a child with another family** (7.3.1) and **residential care** (7.3.3).

Key points about alternate forms of care are:

- In many countries, HIV/AIDS is increasing the number of children who can no longer be cared for by their parents. Most of these children are cared for by their extended families. This form of care needs to be supported and promoted.

- However, this is not available to all children. Some children live **outside of family care** (7.2).

- In these situations and where a child is at **risk of abuse** (8.3) most countries have laws which require and allow the state to take over responsibility for care of a child. This has legal and financial implications.

- There are a range of alternative forms of care available. These include placing a child in **another family** (7.3.1) or in an **institution** (7.3.3).

In situations where children are living outside of family care and/or a child is considered at **risk of abuse** (8.3) most countries have laws which require and allow the state to take over responsibility for that child's care. This means that the state has legal responsibility for the child. The state has to provide care for the child or ensure that this is done. Many forms of community care are informal and not recognised by law. It is difficult for the state o place children under its care in these forms of care.

In addition, the state often has financial responsibility for children under its care. It will usually pay for care provided in this situation. If poverty is widespread, children may be admitted into this type of care for financial reasons. The state is rarely able to provide financial support to people providing care within the extended family in the community.

There are a wide range of terms used to describe various forms of alternative care. Some of these terms overlap. Commonly used terms include:

- **Adoption** – This involves a child being taken into the **care of adults other than their parents** (7.3.1). It is done on a permanent basis and the child legally becomes the child of those parents. The term adoption is usually only

applied where the people 'adopting' the child are not relatives. Once a child is adopted, the state usually stops being financially responsible for that child.

- **Fostering** – This also involves a child being taken into the care of adults other than their parents. It is usually a temporary arrangement and the state retains financial responsibility for the child. It is a formal/legal arrangement and usually involves non-related adults. In many cases, people foster large numbers of children. These 'foster homes' are essentially small institutions.

- **Residential Care** – This term is used to apply to **institutions** (7.3.3) which provide child care. Most of the children in these institutions are placed there by the state. Institutions may be run directly by the state or by other organisations. Many institutions are moving towards structures which try to recreate family life as much as possible. -

7.3.1 Placement of a Child with Another Family

This section looks at situations where a child may be placed with another family, that is one that is not part of the extended family. Other sections look, in general, at other **alternatives to extended family care** (7.3) and in detail at **residential care** (7.3.3).

Various terms are used to describe these situations. Commonly used terms include:

- **Adoption** – This involves a child being taken into the care of adults other than their parents. It is done on a permanent basis and the child legally becomes the child of those parents. The term adoption is usually only applied where the people 'adopting' the child are not relatives. Once a child is adopted, the state usually stops being financially responsible for that child.

  In some cases, the child may be adopted by a person from another country. This is called inter-country adoption. There are many problems with this form of adoption. It should only be used when no other forms of care are available.

- **Fostering** – This also involves a child being taken into the care of adults other than their parents. It is usually a temporary arrangement and the state retains financial responsibility for the child. It is a formal/legal arrangement and usually involves non-related adults. In many cases, people foster large numbers of children. These 'foster homes' are essentially small **institutions** (7.3.3).

7.3.3 Residential Care

This section looks at issues relating to residential or institutional care of children. Other sections look, in general, at other **alternatives to extended family care** (7.3) and in detail at **placing children with other families** (7.3.1).

Key points about residential care for children are:

- Residential care is an ineffective way of providing care for children. It is poor at meeting their **psychosocial needs** (5) and prepares them poorly for adult life. It is also extremely expensive and could never provide care for more than a very small proportion of orphans and vulnerable children.

- Residential care has harmful effects on societies. It promotes **stigma and discrimination** (8.2), consumes resources and undermines community-based care responses.

- Based on this evidence, many countries have agreed that no new child care institutions should be built. However, there continues to be widespread public and political support for these institutions.

- Child care institutions will continue to exist and operate for the foreseeable future. They should be run to agreed standards to improve services provided for children in their care.

- A few organisations are moving away from providing institutional care to supporting community-based methods of care. These efforts need to be encouraged and replicated.

The Problems with Residential Care

A great deal of evidence has been collected from around the world which shows that residential/institutional care is an extremely poor way of providing care for children. Problems of residential care include:

- It prepares children poorly for adult lives as it places little evidence on teaching them skills they need.

- Children who grow up in institutions often fail to develop their own cultural identity. They may feel alienated from their community. They often lack networks of friends and relatives and may lack the social skills needed to develop these. Adults who grew up in institutions form an 'underclass' in some societies.

- Children from institutions often lack interpersonal skills. Some may develop anti-social forms of behaviour.

- Institutions are very poor at providing for children's **psychosocial needs** (5).

- Children in institutions are more vulnerable to **physical and sexual abuse** (8.3).

- Institutions may promote **stigma and discrimination** (8.2). Children in such institutions may be seen as 'different' from other children and stigmatised as a result. Levels of physical care above and beyond those in the local community may also promote stigma.

- The cost of providing care in institutions is extremely high. The costs of building and establishing institutions can be enormous. Institutions have been described as a 'magnet' for resources. They attract them which means that fewer resources are available for other forms of care.

- Institutions undermine community care for orphans by consuming resources that might be available for support to community care. In addition, institutions attract children to them for financial reasons. The higher physical standards of care may be attractive to poor communities. Financial resources available through the institution to support a child may relieve the financial burden on the family/community.

- Institutions only provide care for a very small proportion of orphans and vulnerable children. HIV/AIDS is increasing the number of orphans and vulnerable children. Institutions will never have the capcity to provide care for these children.

- Many institutions lack staff who are skilled in providing child care.

- Children rarely have the opportunity to **participate** (8.1) in decisions that affect them in residential care.

- Much residential care fails to meet the requirements of the **Convention on the Rights of the Child** (8).

Why are there so many Institutions?

There is a great deal of evidence that institutions are not a good way of providing care for children. In developed countries, many have closed and children are largely cared for in other ways. However, in many developing countries institutions are thriving and developing. New institutions are being built. Reasons for this include:

- The widespread belief that institutions are the best or only way to care for children. An example of this would be India where this view is widely held.

- The desire in certain societies to control children and to prevent them from being a nuisance. Many institutions set up for 'street children' are based largely on this desire rather than the best interests of children.

- Moral and religious values. Many institutions are run by religious organisations who seek to promote particular values and beliefs. These beliefs may include the view that certain environments are not suitable for raising children. An example of this is an institution aimed only at children of commercial sex workers in India.

- Political and public support for child care institutions. Many institutions in developing countries are supported by local political figures. This is because they are seen as a worthy cause by the general public. In addition, the general public in developed countries have similar views. This means that child care institutions in developing countries are able to raise funds relatively easily.

- Institutions may represent an 'easy' option for social workers. Administrative, legal and financial issues may make it easier for a social worker to place a vulnerable child in an institution rather than trying to support them in their extended family or community.

- Cultural barriers to **adoption and fostering** (7.3.1). In many societies, there are cultural beliefs which make it difficult for a family to adopt or foster a child who is not related to them.

The Way Forward

Residential care is an inappropriate way of providing care for children. However, some people argue that this should be available as a last resort for children where no other form of care is available, particularly on a short-term basis. The problem with this argument is that it allows institutions to remain. They will continue to be magnets, attracting both children and resources.

The following principles are proposed:

1. No new child care institutions should be built. Current institutions should not expand their residential facilities.

2. Institutional facilities should be adapted to provide services other than residential care. These might include day care facilities and educational services.

3. Guidelines and rules for residential care should be adopted by organisations and countries. These should always have the best interests of the child at their centre. Institutions should develop links with their local communities. They should encourage children to develop links with their communities and extended families. Care should be provided at a level appropriate to the surrounding community. It should seek to provide as close to a family structure as possible. Children should be allowed to participate in all decisions which affect them.

4. Organisations with experience of providing institutional care should move towards community-based models of care. Resistance from staff, donors and children will need to be overcome. Practical steps include visits to birth places, family tracing and payment for foster care. Experience from Ethiopia shows that it may be best to try to reunite children under 15 with their extended families while trying to assist those over 15 to prepare for independent living.

8. Children's Rights

This section looks at issues relating to children's rights, particularly in relation to HIV/AIDS. Other sections look in detail at **children's participation** (8.1), **stigma and discrimination** (8.2), **protection from abuse** (8.3) and **legal issues** (8.4).

Key points about children's rights are:

1. The UN Convention on the Rights of the Child (CRC) is the main international document which defines children's rights. Developed in 1990, it has been adopted by every country in the world apart from the United States and Somalia.

2. This convention has four main principles:

    - A child's right to life, survival and development.
    - A child's right to be treated equally. This means that no child should be **discriminated** (8.2) against.
    - A child's right to **participate** (8.1) in activities and decisions which affect them.
    - All actions should be based on the 'best interests' of the child.

3. There are various ways in which the convention can be used to influence activities in practice.

The Convention in Practice

The United Nations Convention on the Rights of the Child is one of the most widely accepted international conventions. Almost all the countries of the world have agreed to it. However, progress has been quite slow in putting it into practice. Reasons for this include misunderstandings about the Convention, which has been seen by some people as being 'anti-family' or simply about allowing children to have their own way. Neither of these is true but these misconceptions need to be addressed when seeking to increase awareness of the Convention and what it means in practice. Poverty is a major barrier which prevents implementation of the Convention. However, it can be used to guide efforts aimed at promoting development and eliminating poverty. This will ensure that children gain the maximum benefit from such actions.

In practice, the Convention can be used:

- As a framework for designing programmes.

- As a way of evaluating programmes and national strategies. For example, it is possible to look at how practices in a particular country affect orphans and vulnerable children and compare that with the provisions of the Convention.

- As a different way of looking at particular issues.

The last point is a very important one. It is as if the Convention is a pair of glasses or a magnifying glass. It can be used to look more carefully at a particular issue. The way this issue appears may be quite different from the way it appears when looked at from another perspective. Issues which can be examined in this ways include:

- **Terms** (1.1) used to describe orphans and vulnerable children. For example, the term 'AIDS Orphans' increases **stigma and discrimination** (8.2). Using this term goes against the Convention.

- Types of care. For example, care in **institutions** (7.3.3) does not allow children to develop fully, rarely allows for their **participation** (8.1) and promotes stigma and discrimination. It can be seen as going against the Convention.

- Issues of **birth registration** (8.4.1) and **inheritance** (8.4.2).

- Poverty and development.

- Access to **health** (3.1.2) and **education** (4.2.1).

- Access to information.

- Sexual **exploitation and abuse** (8.3).

- **Child labour** (6.2.2).

- Reporting to donors. For example, should these reports contain information which allows a child to be identified, such as names and photographs?

8.1 Participation

This section looks at issues relating to children's participation. This is one of the **rights** (8) described in the UN Convention on the Rights of the Child. Other sections look in detail at **stigma and discrimination** (8.2), **protection from abuse** (8.3) and **legal issues** (8.4).

Key points about children's participation are:

4. There are many reasons why children should participate in activities which affect them. These activities include those focused on HIV/AIDS.

5. In many societies, children's voices are rarely heard. They have little opportunity to participate. Adults often take decisions without talking to them.

6. Programmes which aim to promote children's participation will need to face a number of issues raised by children's participation.

7. Children may participate at different levels ranging from being given information to full partnership. Some forms of 'participation', such as 'tokenism' and 'decoration' exploit children. They should be avoided.

8. Children may participate in a variety of different ways. There are many tools which can be used to promote children's participation.

Why Should Children Participate?

There are many reasons why children should actively participate in HIV/AIDS programmes. These include:

- The right to participate is a basic **human right** (8). Children are entitled to this. This right is contained in the UN Convention on the Rights of the Child.

- Children are the only ones who can describe issues from their perspective.

- Participation builds children's self-esteem and confidence. It allows them to develop important communication skills.

- Through participation, children learn to cooperate with adults and other children.

- Programmes which allow children to participate are better programmes. For example, they are often more responsive to the needs of children.

- Children's participation raises public awareness of the needs of children.

The Reality

Unfortunately, children rarely get the opportunity to participate in activities and decisions which affect them. In order to allow children to participate, adults need to learn to listen and to break the habit of making decisions for children.

Children's participation should not only be encouraged in HIV/AIDS programmes, but also in other settings including in the family and **schools** (4).

Issues Arising from Participation

There are various issues which may arise when children actively participate in programmes. These are:

- Children may risk being identified if they participate in HIV/AIDS programmes. Confidentiality must be observed. This is particularly an issue for activities which raise public awareness of issues affecting children. Careful consultation should be undertaken before any activity takes place which makes it likely that a child will be identified.

- Programmes need additional resources to allow for the participation of children. Children may require additional levels of support. They may require training to provide needed skills and confidence.

- There may be problems with short-term participation, such as involvement in international conferences, if this is not followed up by ongoing participation in the long-term.

Levels of Participation

Children may experience different levels of participation. This has been described as a ladder. Different levels include:

- Being given information – children are given information. Adults make the decisions.

- Consultation – children are asked their opinions and adults take this into account when making decisions.

- Adult-initiated – adults start projects and share decisions with children. This is distinct from child-initiated projects.

- Partnership – children are supported by adults to come up with ideas and set up projects.

Children may be involved in projects in ways which looks like participation but are not. For example, they or their images may be used to promote a particular project although they do not understand what is happening. This is manipulative as children are being used as 'decoration'. Children may be involved simply because projects know they should involve them. This can lead to 'tokenism' where children are 'involved' in a project but they have little ability to influence decisions.

Different Ways of Participating

Participation may take different forms in different settings. Various things need to be considered when trying to find a good way of involving children. These include children's age, sex, ethnicity, religion and family background. Disabled children may need special consideration to enable their participation.

There are a wide variety of ways of allowing children to participate. These include through writing stories and poems, drawing pictures, forming their own clubs/organisations, playing games, attending workshops, drama, music, using puppets, sports and taking part in discussions and surveys.

8.2 Stigma and Discrimination

This section looks at issues relating to stigma and discrimination and how they affect orphans and vulnerable children. Stigma and discrimination mean that people are not treated equally or fairly. The **right to be treated equally** (8) is part of the UN Convention on the Rights of the Child. Other sections look in detail at **participation** (8.1), **protection from abuse** (8.3) and **legal issues** (8.4).

Key points about stigma and discrimination are:

1. Stigma is based on beliefs. A person is 'stigmatised' when another person thinks negatively of them because of something they have experienced or because they belong to a particular group. Discrimination occurs when actions are taken (or not taken) on the basis of a stigmatising belief.

2. HIV/AIDS leads to stigma and discrimination.

3. Stigma and discrimination occur in many settings, including the family, local community, **school** (4) and **health care facilities** (3).

4. There are many negative effects of stigma and discrimination.

5. Stigma and discrimination go against a **child's right** (8) to be treated equally and fairly.

6. There are many actions which can be taken by individuals and organisations to overcome stigma and discrimination.

Stigma, Discrimination and HIV/AIDS

Stigma is about beliefs and attitudes. Discrimination relates to actions. Both are based on negative views of people simply because they are seen as belonging to a particular group. HIV/AIDS is commonly associated with stigma and discrimination. This may be because of HIV's association with death, sex and drug use.

Children in other groups may also experience stigma and discrimination. These include orphans, children of sex workers, street children, refugees, children in detention and children who use drugs. Many of these experience 'double' stigma because they are also more vulnerable to HIV/AIDS.

Effects of Stigma and Discrimination

Children experience stigma and discrimination in different places. These include at home, in their local community, in schools and at health care facilities. This

may result in children lacking **access to health care** (3.1.2) and **education** (4.2.1).

Effects of stigma and discrimination include:

- Fear of members of the stigmatised group.
- Verbal and physical abuse of children.
- Fear of disclosing information, including results of HIV tests. This may mean that people do not get the treatment they need.
- Reduced self-esteem and confidence among children.
- Children being isolated socially. This can mean they are 'excluded' from society.
- Withdrawal, depression and other **psychosocial problems** (5).
- Children running away from the place where they are experiencing this. This may involve them moving from rural to urban areas. This carries the risk of them ending up living on the **street** (7.2.3).

The Right to Equality

Children have a **right** (8) to be treated equally. If a child id treated differently just because they belong to a different group, they are being discriminated against. This is against their human rights.

Proposed Action

The following actions can help overcome stigma and discrimination:

- Laws which ensure that children are treated equally and fairly.
- **Local advocacy** (2.2.1) on behalf of children to ensure that communities support children's rights to be treated equally.
- **Psychosocial support** (5) to children experiencing stigma and discrimination.
- Allowing children to **participate** (8.1) in activities and decisions. Children can then challenge stigma and discrimination themselves.

- Programmes must themselves avoid discriminatory. This means they should not target only children whose parents have died of AIDS. In addition, they should not use **stigmatising terms** (1.1) such as 'AIDS orphans'.

8.3 Protection from Abuse, Exploitation, Neglect and Trafficking

This section looks at issues relating to the protection of children from abuse, exploitation, neglect and trafficking. This is part of children's rights. Other sections look in detail at **participation** (8.1), **stigma and discrimination** (8.2) and **legal issues** (8.4).

Key points about abuse, exploitation, neglect and trafficking are:

1. Abuse takes many forms including physical abuse, physical abuse and sexual abuse. Children may be abused as part of domestic violence, that is violence directed by men against women.

2. Child sexual abuse is defined as involvement of a child in any sexual activity before the legally-recognised age of consent. It includes forms of **sexual exploitation** (6.2.1), including child prostitution and pornography.

3. Exploitation of children includes harmful forms of **child labour** (6.2.2), commercial sex and early marriage. Organisations working with children can also exploit them. For example, use of their identities to promote projects without their full understanding can be considered a form of exploitation.

4. Child neglect occurs widely in developing countries as a result of poverty. It may be difficult to separate deliberate neglect from poverty-related problems.

5. Trafficking is the sale of children for any purpose. It is closely linked to commercial sex in most cases.

Many actions have been identified which will protect children from these things. These include:

- Tackling the root causes of exploitation and trafficking, such as poverty.

- Recognising that children are the victims of these practices and that they need support not punishment.

- Support that may be provided to children in these circumstances includes **counselling** (5.2.1), provision of temporary residential permits and protection to testify in legal proceedings.

- Protecting children from these practices until they reach age 18. Ages of consent below 18 should not be taken to mean that children under the age of 18 can consent to exploitative practices including prostitution and pornography.

- Allowing children to **participate** (8.1) in finding solutions to these problems.
- Actions which tackle the negative side of Internet use.
- Legal provisions which allow sexual exploitation in one country to be prosecuted in another.
- Ongoing research and investigation into these issues.

8.4 Legal Support

This section looks at legal issues relating to **children's rights** (8). Other sections look in detail at **participation** (8.1), **stigma and discrimination** (8.2) and **protection from abuse** (8.3).

Key points about legal issues and children's rights are:

1. There are a number of international conventions which refer to the rights of children. The most important of these is the **UN Convention on the Rights of the Child** (8).

2. Laws in different countries vary greatly. The constitutions of some countries include provision for the rights of the child.

3. There are a wide range of laws relating to children in many different countries.

4. However, the existence of a law is not sufficient to ensure that children enjoy its benefits. People have to know about the law and it has to be implemented or enforced.

Examples of the kinds of laws that countries have include:

- Clear description of the circumstances in which the state can take over responsibility for a child. They will then need to find **alternate accommodation** (7.3) for that child.

- Laws which allow people to **adopt** (7.3.1) children. Many of the arrangements which are made for children whose parents have died are not recognised by law. For example step-parents and guardians are not always recognised as having parental rights and responsibilities. Sometimes these can only be gained by adopting the child or by gaining a court order. Guardians may be recognised legally if this is stated in a person's **will** (5.2.2).

- The age at which a child legally becomes an adult. This is called the 'age of majority'.

- Laws which outlaw harmful cultural practices, such as female genital mutilation.

- Laws which provide for **access to health** (3.1.2) and **education** (4.2.1).

In some cases, laws and agreements may be needed between countries to tackle particular issues, such as inter-country adoption and abduction.

8.4.1 Birth Registration

This section looks at issues relating to birth registration. This is part of the **legal provision** (8.4) needed to promote **children's rights** (8). Another section looks at **inheritance** (8.4.2) issues.

A child has a right to an identity and to have their birth registered. However, this does not happen for many children living in developing countries, particularly in remote rural areas. States have a responsibility to do this but they often do not regard it as a priority. Failure to have their birth registered may deprive a child of other rights. For example, it may not be possible to attend school without this certificate.

Steps which can be taken to increase the number of children having their births registered include:

- States increasing the priority they give to this issue. Birth registration was the theme for the Day of the African Child in June 2003.
- Simplifying and decentralizing the registration process. In some cases, parents have to travel to the capital to register their children. This involves considerable time and expense.
- Targeting birth registration services at the poorest and most marginalised people.
- Linking birth registration to immunisation.
- Removing barriers to registration, such as fines for late registration and petty bureaucratic rules.
- Running information campaigns aimed at parents and adult caregivers explaining the importance of birth registration.

8.4.2 Inheritance

This section looks at issues relating to inheritance that affect orphans and vulnerable children. Rules about inheritance usually form part of national **law** (8.4). Another section looks at **birth registration** (8.4.1).

Many children in developing countries face problems inheriting their parents' property when they die. This may be partially due to cultural traditions concerning property inheritance at death. These may prevent women and young children inheriting property. Instead, property may be inherited by a male relative of the father. It is expected that he would then take on responsibility for care of his brother's family. However, sometimes relatives may take the property without taking on responsibility of care.

In addition, there may be cultural taboos about **succession planning** (5.2.2). It may be believed that planning for death can cause death. This may be one reason why few people in developing countries write wills. It is however easy for people to write their own will using a standard format. This can be used to appoint a legal guardian in case of parental death. Wills can sometimes be written as part of **memory projects** (5.2.2).