

what **difference** does a decade make?

action for orphans
and vulnerable
children in Africa

**a follow-up review
of progress towards
the UN Declaration
of Commitment on
HIV and AIDS**



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Published by: World Vision UK with support from World Vision Germany.
Managed by: Stuart Kean

Cover design and interior layout:
Dodo, Mammoth, Reindeer and Fox
www.dodomammoth.co.uk

Printed by:
Mpress UK Ltd

Cover photo:

A girl waters plants to help her mother who belongs to a farmers association called Tingania Ni Wutomi in Mozambique, that works the land to help members of the community who have been affected by HIV and AIDS.

photo: Paul Bettings/World Vision

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acknowledgements

A wide range of people have been involved in the preparation of this report and special thanks go to all those who took part in the community level research in Ethiopia, Mozambique, Uganda and Zambia. We are particularly indebted to the many orphans and vulnerable children who participated in the study, for their tremendous courage and willingness to share their personal experiences with us. To the many other children and adults who took part in focus group discussions and household surveys, we are truly grateful.

We also pay special tribute to the programme managers, staff and research assistants of the participating Area Development Programmes for their unwavering support and facilitation during this study. Without their commitment and enthusiasm this report would not have been possible. In addition, we would like to thank the many other stakeholders who contributed to this study and whose support continues to encourage and inspire us. We also want to acknowledge the support of Richard Wamimbi who provided technical support to the World Vision staff in the four countries.

We want to thank Stefan Sengstmann and World Vision Germany for providing financial support for the research in Mozambique. We are also grateful to World Vision Germany for allowing the use of three photos from the exhibition by Sönke C. Weiss that was part of the “Trotz-AIDS” campaign organised by about the plight of orphans and vulnerable children in Africa.

Special thanks are due to Clive Bacon, Stefan Germann, Christo Greyling, Jane Chege and Martha Newsome for their comments on the report and acknowledge with gratitude assistance provided by several people including: Claire Bardell with finding appropriate photographs, Nicola Field for her support with the report design process and Marina Mafani with guidance on publishing the report.

Finally, we want to thank Stuart Kean for his energy and commitment as the manager and catalyst for this study.

contents

Acronyms	1
Executive summary	2
Introduction	6
Chapter 1: Research overview and summary of findings	8
Chapter 2: Ethiopia	14
Chapter 3: Mozambique	24
Chapter 4: Uganda	32
Chapter 5: Zambia	40
Conclusion and recommendations	48
Bibliography	54
Appendices	56

acronyms

ADP	Area Development Programme (location of World Vision's community programmes)	MMAS	Ministério da Mulher e Acção Social
AIDS	Acquired Immuno Deficiency Syndrome	MOE	Ministry of Education
ART	Anti-Retroviral Therapy	MOH	Ministry of Health
BOWA	Bureau of Women's Affairs (Ethiopia)	MSYCD	Ministry of Sport Youth and Child Development
CBO	Community Based Organisation	MWYCA	Ministry of Women, Youth and Children's Affairs (Ethiopia)
CCC	Community Care Coalition	NAC	National AIDS Council
CDO	Community Development Officer	NASF	National AIDS Strategic Framework
COVCC	Community Orphans and Vulnerable Children Committee	NGO	Non Governmental Organisation
CWACs	Community Welfare Assistance Committees	NOP	National OVC Policy
DACA	District AIDS Coordinating Adviser	NPA	National Plan of Action
DATF	District AIDS Task Force	NSP	National HIV & AIDS Strategic Plan
DDCC	District Development Coordinating Committee	NSPPI	National Strategic Programme Plan for Intervention
DOVCC	District Orphans and Vulnerable Children Committee	OVC	Orphans and other Vulnerable Children
DOVCCC	District OVC Coordination Committee	PATF	Provincial AIDS Task Force
DWACs	District Welfare Assistance Committees	PLWHA	People living with HIV and AIDS
FBO	Faith Based Organisation	SOVCCC	Sub county OVC Coordination Committee
FGD	Focus Group Discussion	UN	United Nations
FHAPCO	Federal HIV & AIDS Prevention and Control Office (Ethiopia)	UNAIDS	Joint United Nations Programme on HIV & AIDS
HIV	Human Immunodeficiency Virus	UNGASS	United Nations General Assembly Special Session
MCDSS	Ministry of Community Development and Social Services	UNICEF	United Nations Children Fund
MDG	Millennium Development Goal	WFP	World Food Programme
MGLSD	Ministry of Gender, Labour and Social Development	WV	World Vision

executive summary

A decade on since the UN Special Session on HIV and AIDS in 2001 culminated in the first truly global commitment to action for orphans and vulnerable children¹, many challenges remain. Yet, with the world in the midst of a global financial and economic crisis, this commitment to action and resolve to monitor progress is as important as ever.

Following on from the *More than words?* report, published in 2005, this research was undertaken in 2010 to give a further insight into the lives of orphans and vulnerable children in four of the worst-affected countries in sub-Saharan Africa. Based on surveys and focus group discussions with children, parents, caregivers and officials in Ethiopia, Mozambique, Uganda and Zambia, it provides a useful reflection of how far the UNGASS commitments are being met and, more broadly, how much difference a decade of action has made.

Whilst some advances have been made in mitigating the impact of HIV and AIDS in recent years, this follow-up study reveals a mixed picture across the four African countries and shows just how difficult it has been for governments and other stakeholders to meet their commitments. Whilst Uganda continues to demonstrate good progress in ensuring more equal access to services, the overall picture is far less encouraging. In many communities, orphans and vulnerable children continue to be the most likely to be missing out in terms of education, health, nutrition and other basic needs. As in 2005, the most vulnerable children were seen to be:

- least likely to be in school
- least likely to have access to healthcare
- least likely to receive normal meals
- least likely to have their basic needs met
- unlikely to be receiving psychosocial or other support
- unlikely to have their births registered
- frequently victims of property grabbing.

Given this situation, it is crucial that there is a renewed energy for action and a refocusing of efforts to address the shortcomings of the last decade. The care and support of the most vulnerable children must form an integral part of national and international responses to HIV and AIDS. World Vision therefore calls on governments and all other stakeholders to take the following actions:

National

- Fully implement Articles 65-67 of the 2001 UNGASS Declaration of Commitment² on HIV/AIDS to ensure special assistance for children orphaned and affected by HIV and AIDS.
- Fully implement Articles 27,29,32 and especially 34 of the 2006 UN Political Declaration on HIV/AIDS³ to address as a priority the vulnerabilities faced by children affected by and living with HIV including; “providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them”.
- Design national programmes for children made vulnerable by HIV and AIDS based on the forthcoming guidance document ‘Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS’⁴ for implementing the ‘*Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in A World With HIV/AIDS*’.

¹ For the commitments made in 2001 see Appendix I.

² For the commitments made in 2001 see Appendix I.

³ UN General Assembly, Resolution adopted by the General Assembly, 60/262. Political Declaration on HIV/AIDS, June 2006.

For the commitments made regarding children see Appendix I.

⁴ Inter Agency Task Team on Children and HIV and AIDS, 2011, ‘Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS’.

- Integrate a multi-sectoral response for children affected by HIV and AIDS into development instruments, including Poverty Reduction Strategy Papers, national development plans, National AIDS Strategies, National HIV Frameworks and other relevant sectoral plans.
 - Make time-bound and measurable commitments for fulfilling the rights and meeting the needs of children made vulnerable by HIV. These should relate to funding requirements for implementing OVC National Plans of Action, where these exist.
 - Encourage mechanisms for flexible funding which meet community needs with funds being provided in small quantities over the long-term (i.e. drip-fed) and at predictable times to enable them to be better utilized by community based organisations as part of community systems strengthening mitigation approaches.
 - Strengthen national coordination of actions for children affected by HIV and AIDS by strengthening coherence across interventions, ministries and departments relevant to children affected by HIV and AIDS, including those of health, education and social welfare services.
 - Governments to commit to ensure that 80% of eligible vulnerable households have received economic support in the last 3 months.
 - State parties to continue to work towards the progressive realization of all rights committed by state signatories to the Convention on the Rights of the Child (CRC), giving particular attention to specific issues impacting children affected by HIV and AIDS.
- International**
- Support governments in Africa to meet the goals set in the “*Abuja Call for Accelerated Action towards Universal access to HIV and AIDS, TB and Malaria, and Africa’s Common Position to the High Level meeting of the UNGASS on AIDS*”⁵
 - at least 80% of pregnant women have access to prevention of mother to child transmission (PMTCT);
 - 5 million AIDS orphans and 80% of orphans and vulnerable children have access to basic services;
 - at least 80% of those in need, especially women and children, have access to HIV and AIDS treatment, including antiretroviral therapy as well as care and support.
 - Support governments in Africa to meet the goal set in the “*Abuja declaration*” to invest at least 15% of government budget expenditure for national health systems.
 - Support the full implementation of commitments outlined in Articles 65-67 of the 2001 UNGASS Declaration of Commitment on HIV/AIDS and Articles 27,29,32 and especially 34 of the 2006 UN Political Declaration on HIV/AIDS to ensure that assistance is provided for children orphaned and affected by HIV and AIDS.
 - Link efforts under the 2001 UNGASS Declaration of Commitments with efforts under the UN Secretary General’s Global strategy for Women’s and Children’s health from 2010 in areas where appropriate.
 - Make specific commitments to fund the needs of children affected by HIV and AIDS and orphans and vulnerable children through support for OVC National Plans of Action, National Strategic AIDS Frameworks and national social protection plans.
 - Accelerate the existing momentum towards education for all children through the Fast Track Initiative and other financial mechanisms.
 - Accelerate the abolition of local school and health fees and associated costs for all children, paying

⁵ Special Summit of African Union on HIV/AIDS, Tuberculosis and malaria (ATM), Abuja, Nigeria 2–4 May, 2006 Sp/Assembly/ATM/3 (I) Rev.2

special attention to the most vulnerable and disadvantaged children.

- Support governments in highly affected countries to ensure equitable access to a comprehensive package of treatment services integrated into Maternal Newborn Child Health services including; scale up the prevention of mother to child transmission plus (PMTCT-Plus), point of care diagnostics for early infant diagnosis, provision of cotrimoxazole preventative services to all children known to be HIV positive and to those born to positive mothers until HIV status is determined; and ensure children are explicitly included in national HIV treatment targets.
- Encourage the pharmaceutical industry to urgently invest in the development and production of fixed-dose combination anti-retroviral therapy for young children as well as grant voluntary licenses to allow generic production of ARVs and develop affordable point-of-care diagnostic tests for children and infants.
- Provide support to governments to ensure increased coverage and access to comprehensive care and support for adults and children living with and affected by HIV, including carers, as a vital part of the Universal Access agenda.
- Support the implementation of national social protection policies and plans to strengthen the capacity of national social welfare systems with adequate budgetary allocations to ensure the care and protection of children, including the provision of social cash transfers to vulnerable households for economic strengthening, as well as increased access to services and address social exclusion and promote social justice.
- Support governments to protect and promote the human rights of children, such that the most vulnerable are able to access education, health, legal and services, as well as remain free from abuse, exploitation and neglect.

We live with our aunt. She is my best friend. I can talk to her about everything. About school, about boys, about my dreams. She promised to never leave us alone. Sometimes I feel sorry for her. She has given up her own plans for life. She thinks no man will marry her now that she has two AIDS orphans in her luggage. But she says we are more important to her. This is why I am not afraid of the future. My aunt is looking after us very well.
Ethiopia: Meti (10, on the right)

photo: Sönke C. Weiss/World Vision



This photo is from an exhibition by Sönke C. Weiss that was part of the “Trotz-AIDS” campaign organised by World Vision Germany about the plight of orphans and vulnerable children in Africa told in their own words.

introduction

In 2001, the UN General Assembly Special Session on HIV and AIDS culminated in the first truly global commitment to action for Orphans and Vulnerable Children (OVC)⁶. *This Declaration of Commitment on HIV/AIDS*, which contains over 100 articles to guide efforts at national, regional and international level, makes specific reference to children orphaned and made vulnerable by HIV and AIDS and sets a benchmark for success in tackling the many issues they face.⁷ The subsequent *Framework for the Protection, Care and Support of Orphans and Vulnerable Children* proposed five key strategies, giving operational guidance and identifying key indicators against which progress could be measured.⁸

Almost a decade later, and in the midst of a global financial and economic crisis, this commitment to action and resolve to monitor progress remains as important as ever. Whilst advances have been made in mitigating the impact of HIV and AIDS in recent years, many challenges remain – not least in seeking to ensure that the most vulnerable children receive the support and protection they need. Such was the concern expressed in a communique following the Fourth Global Partners Forum in 2008 which noted the ‘persistent impact of HIV and AIDS, which makes it impossible for some children to realise their human rights’.⁹

Whilst there has undoubtedly been a greater focus in policy and programming on addressing the needs of those children orphaned or made vulnerable by HIV and AIDS, evidence from recent studies suggests that children have remained somewhat ‘peripheral to the AIDS response’.¹⁰ Indeed, research by the Joint Learning Initiative on Children and HIV/AIDS (JLICA) has revealed major flaws in the response to date, namely that:

1. Poor families are supporting affected children with minimal assistance, including from their governments;
2. Community responses are poorly understood and supported;
3. Implementation of key services falls short of needs; and
4. Global political commitment and resources are insufficient.¹¹

Rather than be disheartened by this, campaigners have called for renewed energy for action and a refocusing of efforts to address these shortcomings. Building on the strengths of the *Declaration of Commitment and Framework* for action, a new consensus is emerging in support of ‘broader forms of action to protect and empower the most vulnerable members of society, especially children’.¹² Key to this shift in thinking is the idea of child-sensitive social protection which seeks to bolster family-based support through ‘social transfers (including cash and in-kind transfers and vouchers), social insurance, social services (including social welfare services such as legal support, social work and alternative-care services) and social policies and legislation designed to benefit those affected by HIV/AIDS’.¹³ Such measures aim to address family poverty directly, and enhance the capacity of extended families in particular, in order to secure better outcomes for the most vulnerable children. As highlighted in UNICEF’s recent *Children and AIDS: Fifth Stocktaking Report*, ‘there is good evidence to demonstrate that scaling up national social protection can have a positive impact on vulnerable households and children affected by AIDS’.¹⁴

⁶ For the commitments made in 2001 see Appendix I.

⁷ United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, A/RES/S-26/2 (2001).

⁸ UNICEF, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS* (UNICEF, 2004).

⁹ Global Partners Forum on Children Affected by HIV and AIDS, *Communique* (2008).

¹⁰ Joint Learning Initiative on Children and HIV/AIDS (JLICA) *Home Truths: Facing the facts on children, AIDS, and poverty* (2009) p.4.

¹¹ *Ibid* pp.9-10.

¹² *Ibid* p.5.

¹³ UNICEF, *Children and AIDS: Fourth Stocktaking Report, 2009*, (UNICEF, UNAIDS, WHO and UNFPA, December 2009) p.22.

¹⁴ UNICEF, *Children and AIDS: Fifth Stocktaking Report, 2010*, (UNICEF, UNAIDS, WHO, UNFPA and UNESCO, November 2010) p.23.

Given the many challenges that remain, World Vision continues to be a vocal advocate on the issue of orphans and vulnerable children and seeks to be at the forefront of policy and programme development. Back in 2005, the *More than words?* report sought to inform and challenge leaders by presenting a review of progress in four of the worst-affected countries in sub-Saharan Africa (Ethiopia, Mozambique, Uganda and Zambia).¹⁵ This qualitative investigation found that children orphaned and made vulnerable by HIV and AIDS were most likely to be missing out in terms of education, health, nutrition and other basic needs. Now, against the backdrop of a new global agenda and in preparation for the High Level HIV and AIDS meeting to be held in 2011, this follow-up report

uses the same nine indicators to provide a further review of how far the rights and needs of orphans and vulnerable children are being met and makes informed recommendations for action.

Table 1: Definition of Orphans and Vulnerable Children¹⁶

<p>Orphans are children below 18 years of age who have lost either a mother, a father, or both parents to any cause.</p> <p>Vulnerable children are:</p> <ol style="list-style-type: none"> 1. Children whose parents are chronically ill. These children are often even more vulnerable than orphans because they are coping with the psychosocial burden of watching a parent wither and the economic burdens of reduced household productivity and income and increased health care expenses. 2. Children living in households that have taken in orphans. When a household absorbs orphans, existing household resources must be spread more thinly among all children in the household. 	<ol style="list-style-type: none"> 3. Other children the community identifies as most vulnerable, using criteria developed by the community. One of the critical criteria will be the poverty level of the household. <p>At the community level, defining OVC is complex and should not be dictated by others. Not all orphans are vulnerable, and some of the most vulnerable children may not fall into the categories that have been defined here. The term ‘AIDS orphans’ should not be used because parents rarely know their HIV status. The term may lead to stigmatisation and discrimination against orphans.</p>
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¹⁵ World Vision, *More than Words? Action for Orphans and Vulnerable Children in Africa: Monitoring Progress towards the UN Declaration of Commitment on HIV/AIDS* (World Vision, 2005).

¹⁶ Taken from World Vision’s *Guide to Mobilizing and Strengthening Community-Led Care for Orphans and Vulnerable Children*.

chapter 1

Research overview and summary of findings

Follow-up monitoring of progress

World Vision's *More than Words?* report, published in 2005, provided a qualitative assessment of progress being made towards the UNGASS commitments in four African countries: Ethiopia, Mozambique, Uganda and Zambia. Five years later, a follow-up monitoring exercise has been conducted in each country using the same methodology and indicators (see Table 2).¹⁷ As before, monitoring was carried out in four communities within each country (two Area Development Programmes, which are World Vision programme areas, and two adjacent communities not receiving World Vision support). The research used a combination of household surveys, focus group discussion and key informant interviews. The research was conducted

in 2010 and the findings written-up in four country reports, from which this report has been compiled. Intended to give a further insight into the lives of orphans and vulnerable children, this research provides a useful reflection of how far the UNGASS commitments are being met and, more broadly, how much difference a decade of action has made.

Table 2: Indicators

Domain	Indicator
Policies and strategies	Is there a national policy in place for the support, protection and care of orphans and vulnerable children?
Education	School attendance of orphans and vulnerable children (OVC) compared to non-OVC
Health	Healthcare access for OVC compared to non-OVC
Nutrition	Proportion of OVC receiving normal meals compared to non-OVC
Psychosocial support	Proportion of OVC receiving appropriate psychosocial support
Family capacity	Proportion of OVC that have three locally defined basic needs met compared to non-OVC
Community capacity	Proportion of households with OVC that receive free basic external support in caring for the children
Protection	Per cent of children whose births are registered
Protection	Prevalence of land and property grabbing

¹⁷ A common methodology and nine indicators were agreed at a workshop with the research team in Zambia in May 2004. These indicators were based on the set of core national level indicators contained within the Framework, see UNAIDS (2005) Guide to Monitoring and Evaluation of the National Responses for Children Orphaned and made Vulnerable by HIV/AIDS. Guided by this common methodology, use was made of existing community definitions and selection of OVC and non-OVC households, and the process of data collection was tailored to each setting. As with the 2005 research, the sample size for the household survey was 50 OVC households and 50 non-OVC households in both the 2 ADPs and 2 non-ADPs (200 questionnaires in total) in each country. Purposive sampling was employed to select research areas and a combination of purposive and random sampling was then used to select individual households.

Key findings

A summary of the key findings is given below, with greater detail contained in the four country reports that follow.

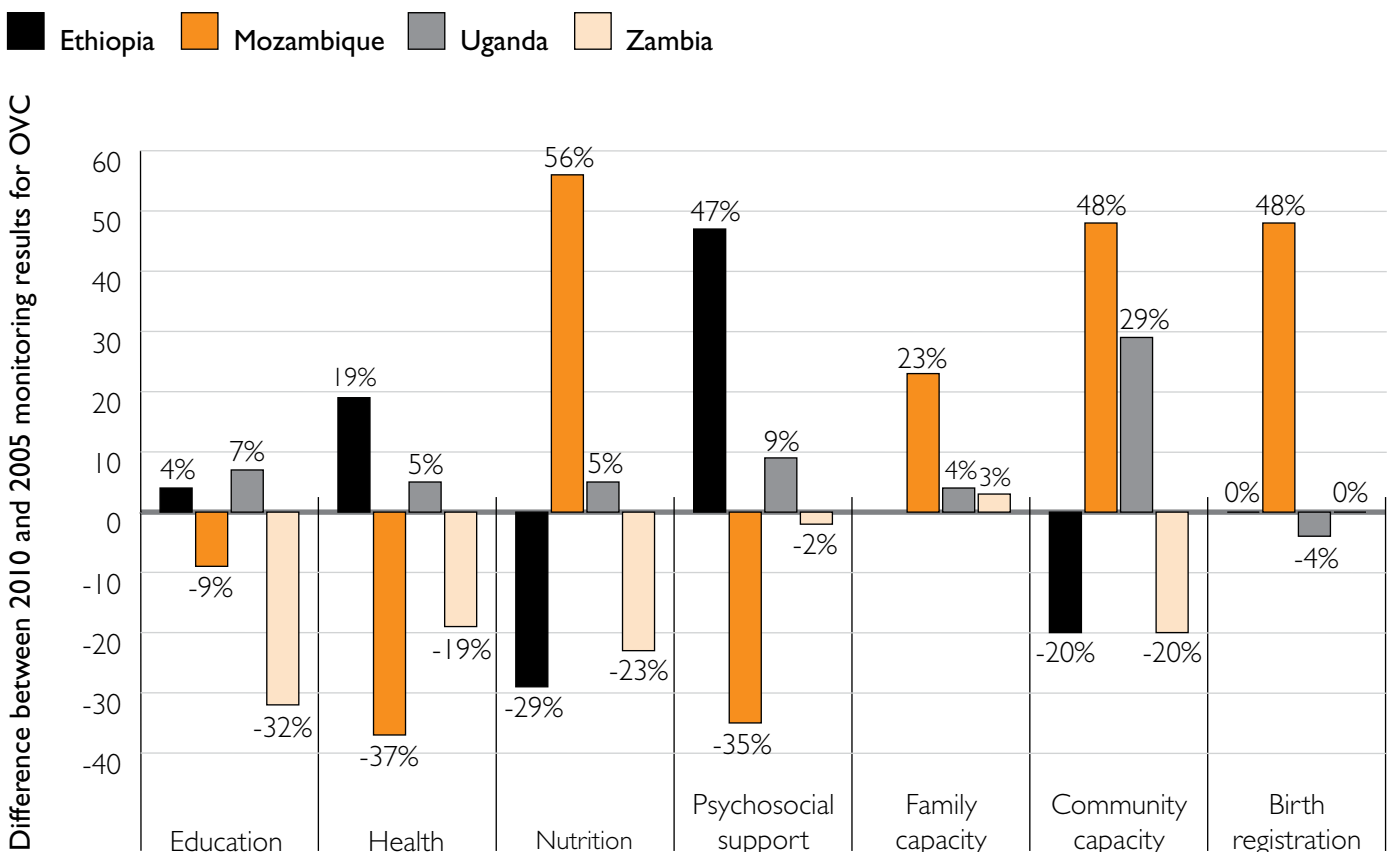
Policies and strategies

A key element of the UNGASS Declaration of Commitment was for each country to develop a national policy on orphans and vulnerable children by 2003 and implement it by 2005. At the time of the previous study only Uganda had devised and implemented such a policy although Ethiopia appeared to be making some progress towards one. Five years later and the situation has changed little. The Government of Mozambique has drawn up a targeted plan of action for OVC and has mechanisms in place

to aid its implementation. However, these require further development and strengthening and a specific OVC policy is yet to be put in place. At the same time, neither Ethiopia nor Zambia has developed a national policy for OVC and this is undoubtedly hampering the overall effectiveness of efforts in both countries to provide comprehensive and sustained care and support for orphans and vulnerable children.

Chart I shows the difference between the 2005 and 2010 figures. For example, 80% of OVC surveyed in Ethiopia had access to healthcare when sick in 2010 compared to 61% in 2005; the 19% difference between these results is expressed as a positive bar on the chart.

Chart I: Difference between 2010 and 2005 monitoring results for OVC



Education

Orphans and vulnerable children are less likely to attend school

Although the success of Uganda's Universal Primary Education (UPE) policy continues to stand out, the overall picture across all four countries in this study is that the most vulnerable children are still the least likely to be receiving an education. The situation is most pronounced in Zambia where orphans and vulnerable children, and particularly girls, are much less likely to be in school compared to other children. This is also the case in the non-ADP areas in Ethiopia. However, it is encouraging to note that there has been a slight improvement in the overall attendance figures since 2005 and that many vulnerable children who are receiving appropriate support from their family, teachers and community care coalition members are seen to be doing well in school.

In Mozambique, there has been a decline in the proportion of children in school despite increased government funding in recent years. This is in part due to population growth as well as the cost and associated challenges of extending provision to upper primary level. On the positive side, this study suggests that orphans and vulnerable children are as likely to be in school as other children. Yet, this is little consolation given the low levels of attendance overall.

As in 2005, there are many reasons why children drop out or are unable to attend school. Those most frequently cited in the focus group discussions across all four countries were: the loss of both parents, having to care for a sick relative, being infected with HIV or living with AIDS, having a disability, early marriage, lack of school materials, the costs of uniform and lunches, heavy work burdens (household chores) and a low awareness amongst some parents of the value of education.

Health

Orphans and vulnerable children are less likely to have access to healthcare

There was some variation across the four countries in terms of the proportion of children receiving medical treatment when sick. However, as in 2005, the overall picture is of the most vulnerable children being the least likely to access healthcare. Once again, Uganda stands out as the exception to the rule with the overwhelming majority of children surveyed, including those considered vulnerable, having received treatment. Yet even here, according to the focus group discussions, there continues to be some prejudice against children who are infected with HIV due to the misconception that medical treatment, because it cannot cure them, is a waste of time. Home visitors felt that this was becoming less of a problem, yet it is still a concern for these particularly vulnerable children. Similar issues were identified in Ethiopia where the most vulnerable children, and particularly those who had lost both parents, were likely to face stigma and discrimination. Interestingly, this is not apparent from the household survey results which show OVC having similar access to healthcare as other children (unlike in 2005 when the contrast was notable), but was raised as a concern during the focus group discussions.

In Zambia, not only are orphans and vulnerable children still the least likely to be receiving appropriate medical treatment, but the overall access to healthcare in those areas surveyed has fallen significantly. Whereas in 2005, 80% of OVC and 95% of non-OVC received treatment, in 2010 just 61% of OVC and 73% of non-OVC were able to access healthcare. As before, a number of reasons were given by the focus group participants for this including the inaccessibility of healthcare facilities (especially in rainy season), a shortage of medical supplies, continuing reliance on traditional remedies, and the prohibitive cost of treatment. These figures also

suggest that, at the time of the research, the degree of poverty being experienced by households overall in these communities was more pronounced than in 2005. At such times, the capacity of the community to help its most vulnerable members is severely diminished, and their situation therefore becomes more acute.

Similarly in Mozambique, there has been a notable decline in access to healthcare compared to the previous study. Though the difference between OVC and non-OVC is not as pronounced as it was in 2005, vulnerable children are still the least likely to be taken for medical treatment when sick. Although the Government has allocated more funds to healthcare in recent years, the focus on employing more health workers rather than building extra health centres has limited its impact on the level of access people have. This is particularly the case in rural areas, such as those surveyed, where long distances to the nearest health centre, a lack of transport, and the costs involved prevent many from seeking medical treatment, and lead many to rely on traditional remedies.

Nutrition

Orphans and vulnerable children are less likely to receive normal meals

As in 2005, food security continues to be a severe challenge for households and communities across all four countries. Although, vulnerable children now appear as likely to receive normal meals (as defined by the community) as other children in Uganda, the contrast in Ethiopia, Mozambique and Zambia remains stark. The situation is particularly bleak in Zambia where only 18% of orphans and vulnerable children were reported to be receiving normal meals compared to 35% of non-OVC. Both figures are clearly very low, due in part to the timing of the data collection which was done during the food-scarce months of January and February. However, as was the case in 2005, it is the most vulnerable children who are most likely to be missing out.

The survey results in Ethiopia revealed a similar situation with orphans and vulnerable children,

particularly in the non-ADP areas, being much less likely to receive normal meals than other children. Food security is low across the board and the lack of adequate nutrition is seen to have a knock-on effect on the growth, development and safety of the most vulnerable children. The same is also true in Mozambique where declining agricultural productivity due to drought and other natural disasters, and the death or sickness of many breadwinners has impacted households. On a positive note, the striking difference observed between orphans and vulnerable children, and other children back in 2005 (when only 9% of OVC compared to 90% of non-OVC were receiving normal meals) has reduced considerably. Yet even though the gap has narrowed, orphans and vulnerable children are still the most likely to go without meals.

Psychosocial support

Most orphans and vulnerable children are not receiving psychosocial support

Despite widespread recognition of the importance of psychosocial support in promoting the healthy social and psychological development of vulnerable children, the provision of appropriate counselling and other psychosocial activities at community level remains a challenge. Whilst some countries have seen an increase in the proportion of vulnerable children receiving support, such as in Uganda where the figure went up slightly and in Ethiopia where it increased significantly from a low of just 5% in 2005 to 52% in 2010, the overall picture is less encouraging. Coverage continues to be patchy and the majority of vulnerable children are failing to receive any form of psychosocial support.

The situation in Mozambique is especially concerning given that only 16% of orphans and vulnerable children were reported to be receiving psychosocial support during the 2010 survey compared to 51% back in 2005. Whilst the absence of specialized psychosocial support services is clearly an issue, more worrying still is the lack of community capacity to provide even the most basic level of informal support. Communities in Zambia

are also struggling to support their most vulnerable children, and the level of provision varies tremendously from area to area. For example, although a third of vulnerable children were reported to be receiving psychosocial support overall, this average masks a high of 51% in the ADP areas and a low of 13% in the adjacent communities where no interventions are taking place. This was also the case in Uganda where just 28% of orphans and vulnerable children in the adjacent areas had received counselling compared to 72% in the ADPs. In this way, the provision of psychosocial support across all four countries appears extremely haphazard and there is an urgent need for a more comprehensive strategy to ensure appropriate support for all vulnerable children regardless of where they live.

Family capacity

Orphans and vulnerable children are less likely to have their basic needs met

As in 2005, an appropriate standard of living has been defined in terms of three basic material needs identified by the communities themselves. These needs range from food and clothing through to bedding, shelter and life skills. In Ethiopia, the survey found that the majority of children, whether considered vulnerable or not, were not having their basic needs (identified here as food, shelter and clothing) met due to food shortages at the time. Many households care for a large number of children, and it is not therefore surprising that orphans and vulnerable children often find themselves last in line for the scant resources available. The situation in Mozambique appears to be more balanced, with 23% of OVC and 29% of non-OVC receiving adequate food, clothing and school materials. However, the most vulnerable children are still the least likely to have their needs met.

In Zambia, the results of the 2010 household survey mirrored that of 2005, with just over a quarter of the most vulnerable children having their basic need for food, education and shelter met compared to 51% of

non-OVC. In those communities outside of the World Vision programme areas, the contrast was even starker with only 14% of orphans and vulnerable children seen to be having these needs met. Clearly, the experience of individual households, and the children within them, can vary tremendously, and supporting the most vulnerable children remains a real challenge.

Even in Uganda, where targeted interventions have meant that orphans and vulnerable children in the areas surveyed are more likely to have their needs met than other children, the situation is not without its challenges. Here the three basic needs were identified as good clothing, decent bedding and life skills, and a programming bias towards orphans and vulnerable children was seen to have inadvertently excluded non-OVC to such an extent that only 5% had their needs met compared to 26% of OVC. Such a disparity is undesirable and care should be taken to avoid resentment building up within households especially when orphans are given clothing and bedding which are of a better quality than that which parents can afford for their own children.

Community capacity

Most OVC households do not receive external support

The nature and extent of external support for households caring for orphans and vulnerable children continues to vary widely. In some cases, community initiatives are successful in identifying and responding to need, and in others government or non-governmental programmes take a central role. Yet, in many communities very little, if any, external provision is being made to ensure the care and protection of the most vulnerable children. Furthermore, even in those areas where external support programmes are functioning well, there are still a significant number of households not receiving appropriate assistance.

Whilst the proportion of OVC households receiving support has gone up significantly in both Mozambique

and Uganda, the situation in Ethiopia and Zambia has deteriorated. In Ethiopia only a quarter of these households reported being given any material or economic support compared to 43% in 2005, and many focus group participants expressed concern about the lack of provision. Similarly, in Zambia less than half of the households surveyed were receiving any form of assistance in caring for orphans and vulnerable children. This figure also masks the fact that in the ADP areas, where Community Care Coalitions (CCCs) are operating, support was much more common (83%) compared to the adjacent communities where it was almost non-existent (14%).

Protection issues

Birth registration

Most orphans and vulnerable children do not have their births registered

As in 2005, the proportion of children having their births registered varied between the four countries. Whilst Mozambique has seen an encouraging rise in registration, aided by a free birth registration campaign in one of the areas under study, the situation in Ethiopia and Zambia is very different. Despite there being a legal basis for birth registration in Ethiopia, the practice is yet to be adopted in more than a few regional states and woredas¹⁸, and there is a continuing lack of awareness amongst parents of its importance. The fact that no birth registration data were available for the areas being surveyed clearly illustrates this. Similarly, in Zambia few births are registered because many parents remain oblivious to or unconvinced of its value, not least because a birth certificate is not required to access most services. Even in Uganda, where the Government and NGOs have been active in promoting registration,

only a third of orphans and vulnerable children were reported to have had their births registered.

This general lack of progress over the last five years is a real concern. Whilst the reasons are complex, a key obstacle in most places is the laborious and time-consuming nature of the registration system as well as the inefficiency of the service offered. Combined with a lack of awareness amongst parents, this is proving a considerable challenge and is limiting the number of children accessing services and receiving legal protection.

Land and property grabbing

Property grabbing is common

Although efforts have been made in all four countries to deal with property grabbing, the practice is still fairly common and much more work is needed to protect the inheritance rights of widows and orphans. The nature and prevalence of property grabbing does vary depending on local customs and traditions, a point stressed by focus group participants in Ethiopia, and some systems have been put in place to combat it. However, these systems are often weak or ineffective and are further undermined by the level of trepidation people tend to feel about going to the police or local court over a case. On a positive note, the practice of property grabbing is seen to be declining in both Uganda and Zambia. Yet, in Ethiopia and Mozambique the issue continues to be a serious problem with little sign that the situation is improving.

¹⁸ A woreda is the Ethiopian term for a district.

chapter 2

Ethiopia

Country Fact File¹⁹

Total population: **73.9 million**

Orphans: **5.4 million**

Orphans due to AIDS (0-17): **898,350**

People living with HIV: **977,394**

Children (0-14) living with HIV: **64,813**

Introduction

Though the national prevalence of HIV in Ethiopia is considerably lower than rates in other sub-Saharan African countries, the number of people living with HIV and orphans continues to grow. With an estimated 5 million orphans, Ethiopia has one of the largest populations of orphans and vulnerable children in Africa. As well as those children who have lost one or both parents to illness, there are many cases of abandonment which exacerbates the situation.²⁰ Given the context, all OVC, directly or indirectly, are vulnerable to HIV and AIDS and other health, socio-economic, psychological and legal problems. This vulnerability may be linked to extreme poverty, hunger, and illegal child labour practices, among other threats. All of these issues fuel and are fuelled by HIV and AIDS.²¹

UNGASS monitoring results 2005 & 2010

Monitoring was undertaken in the communities of Boset Woreda and Fentale Woreda in Eastern Shoa Zone of Oromiya Regional Administration and Badewacho Woreda and Damot Gale Woreda in Hadiya Zone of South Nations, Nationalities and People Regional Government.²² Table 3 gives a combined summary of the results from 2005 and 2010, with further detail given in Appendix 2.

Policies and strategies

Despite the continuing absence of a separate OVC policy and strategies, the Ethiopian Government has taken various steps to address the complex issues surrounding orphans and vulnerable children. Having ratified both the UN Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC), Ethiopia has harmonized its domestic laws and policies with these to create an enabling environment for improving the wellbeing of children. Furthermore, preparations are underway to develop a comprehensive child policy which will address the issues of OVC. A situation analysis is planned in the near future and it is expected that this will serve as a springboard for further government action, forming the basis for a targeted strategy and plan of action. Task forces and committees have been organised to provide technical support for this and these include representatives from various government offices, donors, NGOs, CBOs, communities and beneficiaries.

The Ministry of Women, Children and Youth Affairs (MOWCYA) is currently responsible for coordinating issues relating to children and, more specifically, for ensuring that children in alternative placements are receiving quality care.²³ In addition, the Federal HIV & AIDS Prevention and Control Office (FHAPCO) is charged with leading and coordinating the overall multi-sectoral responses to HIV and AIDS which includes the care and support of OVC. In recent years, local government and community structures, such as kebeles and idirs have begun to take a more proactive role in facilitating support, services, and referrals for orphaned and vulnerable children.²⁴ This community-based response

¹⁹ These figures are the 2007 estimates from the Federal Ministry of Health-Federal HAPCO, *Single Point HIV Prevalence Estimate, June 2007* (Addis Ababa, Ethiopia, 2007). Population figure taken from Federal Democratic Republic of Ethiopia Population Census Commission, *Summary and Statistical Report of the 2007 Population and Housing Census* (UNFPA: Addis Ababa, Ethiopia, December 2008).

²⁰ The high prevalence of unwanted births and consequent abandonment was noted by key informants during this research.

²¹ MoWA & FHAPCO, *Standard Service Delivery Guideline for OVC (2010)*.

²² Woreda is the Ethiopian term for a district.

²³ Prior to October 2010, this ministry was known as the Ministry of Women's Affairs (MOWA).

²⁴ Kebeles are the smallest administrative unit in Ethiopia, similar to a village in other contexts. Idirs are traditional burial societies which take monthly contributions from their members and assist with funeral costs in return.

Table 3: Summary results for Ethiopia 2005 and 2010

Domain	Indicator	Combined survey results				Difference between results	
		2005		2010		OVC	Non-OVC
		OVC	Non-OVC	OVC	Non-OVC		
Policies and strategies	Is there a national policy in place for the support, protection and care of orphans and vulnerable children?	No	–	No	–	–	–
Education	School attendance of orphans and vulnerable children (OVC) compared to non-OVC	68%	73%	72%	77%	+ 4%	+ 4%
Health	Healthcare access for OVC compared to non-OVC	61%	84%	80%	81%	+ 19%	+ 1%
Nutrition	Proportion of OVC receiving normal meals compared to non-OVC	74%	98%	45%	54%	- 29%	- 44%
Psychosocial support	Proportion of OVC receiving appropriate psychosocial support	5%	–	52%	–	+ 47%	–
Family capacity	Proportion of OVC that have three, locally defined basic needs met compared to non-OVC	29%	66%	Capacity very weak due to food shortage		–	–
Community capacity	Proportion of households with OVC that receive free basic external support in caring for the children	43%	–	23%	–	- 20%	–
Protection	Per cent of children whose births are registered	0%	0%	0%	0%	0%	0%
Protection	Prevalence of land and property grabbing	High	–	High	–	–	–

has been documented and appears to be a positive response to the growing needs of Ethiopia's children.

According to MWYCA and FHAPCO, the Government has allocated budget for the coordination and facilitation of programmes from federal to kebele level. The following are some examples of the strategies being used to respond to the needs of OVC:

- Educating and mobilizing the community to own the challenges at grassroots level.
- Building the capacity of community based associations (like idirs) and transforming their agendas for the benefit of the community including OVC.
- Mobilizing and utilizing local and foreign resources.
- Partnership.

- Linkage and integration.
- Using the existing leadership and coordination role by the government offices.
- Encouraging and facilitating conditions for CBOs, NGOs, FBOs, donors and others to provide appropriate responses in line with government guidelines and manuals.
- Sectoral mainstreaming of OVC issues.

Despite these various initiatives, many of the key informants interviewed felt that a specific and comprehensive OVC policy should be developed to provide clear guidance for all those involved in the care, support and protection of orphaned and vulnerable children in the country. The feeling was that such a targeted OVC policy and strategy would be instrumental in addressing the complex and dynamic needs of OVC.

Education

Orphans and vulnerable children are less likely to attend school

As in 2005, orphans and vulnerable children are still less likely to be in school than non-OVC though the difference between the two is not substantial (72% of OVC compared to 77% of non-OVC). Yet, it should be noted that the combined survey figures mask significant differences between the ADPs and adjacent communities. Due to targeted interventions, a higher percentage of OVC (71%) had access to education in the ADP areas than non-OVC (63%). However, in the adjacent communities, the opposite was seen with a much greater divide between the two: whilst 89% of non-OVC were in school, only 74% of OVC were. Despite this contrast, it is encouraging that there has been a slight increase (4%) in school attendance for both sets of children since 2005.

According to the focus group discussions, those children most likely to be out of school were double orphans, girls, those living with HIV and AIDS and those

with disabilities. Harmful traditional practices, such as early marriage, abduction and heavy work burdens (household chores) were cited as the main reasons why girls do not to attend school. More generally, AIDS-induced destitution and a lack of adequate support were seen to be major factors preventing school attendance, with some informants suggesting that spiritual disturbances, trauma, bereavement, stigma and discrimination either prevented orphans and vulnerable children from attending school or limited their performance in the classroom.

One interesting finding from the survey was that some orphans and vulnerable children in Boset and Badawocho (ADP areas) and in Fentale (adjacent district) were seen to be performing in school as well as if not better than non-OVC due to the care and support being given by family members, primary school teachers and community care coalition members.

Health

Orphans and vulnerable children have the same level of access to healthcare

Whereas the 2005 study found that orphans and vulnerable children were much less likely than non-OVC to receive medical care (61% compared to 84%), the recent survey suggested that they have the same level of access. Combining the results from all four communities, 80% of OVC and 81% of non-OVC who had been ill in the three months prior to survey had accessed health services. There was some difference in access between the ADPs and adjacent areas, with children being more likely to receive medical treatment within the programme areas.

Of those children who received medical treatment, the majority (62.5%) went to public health institutions, a significant number (30.8%) to private health centres, and a small percentage either to NGO health facilities (2.5%) or traditional healers (4.2%). These findings indicate that most households prefer to take their sick children to government health institutions which

provide free healthcare to the poor and destitute. It is also interesting to note the continuing reliance on traditional healing, particularly in rural areas.

Interestingly, although the survey revealed little difference in access, the focus group discussions and key informants felt that OVC were still more likely to be denied healthcare than non-OVC. This was seen to be due to stigma and discrimination, lack of adequate care and financial constraints. One participant in the OVC focus group discussion observed that:

When OVC are sick most guardians don't take them to clinics. Instead they give them medicine (tablets) at home. Only when the sickness gets serious would they take them to clinic. There is a big difference between OVC and non-OVC regarding medical treatment. The guardians take their own children to get medication as soon as they feel unwell. But guardians do not do take the same action for OVC.

Similarly, another OVC participant in Badawach Woreda noted that:

Guardians take their children even for minor headaches as soon as the child feels it. But for the OVC they may take 4 to 5 days, waiting until the illness gets more serious. The reasons they give for this are shortage of money and discrimination. Guardians consider the fact that OVC are not their own children and believe that they are useless regarding future benefits to be gained from them. They only want our labour. They really don't care about us. Idirs (social associations) also don't help. They just give money to the guardians when the child dies. But sometimes the neighbours help the child.

Some FGD participants pointed out that despite the increasing availability and use of health clinics in selected woredas, double orphans were less likely than other children to access such services. They also underlined that there is inadequate care for widows and those OVC who are living with HIV. Despite this, however, there was a feeling that the contribution of community care coalitions, NGOs and district authorities in improving healthcare access for OVC was promising.

Nutrition

Orphans and vulnerable children are less likely to receive normal meals

Food shortage is a severe problem in all four of the communities surveyed and the overall results suggest that OVC are less likely than non-OVC to receive normal meals (consisting of breakfast, lunch and dinner). Less than half of the OVC (45%) ate regular meals compared to 54% of non-OVC. Whereas there was no apparent difference between the two in the ADP areas, in the adjacent communities non-OVC were much more likely to receive normal meals (61%) than OVC (45%). As one key informant pointed out:

Eating normal meals 3-4 times might be common among the 'well-to-do' families but very few OVC eat three times, some others eat once per day and there are even times when OVC go to sleep or go to school without eating and feeling hungry.

Significantly, a comparison with the 2005 survey, which found that 73% of OVC and 98% of non-OVC were receiving normal meals, shows that food security has dropped significantly in all four communities since then. Indeed, in Damot-Gale and Badawacho Woredas it was reported that most households only eat one meal a day. Such food shortage at the time had contributed to the vulnerability of OVC by increasing the likelihood of them wandering the streets and engaging in risky jobs. Poor nutrition is also a major factor affecting the growth, development, health and school performance of children in general and OVC in particular.

Psychosocial support

Only half of orphans and vulnerable children are receiving psychosocial support

The importance of psychosocial support for OVC is widely recognised yet, only half of those surveyed (48%) were receiving such support. Whilst this does mark a significant improvement on the 2005 findings which suggested that only 5% had access to counselling, it indicates just how much more work is required to

Our grandmother is the best. She is so cheerful and makes us laugh every day. For us she is mother and father in one person. But she can also be very strict. If, for example, we don't do our homework or go playing instead of helping around the house. She regularly reads us some passage from the Koran. "We are Muslims, and we mustn't forget it," she keeps saying. Which to us means: love, solidarity, and respect. For us and others. Basically, we are fairly happy so.

Ethiopia: Fetja (10, top left)

photo: Sönke C. Weiss/World Vision



ensure that all OVC get this crucial support. Interestingly, a similar percentage of children were receiving psychosocial support in both the ADPS and adjacent areas. However, those in the ADPs were more likely to receive weekly counselling, with OVC in the adjacent areas tending to receive it on a monthly basis. According to the FGD participants and key informants, psychosocial support is usually provided by local community leaders, relatives, school teachers, religious/church leaders and NGO representatives. The presence of NGOs, FBOs and CBOs was seen as particularly important, especially in terms of increasing the frequency of support.

Family capacity

Few orphans and vulnerable children have their basic needs met

The survey found that the majority of households are headed by women above the age of 50 and rely on subsistence farming to support large numbers of children (often between 6 and 10). Due to the high level of poverty in the area and limited sources of income, only a few households reported being able to provide appropriate care and support for OVC. As one FGD participant put it, '*most families have nothing to give to OVC except sharing poverty*'. Given this, families often struggle to meet the basic needs (identified by the communities as food, shelter and clothing) of their own children and are stretched to breaking point when there are additional mouths to feed. In these situations, OVC are often last in the line for resources and least likely to have their needs met.

Case study

Senait*, aged 14, lost her father to an AIDS-related illness. Since then, as well as dealing with the trauma of bereavement, she has faced stigma and discrimination from members of her community. Following her father's death, Senait and her mother were forced to leave their home, which had become dilapidated, and were offered no support. When the local administrators and court failed to address their concerns, their case was finally taken on by the community care coalition who, in collaboration with a NGO, provided iron sheets and other materials to repair their house. Though now resolved, the whole experience has been traumatic for Senait and has left her struggling to come to terms with her situation. She is both angry and upset and desperately needs appropriate and sustained psychosocial support to help her move on with her life.

*The name has been changed.

Community capacity

Three quarters of OVC households do not receive external support

Despite the high levels of poverty in all four communities, only 23% of households caring for OVC had received some form of external economic support in the past 12 months (examples include school materials and uniform, animals and associated resources, or financial assistance for healthcare). As with many of the other indicators, this marks a downward trend since the 2005 survey which saw around 43% of households receiving external support. What is most surprising is that the decline is particularly marked in the ADP areas: whereas in 2005, 61% of OVC households received external support, in 2010 this had fallen to 24%. This decline in external support has been in part due to a general move by many organisations towards an approach of empowering communities and away from giving out handouts.

The overwhelming majority of participants felt that the provision of material and economic support, whether

by government, NGOs, community care coalition or faith-based agencies, was inadequate and that more should be done to support households caring for OVC. The challenge of this has been seen in Boset ADP, where a Community Care Coalition (CCC) was set up to encourage community participation in caring for OVC but has yet to develop the institutional capacity to provide substantial and sustainable support.



After his father died, four year-old Yonas and his family faced stigma. His mother now provides for them and others.

photo: Jon Warren/World Vision



Chaltu is a thirteen year-old orphan who lives with her grandmother to the southwest of Addis Ababa in Ethiopia. She works constantly around the house to help her grandmother, which sometimes means missing school.

photo: Jon Warren/World Vision

Protection issues

Birth registration

Most children do not have their births registered

Although there is now a legal basis for birth registration in Ethiopia, the practice has yet to be adopted in more than a few regional states and woredas. In the areas under study, no data on birth registration was available, suggesting that no children are currently registered, and only some hospitals and religious institutions were seen to be encouraging it. There are plans to register around 70 children through the municipality office to encourage birth registration in these woredas. However, the associated fee for registration is likely to hamper efforts to introduce and normalize the practice. For example, in Bosset Woreda parents are required to pay birr 60 for each child they register and, as expressed by the FGD participants there, this will prevent many from doing so. Combined with a lack of awareness about the importance of birth registration and an absence, as yet, of any enforcement mechanisms, the situation seems unlikely to change soon.²⁵

Land and property grabbing

Property grabbing is decreasing

According to Ethiopian law, property is transferred to children when both parents die but remains under the control of guardians until they reach the age of eighteen. Unfortunately, in some cases, guardians simply ‘grab’ the property in their care (most often cattle, farmland and ornaments) and keep it for themselves or sell it on. Paternal orphans are also vulnerable to this as male relatives may not respect a widow’s right to her deceased husband’s property.

The nature and prevalence of property grabbing was seen to vary depending on local custom and traditions (e.g. in Fentale Woreda where most people are pastoralists, grazing land and mules are highly valued

and are therefore frequently grabbed). Furthermore, the systems in place for challenging property grabbing are often weak or ineffective. If traditional leaders or local government officials are unable to resolve cases, they refer them to court but this rarely leads to timely and appropriate action being taken. Some cases of good practice were noted in the ADP areas and Damot Gale Woreda due to the reform of legal services, yet these were the exception rather than the rule.

Conclusions and recommendations

Although some improvements have been seen with regard to access to education, healthcare and psychosocial support, the situation for children and OVC in particular remains desperate. Given the current level of food insecurity in Ethiopia, OVC appear to be worse off than they were in 2005 and there is little sign that the situation will improve anytime soon. At a strategic level, the fact that the Government does not have a specific child or OVC policy is proving to be a major stumbling block and the lack of strong leadership and direction on this issue is telling. The first Plan of Action on OVC that was drawn up in 2006 has not yet been updated and, although a set of service delivery guidelines for OVC has recently been developed, much more decisive action is needed to ensure widespread and consistent care for the most vulnerable children.

Recommendations

Given the urgency of the situation for OVC in Ethiopia, the following detailed recommendations have been drawn up to reflect the concerns and suggestions of community members, the researchers involved in this study and World Vision Ethiopia staff:

Policy, plan of action, and protection issues

- The Government must develop a separate National OVC Policy or a comprehensive Child Policy which gives due emphasis to OVC.

²⁵ These findings are supported by the recent report by the African Child Policy Forum entitled *The African Report on Child Wellbeing: How Child Friendly are African Governments?* (ACPF: Addis Ababa, Ethiopia, 2008).



A girl takes part in a candlelight vigil as part of a community group “The Hope and Light Association” that advocates to minimize the stigma faced by people living with HIV and AIDS.

photo: Jon Warren/World Vision



Over 2,000 children drawn from 16 schools in Bahir Dar, Ethiopia, participated in a race to advocate for orphans and vulnerable children and sensitize the community to care for them.

photo: Habtamu Yoseph/World Vision

- The Government must develop a new Plan of Action for OVC covering all aspects of their care and protection (including their legal rights).
- Given the prevalence of property grabbing, the police, judiciary and the other concerned government agencies should increase their efforts to ensure the protection of children’s rights when one or both parents die.
- A birth registration system should be put in place across the country with all partners working together to raise awareness, facilitate registration and ensure consistency of practice.

Advocacy

Intensive advocacy should be undertaken to:

- Encourage high level decision makers to develop policies and strategies on OVCs.
- Ensure that government, donors, NGOs, CBOs, FBOs, and other implementing partners, from federal to kebele level, are aware of and focused on meeting the basic needs of OVC. This should be done under the direction of the Ministry of Women, Youth and Children’s Affairs (MWYCA) and the Bureaus of Women’s Affairs (BOWA).
- Sensitize concerned governmental officials, opinion formers, religious and community leaders etc. so that they understand the problems faced by OVC and appreciate the role society has to play in caring for and protecting them.
- Mainstream OVC issues in all sectors, workplaces, CBOs, FBOs etc. so as to promote ownership and appropriate responses.
- The study has shown that a considerable number of OVC are expelled from their familial environment following the death of their parents. Thus, sensitization and advocacy work should be undertaken to encourage and assist communities in developing alternative child support strategies, such as local adoption, to enable OVC to stay within the community.

MWYCA, BOWA and other concerned government agencies

- The capacity of mandated government agencies at all levels should be strengthened to enable them to effectively discharge their responsibilities in developing a National Plan of Action and in ensuring coordination and follow-up (M&E) of OVC related programmes in the country.
- The mandated ministries, through their structures to the grass-roots level, should work on networking and experience sharing so as to cascade best practices like the CCC.
- In 2010, the Government has developed Standard Service Delivery Guidelines for Orphans and Vulnerable Children with a view to improving the scope and quality of services for OVC. MWYCA and other coordinating agencies, donors, NGOs, FBOs, CBOs etc. must now advocate for the application of these guidelines at service delivery points.
- The strategy of Community Conversation (CC) launched by the Ministry of Health is having a positive impact on community-ownership of and response to issues, including those associated with OVC. They are found to be effective in getting communities to own social (traditional/cultural), economic and even political problems and to provide appropriate remedies. A similar strategy of establishing Community Care Coalitions (CCCs) is being implemented by World Vision in its operational areas. This study has shown that these are an effective means of mobilizing and directing community action. Therefore, it is recommended that concerned government agencies, like MWYCA and BOWA at regional level, should adopt the model and establish and strengthen CCCs in all kebeles across the country.
- In light of the magnitude and complexity of the problem, scarcity of data on the situation of OVC, the diversified nature of children's problems and the limitations of the current study, it is recommended that further research be carried out on the status of marginalized OVC.

Organisational level

- The study has shown that services are not currently meeting the needs of OVC. All actors should therefore adopt the recently developed Standard Service Delivery Guidelines for OVC and revise their services accordingly.
- The study has indicated that organisations operating in the study areas are providing the necessary technical and financial supports to community initiatives targeting OVC. Organisations should work to strengthen Community Care Coalitions and expand the experiences to other parts of the country.
- The study has indicated that most of service providers at the service delivery points do not have the necessary human power to respond professionally to the various problems of OVC. For instance, though emotional and social maladjustment is common among OVC, very few service providers have the necessary human power to provide professional counseling services to them. Thus, it is recommended that organisations should work to build their capacities and also that of other actors, including the community initiatives.
- The study has shown that, due to the loss of their parents, the poverty that makes it difficult for them to support themselves and the social stigma attached to HIV, children tend to develop psychological maladjustment. These psychological problems encourage them to resort to antisocial coping mechanisms. Thus, organisations should develop their capacity in providing standardised guidance and counseling services to enable the OVC to develop healthy coping mechanisms.
- The literature and also this study have revealed that following the death of the mother, a considerable number of children drop-out of school since they are no longer able to afford the school fees, supplies and uniforms. Thus, it is recommended that schools, with an appreciation of the magnitude of the problem, should develop mechanisms to protect OVC from dropping out of school through such

measures as exemption from school fees, provision of counseling service to the children etc.

- The survey indicated that the intervention of World Vision has greatly helped the community in the ADPs. The community in the non-ADP woredas urged World Vision to operate in their woredas so as to save the lives of OVCs. Therefore, we recommend World Vision and/or other partners that are providing similar supports to operate in the non-ADP woredas.

At community level

- The literature has shown that the Government is mobilising community action as a key intervention strategy to tackle several challenges in the community. If communities are mobilised and strengthened (like in the ADPs), they can own the problems and provide appropriate responses. But communities in vast parts of the country are not mobilised and not providing the necessary responses. This is primarily because the role of community institutions in addressing the plight of children in general, and OVC in particular, has not been clearly articulated. Thus, it is recommended that national guidelines developed to facilitate the contributions of community institutions to address the problems of OVC should be applied in all parts of the country.
- The study has shown that there are various biases and stigma attached to HIV that expose OVC to stigma and discrimination. It is therefore recommended that sensitisation should be part of the programmes of all actors working on OVC issues at all levels. In this regard, the role of media and religious institutions is indispensable and should be involved in raising awareness of the community.
- Communities should be sensitised and encouraged to mobilise and make full use of the locally available resources to guarantee sustainability of programmes.
- Communities should strengthen their capacity to provide the necessary care and support services in an organised manner as Community Care Coalitions do in the ADP areas.

At family level

- The findings of the study have shown that OVC perceive that they are treated unfairly in education and health services and in food distribution and that unfair disciplinary methods are sometimes used in their households. Thus, families should be sensitised to be able to understand the problems of OVC so as to eliminate misconceptions, mistreatment, stigma and discrimination.
- The study has also shown that female OVC are often the most vulnerable. Families should therefore be sensitised and educated to treat OVC in general, and female OVC in particular, as being equal with their children.
- The study has shown that health is one of the areas in which OVC, and most specifically those under the age of ten, are affected. Thus, families should be sensitised as to the health needs of OVC and be encouraged to take advantage of the available services that facilitate the overall and healthy development of children.
- OVC households were observed to be proportionally less food secure and more often employing various forms of coping mechanisms such as decreasing the amounts of food and skipping meals as compared to the non-OVC households. This implies the need for intensive livelihood support to OVC households.
- The findings of the study have revealed that most OVC are carrying responsibilities and are involved in work which is far beyond their ages and physical conditions. This is affecting their health, education, psychology etc. Thus, families should be sensitised and educated to treat OVC according to their age.

Orphans and vulnerable children

- OVC should be sensitised about their rights and encouraged to take action to ensure the observance of these rights, including forming associations when appropriate.

chapter 3

Mozambique

Country Fact File²⁶

Total population: **23.4 million**

Orphans: **2.1 million**

Orphans due to AIDS (0-17): **670,000**

People living with HIV: **1.4 million**

Children (0-14) living with HIV: **130,000**

Introduction

Since signing the UNGASS Declaration of Commitment, the Government of Mozambique has made various efforts to tackle the HIV and AIDS epidemic and meet its commitments. As well as developing frameworks for action, such as the National AIDS Strategy and National OVC Plan of Action, the Government has sought to allocate more resources to prevention and mitigation interventions, and to improve services overall. Yet, whilst there has been some progress made to meet the needs of some OVC, many challenges remain and the situation for most vulnerable children remains bleak.

UNGASS monitoring results 2005 & 2010

Monitoring was undertaken in the communities of M'boi and Mutange in the district of Namacurra, Zambézia province, and Mulhaniua and Namilasse in the district of Morrupula, Nampula province. In 2005 the survey only collected data from Namacurra district. Table 4 gives a combined summary of the results from 2005 and 2010, with further detail given in Appendix 3.

Policies and strategies

In 2010 there was still no OVC policy in spite of the strong recommendation in the OVC Plan of Action 2006-2010 that a National Child Policy should be developed to comprehensively address the issue of OVC. It is important that a National Child Policy is developed as soon as the National Child Rights Council has become operational at national and provincial levels.

Despite of the lack of an OVC policy, the Government has taken important steps to address the needs of vulnerable children. In November 2003, the Government held a national OVC seminar with representatives from government institutions, national and international NGOs, CBOs, FBOs, etc. This seminar led to the establishment of the OVC Multisectoral Nucleus at national, provincial and district levels to facilitate a coordinated response to OVC. In 2005, this Nucleus played a key role in the formulation of a National OVC Plan of Action which was submitted to the Council of Ministers by the Ministry of Women and Social Action (MMAS) and approved in the following year.

The OVC Plan of Action 2006 – 2010 outlined the six basic services required by vulnerable children: education, health, food and nutritional support, psychosocial support, legal protection and financial support, and the Plan stresses that 'each OVC receiving support provided by any stakeholder, out of these six basic services, should enjoy at least three'. This requirement aims to ensure an effective improvement of OVC's wellbeing would be achieved with the full implementation of this policy.

The OVC Plan of Action defines fourteen different categories of vulnerable children requiring care and protection:

- Children in households below the poverty line
- Children in households headed by children, youth, the elderly or women
- Children in households where an adult is chronically ill
- Children affected or infected by HIV and AIDS
- Street children
- Children living in institutions (e.g. orphanages, prisons, mental health facilities)

²⁶ Figures taken from UNDP, Human Development Report 2010, UNAIDS, Global Report (2010) and UNICEF, *Children and AIDS: Fifth stocktaking report*, 2010, (UNICEF, UNAIDS, WHO, UNFPA and UNESCO, November 2010).

Table 4: Summary results for Mozambique 2005 and 2010

Domain	Indicator	Combined survey results				Difference between results	
		2005		2010		OVC	Non-OVC
		OVC	Non-OVC	OVC	Non-OVC		
Policies and strategies	Is there a national policy in place for the support, protection and care of orphans and vulnerable children?	No	–	No	–	–	–
Education	School attendance of orphans and vulnerable children (OVC) compared to non-OVC	75%	84%	66%	59%	-9%	-25%
Health	Healthcare access for OVC compared to non-OVC	71%	96%	34%	40%	-37%	-56%
Nutrition	Proportion of OVC receiving normal meals compared to non-OVC	9%	90%	65%	74%	+56%	- 16%
Psychosocial support	Proportion of OVC receiving appropriate psychosocial support	51%	N/A	16%	N/A	-35%	N/A
Family capacity	Proportion of OVC that have three, locally defined basic needs met compared to non-OVC	0%	16%	23%	29%	+23%	+13%
Community capacity	Proportion of households with OVC that receive free basic external support in caring for the children	13%	N/A	61%	N/A	+48%	N/A
Protection	Per cent of children whose births are registered	11%	33%	59%	68%	+48%	+35%
Protection	Prevalence of land and property grabbing	High	–	High	–	–	–

- Children in conflict with the law (e.g. children wanted for petty crimes)
- Children with disabilities
- Children victims of violence
- Children victims of sexual abuse and exploitation
- Children victims of trafficking

- Children victims of the worst forms of child labour (ILO 1999)
- Children who are married before the legally defined age
- Refugee and displaced children.

The OVC Multisectoral Nucleus has also played a major role in coordinating the process of implementing the

OVC Plan of Action. As well as calling on all stakeholders to own the Plan by incorporating it into the planning, implementation and monitoring and evaluation of their programmes, and to hold them accountable to this, the Nucleus has provided mutual learning through experience and information sharing amongst the stakeholders.

Despite these efforts, however, there is concern that the Nucleus is not operating as effectively as it could, particularly at the provincial and district levels. Of particular concern is the fact that the Government has not allocated funds to support its work (UNICEF is continuing to fund it) and lacks the technical capacity at all levels to drive it forward. Another major concern is that the OVC Plan of Action has not been disseminated very widely amongst the different stakeholders including the various government institutions, particularly at district level.²⁷

Education

Orphans and vulnerable children are as likely to attend school

In contrast to the 2005 study, the latest research found that a similar percentage of OVC (66%) and non-OVC (59%) were attending school. However, for both sets of children, the proportion of those in education is down on the 2005 figures, when 75% OVC and 84% of non-OVC were attending school. This decline is surprising given the Government's increased budget allocation to education in recent years and the provision of free primary schooling (including distribution of school materials) throughout the country. One explanation for this may be that, despite raising expectations that children should be able to attend school through to upper primary level (EP2), the funding has not been sufficient to ensure adequate places for this extended provision. This is in part due to population growth in recent years

and, combined with other factors mentioned below, has resulted in a relative decline in the proportion of children in education.

The focus group discussions involving community leaders and caregivers gave a valuable insight into why so many children are still not attending school. Both groups emphasized the following reasons:

- high level of poverty
- low quality of education
- long distances to get to the nearest school.

There was also specific discussion of why children drop out of school and the following causes were cited:

- children expected to stay at home to do housework and other jobs
- early marriage of girls
- lack of school materials, including uniform
- low awareness amongst parents of the value of education that means some do not encourage their children to attend.

Health

Orphans and vulnerable children are less likely to access healthcare

There has been a dramatic decline in the number of children accessing healthcare since the last study and OVC are still the least likely to receive treatment when ill. The percentage of those receiving medical treatment, both OVC and non-OVC, is around half of what it was in 2005. Whereas 71% of OVC who were sick accessed healthcare in 2005 only 34% did so in 2010. Similarly, just 40% of non-OVC received medical treatment in 2010 compared to 96% back in 2005. Again these figures are surprising given that the health sector has, like education, received increased budget allocation in recent years. The task of translating this into concrete

²⁷ After finding out this fact, a group of WV youth volunteers in 2006 in Zambézia province, conducted a public demonstration march handing over one hundred copies of the OVC action plan to the target district administrators appealing them to fully implement it.

action to ensure greater healthcare access at community level is clearly proving a challenge. In particular, the fact that the funding has been used to employ more health staff rather than to build more health facilities means that access, particularly in rural areas, remains poor. The growth in population over the last few years has further exacerbated this.

According to the focus group discussions, there are a number of reasons why not all children are taken to a hospital or health centre when sick, the main ones being:

- long distances to the nearest clinic
- lack of transport and money to access healthcare facilities
- low awareness amongst parents of the importance of modern health services
- propensity to take children to traditional healers who are close by (conventional medicine is often seen as a last resort if children do not get better).

There was also a general feeling that OVC and non-OVC had equal access to health care and treatment, and certainly the figures from the survey suggest that there was not much difference. However, it was acknowledged that households with vulnerable children were less likely to have the resources to take sick children for medical treatment.

Nutrition

Orphans and vulnerable children are less likely to receive normal meals

The follow-up study found that a far greater percentage of OVC had received normal meals (identified as two a day consisting of cassava, maize, fish, beans or rice) in the week prior to the survey in comparison to the 2005 findings. In 2005, only 9% of OVC received normal meals compared to 65% in 2010. Whilst the figures for non-OVC have, in contrast, gone down from 90% to 74% the overall picture remains that OVC are still less likely to receive normal meals than non-OVC. The

contrast between them is nowhere near as great, particularly in the ADP areas where no real difference in meals was observed, but food security continues to be a serious concern for OVC households in particular.

During their focus group discussion, both the community leaders and caregivers raised concerns about declining agricultural productivity in recent years due to drought and other natural disasters. Furthermore, they acknowledged the negative impact that HIV and AIDS has had on the productive capacity of households with sickness and death seriously undermining their ability to provide even the most basic nutrition for their children.

A girl waters plants to help her mother who belongs to a farmers association called Tingania Ni Wutomi in Mozambique, that works the land to help members of the community who have been affected by HIV and AIDS.

photo: Paul Bettings/World Vision



Psychosocial support

Very few orphans and vulnerable children are receiving psychosocial support

Whereas around half of OVC were receiving some form of psychosocial support back in 2005, only 18% of those surveyed in 2010 had similar support. During the focus group discussions, most of the community leaders and caregivers acknowledged the importance of counselling for orphans and vulnerable children and its role in helping them to cope with the issues they face. However, very few specialized psychosocial support services are in place and most communities are struggling to provide even a most basic level of informal support. Such informal support, recognized as being as simple as paying regular visits to a household to check how they are doing, is clearly a first step but more formal approaches are clearly needed if communities are to be able to respond appropriately to the psychosocial needs of some vulnerable children.

In the ADP areas, the role of community caregivers who have received training in psychosocial support was highlighted and particular mention was made of their efforts to bring children together for games and sport. Such activities were seen as an important part of providing psychosocial support to children, both OVC and non-OVC. Yet, given the fact that around 82% of the children surveyed had not received psychosocial support of this or any kind, there is an urgent need to build up the capacity within communities so that they have the appropriate knowledge, skills and motivation to provide widespread and consistent psychosocial support to OVC.

Family capacity

Fewer orphans and vulnerable children have their basic needs met than non-OVC

For the purposes of this study, the three basic material needs identified were food, clothes and school materials. According to the household survey, the



Esmenia is a nine year-old orphan and she is now being taken care of by her grandmother.

photo: Paul Bettings/World Vision

percentage of children, both OVC and non-OVC, having these needs met was higher in 2010 than it was in 2005. However, the figures are still extremely low with only 23% of OVC and 29% of non-OVC receiving adequate food, clothing and school materials. The high level of food insecurity being experienced was raised as a particular concern during the focus group discussions, and this was seen to impact on all other areas of life.

Community capacity

Around two thirds of OVC households receive external support

Whereas only 13% of OVC households surveyed in 2005 reported receiving some form of external support, in the 2010 study around 61% of similar households had been given support. The type of support received did vary between households and was not always substantial or ongoing. However, the very fact that so many had access to assistance is a positive sign. The real challenge now is to ensure greater coverage and depth of support for OVC households so that all those in need receive appropriate and sustained support for as long as required.

During the focus groups discussions, various providers of support were mentioned. The main ones highlighted were the church, the mosque, AMME (a local NGO providing education support in Mutange), World Vision and Save the Children. The support being given included school materials and uniform, clothes, birth certificates, farm tools, food and shelter.

Lydia Moiana is the leader of a AIDS association that was created to assist people who are affected by HIV and AIDS.

photo: Paul Bettings/World Vision



Protection issues

Birth registration

Fewer OVC have their births registered than non-OVC

The latest survey suggests that birth registration is much more common than it was five years ago, with over half of OVC and non-OVC now having their births registered. In 2005 only 11% of OVC and 33% of non-OVC had been registered but in 2010 the figures stood at 59% for OVC and 68% for non-OVC. Whilst it is a concern that OVC are still less likely to have their births registered, the significant increase in registration in recent years is encouraging. A free birth registration campaign was held in the district of Namacurra in 2006 and this clearly had a positive effect.

During the focus group discussions it became clear that the drive for birth registration in each area is coming from the community leaders who recognise its importance for their children. However, there is still some way to go before all parents and caregivers give it the same priority and are able to overcome the obstacles associated with registration, such as the requirement to travel to the District Birth Registration Department and the inefficiency of the service when they do.

Land and property grabbing

Property grabbing is common

According to the community leaders and caregivers who took part in focus group discussions, property grabbing is still a serious problem. Whereas traditionally families would meet together when someone died to discuss how the property and any children were to be taken care of, in recent times it has become more common for different family members to make competing claims for the property and to grab what they can. Houses and land are the main targets for such property grabbing but other items including trees,

bicycles, animals (chickens, goats, pigs etc.) and furniture are also taken.

Although local community leaders, CBOs and FBOs do try to address cases of property grabbing, sometimes using the police and courts to resolve disputes, for the most part they remain in the family sphere where little effective action is taken.

Conclusions and recommendations

Whilst many stakeholders in Mozambique have taken a number of steps to promote the care and protection of OVC, most notably the development of a comprehensive national action plan for OVC, many challenges remain. Improvements are apparent in the provision of external support to OVC households and in the level of nutrition being received by OVC. Birth registration is also on the increase. However, access to education and healthcare is more limited than it was five years ago, fewer OVC are receiving psychosocial support and only a small proportion of children are having their basic material needs met. Given this situation, a renewed effort is needed to drive forward the action plan for OVC with a focus on meeting the UNGASS commitments and making them a meaningful reality for the country's most vulnerable children.

Recommendations

In light of the research findings in Mozambique it is recommended that:

- A National Child Policy should be developed as soon as the National Child Rights Council has become operational at national and provincial levels.
- The Government should target funding to increase the number of health centres, particularly in rural areas, to improve access to healthcare provision.
- Special attention should be paid to the nutritional needs of the most vulnerable children. Government, communities and Civil Society Organisations (CSOs) must work together to ensure the provision of adequate meals.



A young child in Mozambique runs with a toy stick.

photo: Andre Peer/World Vision

- Given the importance of psychosocial support for orphans and vulnerable children, stakeholders should seek to strengthen the capacity of community members to provide such support in a sustained and comprehensive manner.
- Stakeholders should work together to raise awareness of the importance of birth registration and improve the efficiency and accessibility of the registration system.

The following Action Plans have also been drawn up for the communities under study:

**Action plan for Murrupula District:
Mulhaniua and Namilasse**

Education:

- Mobilize work for supporting and maintaining OVC in schools.
- Disseminate code of conduct for teachers and social welfare policy for OVC in schools.

Health:

- Disseminate National OVC Plan of Action in community settings.
- Train community activists, home visitors, parents and community leaders to provide psychosocial support for OVC.

- Train community activists, home visitors, parents and community leaders to provide basic home care for PLWHA and OVC.

**Action plan for Namacurra District:
Mboi and Mutange**

Education:

- Run community led awareness-raising campaigns to prevent drop out of children from school.
- Disseminate Law 6/99 against the access of children to night clubs to discourage behaviour that exposes children to abuse, sexually transmitted diseases (STDs), alcohol, drugs, prostitution, early marriage, etc.

Health:

- Undertake community led awareness-raising on access to health care services, to encourage their use and dissuade people from using traditional healers.
- Campaign for the availability and accessibility to health care services for HIV, maternal care, medication for malaria, TB, HIV and children's related diseases.
- Build the capacity of home visitors to provide psychosocial support for OVC.

chapter 4

Uganda

Country Fact File²⁸

Total population: **31.8 million**

Orphans: **2.7 million**

Orphans due to AIDS (0-17): **1.2 million**

People living with HIV: **1.2 million**

Children (0-14) living with HIV: **150,000**

Introduction

Despite concerted efforts to mitigate the impact of HIV and AIDS in Uganda and significant progress in some areas, the epidemic continues to pose a serious threat to the health and development of millions of children across the country. With most of Uganda's orphans being cared for by extended family, the pressure on these households can be immense. Many caregivers are overburdened and struggle to provide the care and support required. This may mean that children's basic needs are not met, or that they are required to 'grow up fast' and take on responsibilities far beyond their years. Worse still, they may find themselves the victims of exploitation and abuse, being forced into child labour or made to endure the trauma and degradation of sexual abuse.

UNGASS monitoring results 2005 & 2010

Monitoring was undertaken in two communities within the sub-county of Rukiga in Kabale district and two communities in the sub-county of Kasangombe in Luweero district. Table 5 gives a combined summary of the results from 2005 and 2010, with further detail given in Appendix 4.

Policies and strategies

Uganda has various policies and national guidelines in place to support a multi-disciplinary national response to the HIV epidemic. These include policies on Orphans

and Other Vulnerable Children (OVC), Universal Primary Education (UPE), Universal Secondary Education (USE), HIV Counselling and Testing (HCT) policy, and Anti-Retroviral Therapy (ART). In addition, a National HIV and AIDS Strategic Plan (NSP) 2007/08 -2011/12 has been developed to guide programmatic responses under the four themes of prevention, care and treatment, social support and systems strengthening. This Strategic Plan was formulated through a highly consultative process that involved a wide range of stakeholders (government ministries, research institutions, private sectors, national and international NGOs, UN agencies, donor agencies and individuals) and provides an agreed framework for action.

The national policy on Orphans and Other Vulnerable Children was launched in June 2005 and laid the foundation for a multi-sectoral, integrated, gender-sensitive, rights-based approach to tackling the issues faced by Orphans and Vulnerable Children (OVC). Its main objectives are to:

- create a conducive environment for the survival, growth, development and participation of vulnerable children and households;
- deliver integrated and equitably distributed quality essential services;
- strengthen the legal, policy and institutional frameworks; and
- enhance the capacities of households, communities and other implementing agents and agencies.

The accompanying Strategic Programme Plan for Intervention (NSPPI) provides a framework for policy implementation and has become an integral part of the Uganda Social Development Investment Plan (SDIP) and PEAP, within the framework of the Millennium Development Goals (MDGs) and the UNGASS commitments. Its guiding principles include:

²⁸ Figures taken from: Uganda Bureau of Statistics, *2010 Statistical Abstract*; UNDP, *Human Development Report 2010*; UNAIDS, *Global Report (2010)*; and UNICEF, *Children and AIDS: Fifth stocktaking report, 2010*, (UNICEF, UNAIDS, WHO, UNFPA and UNESCO, November 2010).

Table 5: Summary results for Uganda 2005 and 2010

Domain	Indicator	Combined survey results				Difference between results	
		2005		2010		OVC	Non-OVC
		OVC	Non-OVC	OVC	Non-OVC		
Policies and strategies	Is there a national policy in place for the support, protection and care of orphans and vulnerable children?	Yes	–	Yes	–	–	–
Education	School attendance of orphans and vulnerable children (OVC) compared to non-OVC	90%	97%	97%	94%	+7%	-3%
Health	Healthcare access for OVC compared to non-OVC	93%	96%	98%	98%	+5%	+2%
Nutrition	Proportion of OVC receiving normal meals compared to non-OVC	70%	92%	75%	69%	+5%	- 23%
Psychosocial support	Proportion of OVC receiving appropriate psychosocial support	41%	N/A	50%	N/A	+9%	N/A
Family capacity	Proportion of OVC that have three, locally defined basic needs met compared to non-OVC	22%	63%	26%	5%	+4%	-58%
Community capacity	Proportion of households with OVC that receive free basic external support in caring for the children	33%	N/A	62%	N/A	+29%	N/A
Protection	Per cent of children whose births are registered	37%	44%	33%	19%	-4%	-25%
Protection	Prevalence of land and property grabbing	High	–	Moderate	–	Decrease	–

- building on the human rights-based approach to programming
- making the family and community the first line of response
- focusing on the most vulnerable children and communities
- reducing vulnerability
- facilitating community participation and empowerment
- promoting gender equity
- treating recipients with respect
- reducing discrimination and stigmatisation
- ensuring the social inclusion of marginalised groups

- ensuring the participation of vulnerable children and families
- strengthening partnerships
- delivering integrated and holistic services
- supporting services delivery through decentralization
- designing age-sensitive programmes.

In an effort to ensure effective implementation of the above, the Government has put various enabling structures in place. An OVC secretariat exists in the Ministry of Gender, Labour and Social Development and there is continued effort to replicate or mirror the same structure at district and sub county levels of local government. At district level there is the District OVC Coordination Committee [DOVCCC] while at the sub county level efforts are being explored to establish OVC coordination committees. At all levels the committees are multi-disciplinary and include the departments of health, education, production, community-based services and the political leadership.

To enhance service delivery to OVC, a Civil Society Fund (CSF) was created in 2007 to pool funds and encourage common ownership of strategic responses. The CSF harmonises donor funding and aligns it to key elements of the National Strategic Plan. Over the last few years, the CSF has disbursed grants to local Community Based Organisations (CBOs,) Faith Based Organisations (FBOs), Non-Governmental Organisations (NGOs), and district local governments.

Education

Orphans and vulnerable children are just as likely to attend school

Due to the enrolment success of Uganda's Universal Primary Education Policy (UPE), the 2005 research found that a high percentage of both OVC (90%) and non-OVC (97%) were in education. Five years later the same remains true, with a slight increase in the proportion of OVC attending school (97%).

However, as before, many challenges remain in seeking to translate this high coverage into a quality education for all.

As in 2005, the focus group discussions involving parents/guardians and community leaders revealed a host of reasons why some children still drop out of school. These are:

- Children can be discouraged by poor academic performance.
- High extra charges such as development funds and exam fees/registration.
- Inability of parents/guardians to afford school requirements (scholastic materials, uniforms, meals while at school). This situation was said to be more associated with parents/guardians who have many children to take care of.
- The need in poor households for children to do household chores and help with farming e.g. look after cattle and help with cultivating crops.
- There is inadequate monitoring of school attendance under the UPE system by the school administration and district education department.
- Low parental involvement in children's education.
- Girls falling pregnant.
- Inadequate support for the OVC, especially those left in the care of their grandparents.
- Unfavourable learning conditions for children with disabilities.
- Absence of or inadequate alternative school system to provide vocational skills.
- Peer pressure often drives many boys into destructive behaviour e.g. heavy drinking, nightclubbing, gambling and consequent irresponsible living.
- Lure of employment. During the school holidays, boys are encouraged to take on jobs to earn money and this may lead to them dropping out of school for business.

Health

Orphans and vulnerable children have the same level of access to healthcare

According to the survey, 191 children (22%) had suffered illness at some point during the previous three months. Of these, the overwhelming majority of both OVC (98%) and non-OVC (98%) were able to access medical treatment. Though this was also the case in 2005, the recent research suggests a slight increase in the percentage accessing healthcare since then.

During the FGDs and key informant interviews, the following reasons for children not receiving medical treatment were given:

- Long distances to the health facilities and the associated problems with transport.
- Shortage of drugs in health centres.
- Discrimination against orphans, especially those whose parents died of HIV and AIDS. Some guardians think that offering medical attention is a waste of resources to an orphan who is HIV infected and therefore thought to be going to die (though the Home Visitors focus group discussion did suggest that such discrimination is reducing).
- Some households are unable to afford private medical services if there is a shortage of drugs in the government health centres.
- Due to child neglect, some children are not taken to hospital. A case was cited where a mother locked a child suffering from epilepsy in the house instead of seeking medical attention.

Nutrition

Orphans and vulnerable children are as likely to receive normal meals

Back in 2005, OVC were much less likely to be receiving normal meals than non-OVC. However, according to the recent survey, this gap has narrowed

considerably with 75% of OVC and 69% of non-OVC reported to have had normal meals (considered to be two a day) over the last week. There was also no significant difference between meals given to boys and girls in any of the communities. It is of course important to recognise that, as observed in the FGDs, access to food varies depending on the agricultural season with food being most scarce during planting time. It was also noted that children are likely to eat less on the days they are at school.

Psychosocial support

Only half of orphans and vulnerable children are receiving psychosocial support

The focus group discussions identified trauma, bereavement, stigma and discrimination as the main causes of psychosocial problems amongst OVC. However, despite these recognised needs, there continues to be a marked difference in the level of psychosocial support given to OVC in the World Vision programme areas compared to the adjacent communities. Whereas, 72% of OVC households in the ADP areas reported receiving counselling, only 28% of those in the adjacent communities received similar support. In some ways, this is not surprising, but it is indicative of the need for a more comprehensive strategy for ensuring appropriate psychosocial support for OVC across the country. The patchy nature of support seen in 2005, remains the same five years on with many vulnerable children still failing to receive even the most basic counselling. This is reflected in the combined figure which suggests that only 50% of OVC households are receiving psychosocial support. This is up a few percent on the 2005 figures when only 41% were reported to have received counselling, but is still worryingly low.

Family capacity

Due to targeted interventions, more orphans and vulnerable children have their basic needs met than non-OVC

The three basic material needs identified by community caregivers were good clothing, decent bedding and life skills. Interestingly, this varies from the 2005 survey which highlighted shelter, water and clothing as the most important after food, education and healthcare.

According to the survey, only 26% of orphans and vulnerable children had all three material needs met, with the majority of these living in ADP areas. This represents a slight increase on the 2005 figures which saw this at 22%, but still suggests that around three quarters of OVC are not having their basic needs met. More worrying still is the fact that just 7% of the non OVC were reported to have good clothing, decent bedding and life skills. This marks a dramatic decrease from the 63% reported in the previous study, though it

is important to bear in mind that the definition of basic needs has changed since then. However, in terms of the difference between the experiences of OVC and non-OVC, the focus group discussions and interviews with key informants highlighted some pertinent issues relating to the impact of programme interventions:

- Programming bias towards supporting orphans and other vulnerable children may inadvertently exclude non OVC from service provision. In particular, life skills support at household level tends to be targeted to OVC.
- It was noted that it is common for orphans to be given clothing, bedding and guidance/life skills of a better quality and higher cost than that which the parents can afford for their own children. As one FGD participant observed, *'When the home visitor comes to my home she only asks and attends to my niece because she is an orphan'*.



Sunday is a seven year-old orphan living with his grandmother in Uganda. World Vision gave Sunday a goat and his grandmother is hopeful that when it gives birth she will sell the kids and get money to take care of Sunday.

photo: Sylvia Nabanoba/World Vision

Community capacity

Almost two thirds of OVC households receive external support

Supported by the national policy framework, both the ADPs and their adjacent communities have functioning community based structures that respond to the needs of OVC. In the ADP communities, a Community Care Coalition (CCC) model is pursued which complements government efforts to scale up responses for OVC and ensures quality improvement in the services offered.

In Kasangombe ADP there are currently 13 Community Care Coalitions and 1605 home visitors providing support to 11093 OVC. Likewise, Rukiga ADP has 12 Community Care Coalitions and 380 home visitors serving 3098 OVC. The CCCs aim to take a holistic approach and support a range of interventions to ensure adequate care and support for OVC. These include production enterprise support (distribution of cows, pigs, goats and hens), educational support (provision of scholastic materials), improving housing conditions (shelter construction), as well as enhancing social child protection (advocacy skills training).

During the recent survey, 62% of households reported receiving some form of external support compared to just 33% back in 2005. Medical support was the one most often cited and there has been a particularly

marked increase in this kind of support in the communities adjacent to the ADPs (rising from 2% in 2005 to 43% in 2010). School support is also provided but not to the same level and ADP households are much more likely to receive this (15% compared to 2% in the non-ADP areas). This increase in external support is clearly a positive step forward but more needs to be done to ensure that the remaining 38% of households are also supported.

Some other aspects of the support provided by the Community Care Coalitions, identified by the FGDs, key informants and through a document review, are:

- Training – mainly covering advocacy, child rights, responsibilities and protection
- Tangible items such as:
 - stationery for coalition records
 - offers by schools to take care of OVC especially in the lower primary level (e.g. Believers Hope Primary School, Good Morning Primary School and Kiziba Primary Schools in Kasangombe ADP)
 - Political support whereby leaders complement the advocacy efforts of the CCCs. Particular cases include the involvement of political leaders in the sourcing of resources towards OVC care from the NGOs, taking responsible action to protect children and apprehending people who abuse children's rights.

Bernard Ssekirevu is a home visitor with the Kalokola Community Care Coalition in Uganda, and he watches over 12 vulnerable children in his village such as 14 year-old Ssenfuka who was orphaned at the age of nine.

photo: Paul Bettings/World Vision



Protection issues

Birth registration

Most children do not have their births registered

In spite of growing recognition of the importance of birth registration and support from the Government and NGOs, only 33% of OVC and 19% of non-OVC were reported to have had their births registered. This marks a decrease on the 2005 survey results and suggests that a great deal more effort is needed to encourage and facilitate birth registration in Uganda.

Land and property grabbing

Property grabbing is decreasing

According to the FGDs and key informant interviews, intensive efforts have been made by the Government, communities and NGOs in recent years to protect the property of OVC and widows. This has been done through awareness-raising and the strengthening of established structures. It was mentioned that there was a higher likelihood of property grabbing when a man dies than a woman and that the most common target is land, followed by housing, farm animals, family assets and household furniture. Losing property in this way was seen to hasten the vulnerability of people who care for children and the children themselves (the point was also made that, in the event of the loss of one of the parents, women are likely to take better care of their children than men).

During the six months prior to the study, eleven cases of property grabbing were reported by the Community Development Officers and the overall impression is that the problem is decreasing. The following community actions were seen to have contributed to this:

- Responsive political local leadership
- Involvement of the Community Development Officer
- High awareness of the property rights of women and children
- Multi-disciplinary approach pursued to support OVC.

Conclusions and recommendations

In many ways, the last five years have been a success story for Uganda. Education and access to medical care continue to be strong points and the indications are that support for orphans and vulnerable children has strengthened. However, there is still a long way to go before all OVC have their basic needs met and the households caring for them receive adequate support. The provision of psychosocial support is of particular concern, with only half of OVC having access to appropriate counselling and support. While property grabbing is seen to be decreasing, birth registration continues to be low which undermines the legal status of many vulnerable children and hinders efforts to realise their rights.

With no easy fixes on the horizon, Uganda must keep up the momentum in seeking to ensure the care and protection of its orphaned and most vulnerable children. A decade on, there needs to be a renewed sense of urgency about meeting the UNGASS targets and a commitment at every level to build on existing strengths and target continuing areas of weakness.

Recommendations

In light of the research findings in Uganda, the following recommendations have been made:

- Ensure regular monitoring of school attendance under the Universal Primary Education (UPE) system by the school administration and district education department. This will enable sustained improvement in children's academic performance.
- Undertake monitoring to avert school drop outs as a result of inability to meet school charges such as development funds and exam fees/registration.
- Mobilize parents/guardians to be continually involved in their children's education.
- Enhance life skills education to check the occurrence of pregnancies among school children.
- Mobilize multi-support mechanisms for OVC, especially those left under the care of their grandparents.



Students at the school in Kasangombe, Uganda, perform AIDS educational dramas.

photo: Jon Warren/World Vision

- Improve learning conditions of children with disabilities.
 - Scale up programmes that provide vocational skills to serve as an alternative school system.
 - Advocate for adequate medical supplies at government health facilities.
 - Promote equity and equality in child care to avert child neglect and discrimination especially orphans whose parents died of AIDS.
 - Scale up programmes that boost household financial capacity to enable households to afford medical services.
 - Scale up provision of psychosocial support to OVC.
 - Advocate and explore mechanisms that ensure children have access to normal meals all year round. This effort should avert food scarcity associated with the time of planting as well as less feeding by some children during schooling days.
 - Ensure the OVC programming and consequent delivery of basic material needs (clothing, bedding and life skills) does no harm to the non-OVC.
- Reasonable effort should be undertaken to avoid creating a unique social class for the supported OVC.
- Strengthen the complementary approach at the sub county level between the tripartite structures of the Community Care Coalition, OVC CSOs and the Sub county OVC co-ordination committee through regular interface forums.
 - Strengthen advocacy efforts to ensure enactment of by-laws that necessitate all schools to engage in social responsibility of supporting OVC welfare.
 - Strengthen responses that ensure child birth registration as a step towards child protection.
 - Strengthen community actions to deter any incidences of OVC property grabbing through a multi-disciplinary approach involving the political leadership, Community Development Officer and awareness creation of the property rights of women and children.

chapter 5

Zambia

Country Fact File²⁹

Total population: **13.3 million**

Orphans: **1.3 million**

Orphans due to AIDS (0-17): **690,000**

People living with HIV: **980,000**

Children (0-14) living with HIV: **120,000**

Introduction

The HIV pandemic has had a complex and multifaceted socio-economic impact on households, communities, and government in Zambia. The loss of a significant proportion of the productive age group due to HIV and AIDS has deepened poverty and left many grandparents and children as head of the household with responsibility for caring and supporting orphaned children. In rural communities, the strong extended family and kinship networks that have traditionally functioned as a social support system in times of need are facing serious challenges. Households and communities are ‘collapsing’ under the weight of care and support needs brought about by HIV and AIDS and require urgent assistance.

UNGASS monitoring results 2005 & 2010

Monitoring was undertaken in the communities of Kanchindu and Siansowa in the District of Sinazongwe, Southern Province, and Nyampande and Matonga in the District of Petauke, Eastern Province. Table 6 gives a combined summary of the results from 2005 and 2010, with further detail given in Appendix 5.

Policies and strategies

Although the Zambian Government has revised its national child policy, launched in 2006, to incorporate OVC issues, the continuing absence of a separate OVC

policy is hampering progress. A key informant from the Ministry of Sport Youth and Child Development (MSYCD) revealed that the Government has been reluctant to develop a specific OVC policy for fear of increasing stigma and discrimination against orphans and vulnerable children by singling them out. Instead they have opted to merge assistance funds for OVC into general aid categories such as HIV and AIDS, children, and youth. There is concern, however, that this approach has resulted in a lack of prioritization for OVC within national development plans. As the results from the survey show, this failure to prioritize has weakened efforts to ensure the care and support of OVC and has left Zambia struggling to meet the UNGASS commitments.

Despite its reluctance to develop an OVC policy, the Government has put a number of policy frameworks and national support structures in place. These include a high level Cabinet Committee of Ministers on HIV and AIDS which provides policy direction as well as supervising and monitoring the implementation of HIV and AIDS programmes, and the National AIDS Council and Secretariat (NAC) which was established through an Act of Parliament in 2002 to be a broad-based corporate body with government, private sector and civil society representation. The NAC is the national mechanism, mandated and guided by the National HIV/AIDS/STI/TB policy of 2005, to coordinate and support the development, monitoring and evaluation of a multi-sectoral national response to HIV and AIDS. Its overall mission is to combat and prevent the spread of HIV and AIDS and reduce the personal, social and economic impacts of the epidemic. The NAC sub-group on Impact Mitigation has drafted a set of national OVC guidelines, but these have yet to be finalised with the inclusion of a Monitoring and Evaluation (M&E) framework.

²⁹ Figures taken from UNDP, Human Development Report 2010, UNAIDS, Global Report (2010) and UNICEF, *Children and AIDS: Fifth stocktaking report, 2010*, (UNICEF, UNAIDS, WHO, UNFPA and UNESCO, November 2010).

Table 6: Summary results for Zambia 2005 and 2010

Domain	Indicator	Combined survey results				Difference between results	
		2005		2010		OVC	Non-OVC
		OVC	Non-OVC	OVC	Non-OVC		
Policies and strategies	Is there a national policy in place for the support, protection and care of orphans and vulnerable children?	No	–	No	–	–	–
Education	School attendance of orphans and vulnerable children (OVC) compared to non-OVC	64%	72%	32%	48%	-32%	-24%
Health	Healthcare access for OVC compared to non-OVC	80%	95%	61%	73%	-19%	-22%
Nutrition	Proportion of OVC receiving normal meals compared to non-OVC	31%	81%	18%	35%	-13%	-46%
Psychosocial support	Proportion of OVC receiving appropriate psychosocial support	36%	–	34%	–	-2%	–
Family capacity	Proportion of OVC that have three, locally defined basic needs met compared to non-OVC	25%	64%	28%	51%	+3%	-13%
Community capacity	Proportion of households with OVC that receive free basic external support in caring for the children	68%	–	48%	–	-20%	–
Protection	Per cent of children whose births are registered	92%*	96%*	0%	1%	No change	No change
Protection	Prevalence of land and property grabbing	High	–	Moderate	–	Slowly decreasing	–

* On reflection it appears that the figures from the previous study may have been a result of parents/carers mistaking birth registration for receipt of an under five card issued by health facilities.

In addition, there is a National OVC Steering Committee but this has been fairly inactive in recent years. Using the national child policy as the guiding policy framework on OVC issues, the Government has been working with other stakeholders to produce a National Plan of Action (NPA). However, the fact that this plan has remained in draft form

for a long time suggests a lack of strong leadership and a level of complacency in tackling the specific needs of OVC. Whilst HIV is clearly articulated in the Fifth National Development Plan as well as other development plans, clear policy direction for the care and protection of orphans and other vulnerable children is somewhat lacking.

Education

Orphans and vulnerable children are just as likely to attend school

There has been a notable decline in school attendance since the 2005 survey and OVC are still the most likely to be missing out on an education. According to the recent research, only 32% of OVC aged 7-14 were attending school compared to 48% of non-OVC. It is also interesting to note that girls were significantly less likely to be in school than boys, with only 28% of female OVC and 42% of female non-OVC attending.

There are many reasons why children, and girls in particular, are unable to attend school. Many households do not have the funds to pay the necessary school fees and children may be kept at home to help with housework or to care for sick parents or younger siblings. The focus group discussions also revealed that children may drop out of school because of the distance they have to travel or the inaccessibility of their local school during the rainy season (when streams overflow and bridges may be washed away). Other issues mentioned were the need to care for incapacitated guardians, early marriage/child pregnancy, poverty, lack of school/educational support and little appreciation by most parents of the value of education.

The study found that a small percentage of the OVC attending government schools had either obtained a bursary from the Department of Social Welfare or the Ministry of Education, though the kind of support provided was inadequate and limited in coverage. It was also interesting to note that 87% of the respondents were unaware of the existence of this bursary scheme. Some other children received educational support from NGOs including World Vision, Save the Children Norway and Child Fund.

Health

Orphans and vulnerable children are less likely to have access to healthcare

As with education, the figures from the recent survey suggest that fewer children have been able to access healthcare compared to 2005 and that OVC remain the least likely to receive medical treatment. Of those OVC who were ill during the three months prior to the study, only 61% accessed some form of healthcare compared to 73% of non-OVC.

During the focus group discussions, a number of reasons were cited to explain why children may not receive medical treatment when they are ill. As well as the inaccessibility of healthcare facilities (particularly during



Royd is determined to make the most of his schooling in spite of living with HIV.

photo: Collins Kaumba/World Vision



These children in Gwembe District, Zambia are now looked after by their 75 year-old grandmother after they lost both their parents.

photo: Collins Kaumba/World Vision

the rainy season) and the shortage of medical supplies, the cost of treatment was seen to be prohibitive for many households, particularly those caring for orphans. It was also acknowledged that some guardians give priority to their own children and fail to provide OVC with the same level of care. Alongside these issues, the fact that some communities maintain a strong belief in the efficacy of spiritual and traditional remedies means that parents/guardians are more likely to turn to these than take children for conventional health treatment.

Nutrition

Orphans and vulnerable children are less likely to receive normal meals

A scarcity of food, and consequent poor nutritional content of meals, was a real concern across all four communities surveyed. Very few children overall were receiving normal meals and OVC were the least likely to eat regularly (18% compared to 35% of non-OVC). The fact that the percentage of non-OVC receiving normal meals is significantly lower than in 2005

(when 81% were reported to receive them) can be explained in part by the timing of data collection; whereas in 2005 the survey was carried out between August and September, this time it was done in January and February, the months when food shortage is most severe. Whilst this makes the figures hard to compare, the survey results highlight the level of food insecurity in these communities as well as revealing that, whatever the season, it is the orphans and vulnerable children who are most likely to go hungry.

During the focus group discussions, most people attributed this problem to the size of OVC households, which tend to be larger than non-OVC households, and to the death or illness of the main breadwinner. Hunger and starvation are common place in such households and children survive as best they can. As one child in Nyamphande ADP put it, *'we just survive on mangoes this season, but when we are at school...we at least feed on porridge under the WFP – school feeding programme. This only happens during the school term, otherwise during weekends and when schools are on recess, we really starve'*.

Psychosocial support

Only a third of orphans and vulnerable children are receiving psychosocial support

As in 2005, many OVC are not receiving psychosocial support. Whilst in the ADP areas, 51% of OVC households reported that they had been visited by community care givers either weekly, once a month or once in a while, only 13% of those in the adjacent communities were given similar support. This means that only 34% of the total number of OVC received some form of psychosocial support. Whilst it was noted that a further 27% of the OVC did not need support, this is open to interpretation and should not be taken to mean that their psychosocial needs were being met.

Clearly, much work is still needed to raise awareness of and build the capacity of communities to provide psychosocial support to orphans and vulnerable children. Amidst the myriad of challenges faced by households in Zambia, such provision is perhaps low down on the priority list, but it should be seen as a fundamental part of mitigating the long-term impact of HIV and AIDS.

Family capacity

Fewer orphans and vulnerable children have their basic needs met than non-OVC

Mirroring the results of 2005, the recent survey found that OVC were much less likely to have their three basic needs met (identified as food, education and shelter).³⁰ Given the many challenges faced by OVC households, only 28% of OVC had these basic needs fulfilled compared to 51% of non-OVC. The contrast between the two was even starker in the adjacent communities where only 14% of OVC were considered to have adequate food, education and shelter.



Orphan Enoch with caregiver Roderick. Caregivers provide essential emotional, social and practical support to children and their guardians.

photo: Jon Warren/World Vision

Community capacity

Around half of OVC households receive external support

Due to World Vision's programme activities, 83% of OVC households in the ADP areas reported receiving some form of external support (either school, medical or other). However, the story was very different in the adjacent communities where only 14% received similar support. Combining these results suggests that, at best, around half of OVC households are receiving some level of support from external sources. Given the level of poverty in these households and the fact that many OVC are not having even their most basic needs met, this is a disturbing reality.

³⁰ The three basic needs identified in this study were slightly different from those highlighted in 2005, when water, shelter and clothes were seen to be the main essentials.

In terms of the support currently being given by World Vision, the ADPs are implementing a community-led model known as Community Care Coalition (CCC). This model involves mobilizing and strengthening existing community structures to enable them to provide care and support for the OVC as well People Living with HIV and AIDS (PLWHA) in the community. The CCCs operate at village level or according to the social and geographic realities of the area. In most cases, the Community Care Coalitions are built around existing structures (such as churches, women's groups or lay pastoral caregivers) which take the lead in strengthening the coalitions. Formed through community elections, self-nomination of interested community members or nomination by the OVC themselves, each CCC then elects its leadership including a chair, secretary, and treasurer.

Other sources of support were identified but these were regarded as having minimal impact. These included the bursaries scheme for OVC implemented by the Social Welfare department, as well as the District Welfare Assistance Committees (DWACs) and the Community Welfare Assistance Committees (CWACs) which sometimes provide food, blankets and clothing to vulnerable households.

Caregivers in Zambia mix a high protein powder of soy flour, corn flour, sugar and powdered milk that is distributed to malnourished people living with HIV and vulnerable children.

photo: Jon Warren/World Vision



Protection issues

Birth registration

The vast majority of children do not have their births registered

According to the survey, parents in each of the four communities were unaware that they could, and indeed should, obtain an official birth certificate for their children. Interestingly, many parents were confused about the meaning of birth registration, and mistook the recording of a birth at a health facility and the receipt of an Under Five Card for formal registration. The 2005 study suggested that a high proportion of births, both of OVC and non-OVC, were registered but it is now clear that this was not the case and that the respondents were actually referring to the Under Five Card as a form of registration. In the latest survey, only one child had been registered and given a birth certificate. As it turned out, this was only because the family had been in Lusaka at the time and was encouraged to do so.

Although the importance of birth registration is widely recognised, particularly in terms of conferring citizenship and ensuring legal protection, the focus group discussions in Zambia revealed a level of nonchalance about it. The fact that birth certificates are not required to access most services means that many people are either oblivious to or unconvinced of the value of birth registration. This came across strongly in the focus group discussions, and even those who were aware of registration complained that the district offices were too far away and that the certificates took too long to be issued (anything up to two years due to the centralized system).

Land and property grabbing

Property grabbing is decreasing

Although property grabbing is still a serious concern in Zambia, this study suggests that the practice is slowly declining. This was particularly evident in Petauke

District where 91% of the households surveyed (in both the ADP and adjacent area) indicated that property transfer was now being guided by a legal framework. In Sinazongwe District, property grabbing (mainly of symbols of wealth such as cattle, ploughs and land) is still taking place but not to the extent that it was. The focus group discussions in this area revealed that despite the passing of legislation on property transfer, some sections of the community were not adhering to the law as they saw the confiscation of property as part of their culture. The study found that this practice was more pronounced amongst certain ethnic groups than others, especially amongst paternal and polygamous families. It is also interesting to note that the majority of the men who took part in the focus group discussions expressed some disquiet about the legislation, and complained that it was only meant to disempower them. Furthermore, whilst most victims knew that they could go to the police or local court to complain, there was often a feeling of trepidation about doing so.

Conclusions and recommendations

The picture from Zambia is a worrying one. Fewer children are now in education or accessing healthcare and the overwhelming majority of OVC are not having their most basic needs met. Whilst some efforts are being made to ensure the care and protection of orphans and vulnerable children, a lack of focus and drive at a national level is hampering progress at the grassroots. The continuing absence of an OVC policy is symptomatic of this and a timely and targeted response is now desperately needed.

Recommendations

In light of the research findings in Zambia, the following recommendations have been made:

- There is need for clear policy direction from the Government for care and protection of orphans and other vulnerable children through explicit policy guidance. There is need to speed up the

process to implement the National Plan of Action for Children.

- The Government should ensure that local level health and education service providers are educated about the health user fee exemption policy for vulnerable groups and the free basic education policy respectively. This is to respond to the study findings that user fees and PTA/project fees imposed by service providers at facility level impacted negatively on vulnerable members of the community in terms of access to health and education services.
- The Government should scale up the school feeding programme which it is currently implementing in collaboration with UNICEF in selected schools. Most children and care givers spoken to during focus group discussions felt that it was a good incentive to keep vulnerable children in school.
- Given the gap in the provision of psychosocial support in both ADP and non-ADP communities in the two Districts of Sinazongwe and Petauke, these communities should be empowered to provide psychosocial support to OVC through capacity building; the study revealed that in both ADP and non-ADP zones, community members were not actively involved in the care of orphans through provision of material support and psychosocial counseling.
- The Government and civil society should embark on civic education on the importance of birth registration, particularly highlighting their importance for protecting the legal rights of children. The process of applying and acquiring legal birth certificates should be decentralized to make it more accessible than the current system which requires it to be done centrally in Lusaka. This could be done by setting up registration offices at health centre level.
- The Government should produce a social protection policy supporting the national scale-up of social cash transfers and strengthening child welfare services, including bursaries for vulnerable children.
- The family model of caring for OVC should be improved by training of guardians, parents and communities (caregivers) in child rearing and counselling skills and other coping mechanisms such as managing grief and bereavement. The findings of the study also indicate that some carers require training in parenting and fostering as their relationship with OVC is not good.
- The Government and civil society organisations should create awareness on the property transfer legislation and help ordinary citizens with its interpretation.
- The Government should strive for sustainable funding for the impact mitigation unit of the National AIDS Council as this unit addresses strategic objectives relating to OVC and families made vulnerable by HIV and AIDS. This can possibly be achieved through the establishment of a trust fund.

conclusion & recommendations

Whilst advances have been made in mitigating the impact of HIV and AIDS in recent years, many challenges remain in seeking to ensure that the most vulnerable children receive the support and protection they need. Following on from the 2005 *More than words?* report, this study reveals a mixed picture across the four African countries and shows just how difficult it has been for governments and other stakeholders to meet the commitments made at the UN General Assembly Special Session on HIV and AIDS back in 2001. On the one hand, Uganda continues to demonstrate good progress in ensuring that orphans

and vulnerable children have equal access to education, healthcare and other services. Yet, the overall picture is far less encouraging with Zambia in particular struggling to support its most vulnerable children. Extreme poverty and low community capacity is proving an almost insurmountable problem in some areas of the country and the situation for children in general, and the most vulnerable in particular, appears bleak. Perhaps most worrying of all is the continuing lack of a specific national policy for orphans and vulnerable children in three of the four countries surveyed. The absence of such a targeted policy in Ethiopia, Zambia and Mozambique is undoubtedly hampering the overall effectiveness of their efforts to provide comprehensive and sustained support for vulnerable children, and requires urgent attention.

Given the situation, the task of ensuring the protection, care and support of all orphans and vulnerable children remains as daunting as ever. Yet, now is not the time to be disheartened. Building on the work that has already been done, there needs to be a renewed energy for action and a refocusing of efforts to address the shortcomings of the last decade. As a new consensus emerges for *'broader forms of action to protect and empower the most vulnerable members of society'*, it is crucial that governments and all other stakeholders commit to and take targeted action to ensure that the next decade of action can make a real difference in the lives of the most vulnerable children.³¹ In recognition of this, and drawing on the findings from this research and the action plans put forward by communities themselves, World Vision makes the following series of recommendations.

My brother is never really focused. He always tells stories and jokes. I think he wants to become a comedian. However, he is trying to help in the house. But mostly I send him to the village in order to make some money. He is better in doing that. Somehow he always manages to organize something edible for us. Our parents died together. My mother one day after my father. I promised them to take care of my brother. I am going to keep that promise. Even though it's difficult sometimes.

Malawi: Khembo (18, right)

photo: Sönke C. Weiss/World Vision



National

- Fully implement Articles 65-67 of the 2001 UNGASS Declaration of Commitment on HIV/AIDS³² to ensure special assistance for children orphaned and affected by HIV and AIDS.

³¹ JLICA, Home Truths, p.5.

³² UN General Assembly, Resolution adopted by the General Assembly, 60/262. Political Declaration on HIV/AIDS, June 2006.

- Fully implement Articles 27,29,32 and especially 34 of the 2006 UN Political Declaration on HIV/AIDS to address as a priority the vulnerabilities faced by children affected by and living with HIV including; “providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them”.
- Design national programmes for children made vulnerable by HIV and AIDS based on the forthcoming guidance document “Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS”³³ for implementing the *‘Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in A World With HIV/AIDS’*.
- Integrate a multi-sectoral response for children affected by HIV and AIDS into development instruments, including Poverty Reduction Strategy Papers, national development plans, National AIDS Strategies, National HIV Frameworks and other relevant sectoral plans.
- Make time-bound and measurable commitments for fulfilling the rights and meeting the needs of children made vulnerable by HIV. These should relate to funding requirements for implementing OVC National Plans of Action, where these exist.
- Encourage mechanisms for flexible funding which meet community needs with funds being provided in small quantities over the long-term (i.e. drip-fed) and at predictable times to enable them to be better utilized by community based organisations as part of community systems strengthening mitigation approaches.
- Strengthen national coordination of actions for children affected by HIV and AIDS by strengthening coherence across interventions, ministries and departments relevant to children affected by HIV and AIDS, including those of health, education and social welfare services.
- State parties to continue to work towards the progressive realization of all rights committed by state signatories to the Convention on the Rights of the Child, giving particular attention to specific issues impacting children affected by HIV and AIDS.

Education

- Governments must commit to ensuring that the most vulnerable children affected by HIV and AIDS are supported to stay in school, including through the creation of safe and non-stigmatising learning environments and the expansion of social protection and care and support programmes for the most vulnerable families – with a target of equal education access between orphans and non-orphans by 2015.
- Support effort behind Education For All to improve quality education, promote gender equality, enable all children to complete both primary and secondary school education.
- Ensure access to early childhood education, especially for children from vulnerable and marginalized population groups.
- Eliminate school fees and other associated costs of school attendance for all children.

Health

- Governments to respect the right of the child to health as laid down in Article 24 of the Convention on the Rights of the Child (CRC) by ensuring that the most vulnerable children are provided with the appropriate health services and underlying

³³ Inter Agency Task Team on Children and HIV and AIDS, 2011, “Taking evidence to impact: making a difference for vulnerable children living in a world with HIV and AIDS”.

determinants of health, including health education, legal and other related services.

- Increase investment in health systems, ensuring that healthcare is free at the point of use and ensure that vulnerable children have access to these services. Health systems should provide holistic care, including access to home-based care that enables parents and carers to stay in their homes and care for their children.
- Ensure equitable access to a comprehensive package of integrated Maternal Newborn Child Health services including; access to comprehensive family planning services, scale up of prevention of mother to child transmission plus (PMTCT-Plus), point of care diagnostics for early infant diagnosis, provision of cotrimoxazole preventative services to all children known to be HIV positive and to those born to positive mothers until HIV status is determined; and ensure children are explicitly included in national HIV prevention and treatment targets.
- Ensure that vulnerable children and youth have access to prevention services and information so that they can avoid infection.

Nutrition

- Establish community based nutrition programmes to assist households caring for vulnerable children, with a particular focus on pregnant women and children under 2 years of age.
- Strengthen efforts to improve the food security of vulnerable households, especially those caring for vulnerable children.

Psychosocial support

- Intensify efforts to eliminate stigma and discrimination against all persons affected by HIV and AIDS, including children.
- Establish a system for the psychosocial support of children, with a particular focus on orphans and vulnerable children (to include training and support of community caregivers).

Community capacity

- Strengthen the capacity, effectiveness and participation of civil society to fulfil its complementary role in increasing accountability of government, mobilizing communities, and delivering services that governments cannot offer to vulnerable children.
- Fully utilise funding opportunities for community systems strengthening to strengthen community-based care and protection activities.
- Encourage children's participation in the design, implementation and evaluation of plans and programmes intended to meet their needs and strengthen their capacity to participate in community and national advocacy.

Social protection

- Governments to commit to ensure that 80% of eligible vulnerable households have received economic support in the last 3 months
- Build the capacity of families and communities to care for children through child sensitive social protection instruments that promote economic strengthening, increase access to services and address social exclusion and promote social justice.
- Develop the capacity of national social welfare systems with adequate budgetary allocations to ensure the care and protection of children.

Legal protection

- Governments to respect the right of children to be free from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, as imposed by article 19 of the Convention on the Rights of the Child.
- Promote protection under both statutory and customary law for orphans and vulnerable children to be free from violence, abuse, exploitation and neglect e.g. ensure effective property transfer.

- Enhance awareness of and support for existing laws and policies on succession planning and inheritance among traditional leaders and their communities.
- Strengthen birth registration services to enable vulnerable children to be able to access essential services including child protection services, social grants and legal assistance.
- Strengthen measures to address and prevent all forms of gender-based violence and violence against women and girls, including HIV-related violence and abuse.
- Link efforts under the 2001 UNGASS Declaration of Commitments with efforts under the UN Secretary General's Global strategy for Women's and Children's health from 2010 in areas where appropriate.
- Provide support to ensure that 80% of all countries have comprehensive HIV and AIDS care and support policies and programmes.
- Make specific commitments to fund the needs of children affected by HIV and AIDS and orphans and vulnerable children through support for OVC National Plans of Action, National Strategic AIDS Frameworks and national social protection plans.

International

- Support governments in Africa to meet the goals set in the *“Abuja Call for Accelerated Action towards Universal access to HIV and AIDS, TB and Malaria, and Africa's Common Position to the High Level meeting of the UNGASS on AIDS”*³⁴
 - at least 80% of pregnant women have access to prevention of mother to child transmission (PMTCT);
 - 5 million AIDS orphans and 80% of orphans and vulnerable children have access to basic services;
 - at least 80% of those in need, especially women and children, have access to HIV and AIDS treatment, including antiretroviral therapy as well as care and support.
- Support governments in Africa to meet the goal set in the “Abuja declaration” to invest at least 15% of government budget expenditure for national health systems.
- Support the full implementation of commitments outlined in Articles 65-67 of the 2001 UNGASS Declaration of Commitment on HIV/AIDS and Articles 27,29,32 and especially 34 of the 2006 UN Political Declaration on HIV/AIDS to ensure that assistance is provided for children orphaned and affected by HIV and AIDS.
- Accelerate the existing momentum towards education for all children through the Fast Track Initiative and other financial mechanisms.
- Accelerate the abolition of local school and health fees and associated costs for all children, paying special attention to the most vulnerable and disadvantaged children.
- Support governments in highly affected countries to ensure equitable access to a comprehensive package of treatment services integrated into Maternal Newborn Child Health services including: scale up the prevention of mother to child transmission plus (PMTCT-Plus), point of care diagnostics for early infant diagnosis, provision of cotrimoxazole preventative services to all children known to be HIV positive and to those born to positive mothers until HIV status is determined; and ensure children are explicitly included in national HIV treatment targets.
- Encourage the pharmaceutical industry to urgently invest in the development and production of fixed-dose combination anti-retroviral therapy for young children as well as grant voluntary licenses to allow generic production of ARVs and develop affordable point-of-care diagnostic tests for children and infants.

³⁴ Special Summit of African Union on HIV/AIDS, Tuberculosis and malaria (ATM), Abuja, Nigeria 2–4 May, 2006 Sp/Assembly/ATM/3 (I) Rev.2

- Provide support to governments to ensure increased coverage and access to comprehensive care and support for adults and children living with and affected by HIV, including carers, as a vital part of the Universal Access agenda.
- Support the implementation of national social protection policies and plans to strengthen the capacity of national social welfare systems with adequate budgetary allocations to ensure the care and protection of children, including the provision of social cash transfers to vulnerable households for economic strengthening, as well as increased access to services and address social exclusion and promote social justice.
- Support governments to protect and promote the human rights of children, such that the most vulnerable are able to access education, health, legal and services, as well as remain free from abuse, exploitation and neglect.

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Metages (age 28) with her two sons, aged four and nine. She is a member of the Hope and Light association, a support group of people living with HIV and AIDS.

photo: Jon Warren/World Vision

appendices

Appendix I:

Global commitments related to children made in 2001 and 2006

Articles 65-67 of the UN Declaration Commitment on HIV/AIDS (2001)

Children orphaned and made vulnerable by HIV/AIDS

65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa;

UN Political Declaration on HIV/AIDS (2006) (Selections from Articles related to children)

27: "Commit ourselves to ... ensure to increase the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV..."

29: "Commit to intensify efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination ... in particular to ensure their access to, inter alia, education, inheritance..."

32. "Commit ourselves also to addressing as a priority the vulnerabilities faced by children affected by and living with HIV; providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them;"

34: "Commit to expand to the greatest extent possible ... our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems... including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health ... children affected, orphaned or made vulnerable by HIV/AIDS, as well as formal and informal education."

Appendix 2: Survey results for Ethiopia, 2005 & 2010

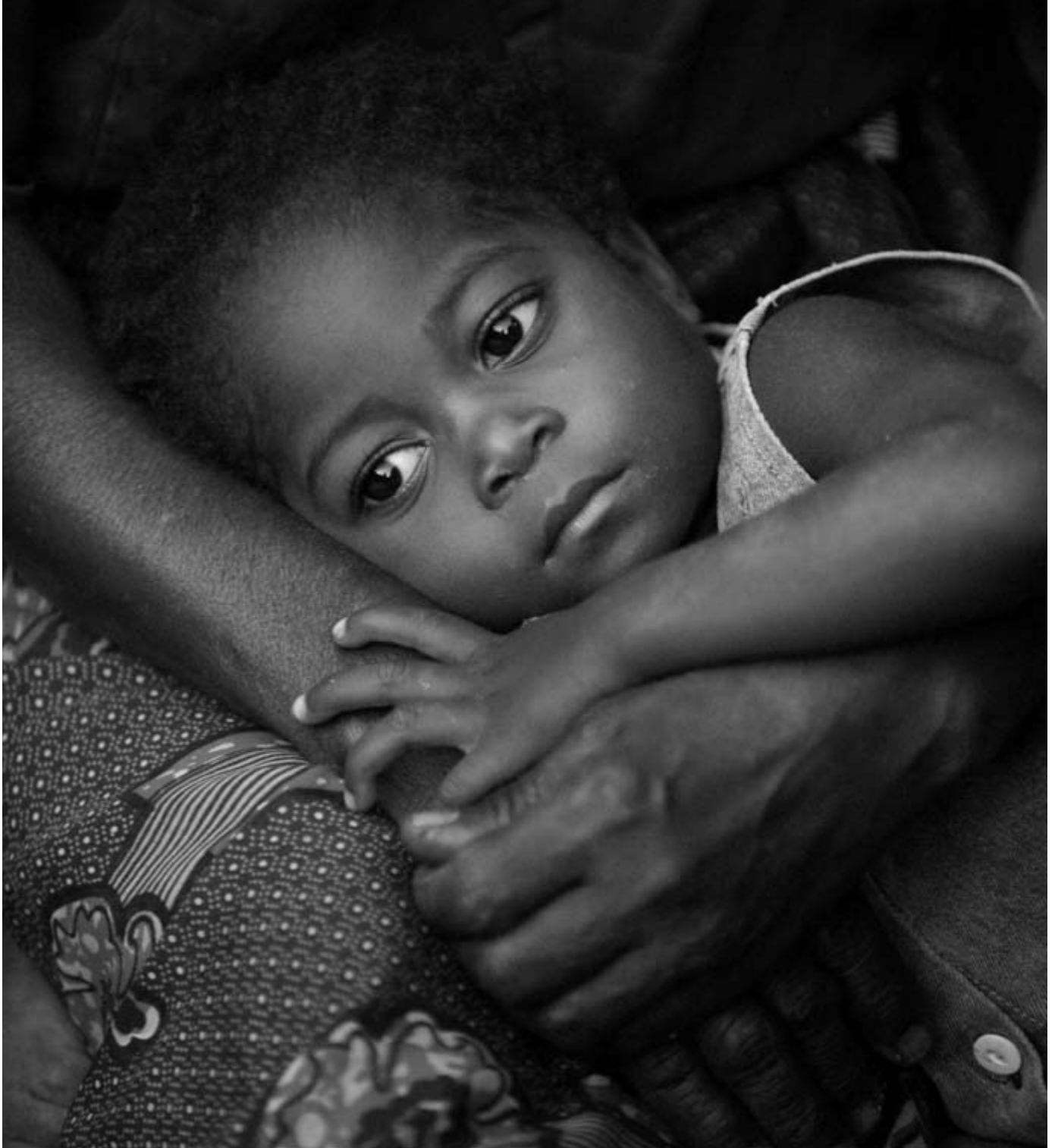
	ADP												Adjacent community												Combined total											
	OVC						Non-OVC						OVC						Non-OVC						OVC						Non-OVC					
	2005		2010		2005		2010		2005		2010		2005		2010		2005		2010		2005		2010		2005		2010									
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%								
School attendance 7-14 years	Girls	55 (75)	73	-	-	91 (119)	76	-	-	57 (89)	64	-	-	60 (93)	65	-	-	112 (164)	68	-	-	151 (212)	71	-	-	-	-									
	Boys	65 (95)	68	-	-	75 (98)	77	-	-	42 (65)	65	-	-	65 (86)	76	-	-	109 (160)	68	-	-	140 (184)	76	-	-	-	-									
	Total	120 (170)	71	171 (242)	71	166 (217)	76	109 (173)	63	99 (154)	64	138 (187)	74	125 (179)	70	187 (209)	89	221 (324)	68	309 (429)	72	291 (396)	73	296 (382)	77											
Access to medical treatment	Girls	18 (29)	62	-	-	30 (34)	88	-	-	18 (24)	75	-	-	16 (24)	67	-	-	36 (53)	68	-	-	46 (58)	79	-	-	-	-									
	Boys	22 (33)	67	-	-	33 (33)	100	-	-	15 (33)	45	-	-	16 (22)	73	-	-	37 (66)	56	-	-	49 (55)	89	-	-	-	-									
	Total	40 (62)	65	80 (93)	86	63 (67)	94	62 (73)	85	33 (57)	58	51 (72)	71	32 (46)	70	42 (56)	75	73 (119)	61	131 (164)	80	95 (113)	84	104 (129)	81											
Counselling from community care givers	Weekly	1 (99)	1	69 (259)	27				0 (98)	0	16 (187)	9						1 (197)	1	85 (446)	19															
	Monthly	3 (99)	3	50 (259)	19				3 (98)	3	72 (187)	38						6 (197)	3	122 (446)	27															
	Longer than a month	2 (99)	2	22 (259)	8				0 (98)	0	5 (187)	3						2 (197)	1	27 (446)	6															
Once only	0 (99)	0	-	-	-	-	-	0 (98)	0	-	-	-	-	-	-	-	0 (197)	0	-	-	-	-	-	-	-	-										
Never	93 (99)	94	118 (259)	46				95 (98)	97	94 (187)	50						188 (197)	95	212 (446)	48																
Nutrition	Girls	93 (130)	72	-	-	221 (227)	97		107 (144)	74	-	-	162 (163)	99	-	-	200 (274)	73	-	-	383 (390)	98	-	-	-	-										
	Boys	122 (159)	77	-	-	203 (210)	97		80 (114)	70	-	-	160 (160)	100	-	-	202 (273)	74	-	-	363 (370)	98	-	-	-	-										
	Total	215 (289)	74	118 (259)	46	424 (437)	97	89 (190)	47	187 (258)	72	86 (193)	45	322 (323)	99	134 (219)	61	402 (547)	73	204 (452)	45	746 (760)	98	220 (409)	54											
Basic material needs	Girls	38 (130)	29	-	-	174 (227)	77		39 (144)	27	-	-	87 (163)	53	-	-	77 (274)	28	-	-	261 (390)	67	-	-	-											
	Boys	58 (159)	36	-	-	158 (210)	75		23 (114)	20	-	-	85 (160)	53	-	-	81 (273)	30	-	-	243 (370)	66	-	-	-											
	Total	96 (289)	33	Very weak	332 (437)	76	Very weak	62 (258)	24	62 (258)	24	Very weak	172 (323)	53	Very weak	158 (547)	29	Very weak	504 (760)	66	Very weak															
Households receiving external support	School	3 (99)	3	-	-				5 (98)	5	-	-					8 (197)	4	-	-																
	Medical	4 (99)	4	-	-				0 (98)	0	-	-					4 (197)	2	-	-																
	School & medical	4 (99)	4	-	-				5 (98)	5	-	-					9 (197)	4	-	-																
	Other	1 (99)	1	-	-				3 (98)	3	-	-					4 (197)	2	-	-																
	School & other	36 (99)	36	-	-				7 (98)	7	-	-					43 (197)	22	-	-																
	Medical & other	5 (99)	5	-	-				0 (98)	0	-	-					5 (197)	3	-	-																
	All three	8 (99)	8	-	-				4 (98)	4	-	-					12 (197)	6	-	-																
	Total	61 (99)	61	61 (257)	24				24 (98)	24	40 (191)	21					85 (197)	43	101 (448)	23																

Appendix 3:
Survey results for Mozambique, 2005 & 2010

	ADP												Adjacent community												Combined total											
	OVC						Non-OVC						OVC						Non-OVC						OVC						Non-OVC					
	2005		2010		2005		2010		2005		2010		2005		2010		2005		2010		2005		2010		2005		2010									
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%								
School attendance 7-14 years	Girls	49 (72)	68	41 (60)	68	14 (18)	78	268 (459)	58	47 (63)	75	38 (59)	64	7 (7)	100	179 (316)	57	96 (135)	71	79 (119)	66	21 (25)	84	447 (775)	58											
	Boys	48 (58)	83	48 (64)	75	13 (16)	81	338 (519)	65	62 (81)	77	40 (71)	56	2 (2)	100	137 (279)	49	110 (139)	79	88 (135)	65	15 (18)	84	475 (798)	60											
	Total	97 (130)	75	89 (124)	72	27 (34)	79	606 (978)	62	109 (144)	76	78 (130)	60	9 (9)	100	316 (595)	53	206 (274)	75	167 (252)	66	36 (43)	84	922 (1573)	59											
Access to medical treatment	Girls	64 (81)	76	7 (42)	17	23 (23)	100	84 (233)	36	52 (91)	57	25 (47)	53	11 (11)	100	119 (231)	52	116 (172)	67	32 (89)	36	34 (34)	100	203 (464)	44											
	Boys	66 (81)	82	9 (66)	14	15 (15)	100	46 (215)	21	62 (90)	69	27 (43)	63	0 (2)	0	114 (225)	51	128 (171)	75	36 (109)	33	15 (17)	88	160 (440)	36											
	Total	130 (162)	80	16 (108)	15	38 (38)	100	130 (448)	29	114 (181)	63	52 (90)	58	11 (13)	85	233 (456)	51	244 (343)	71	68 (198)	34	49 (51)	96	363 (904)	40											
Counselling from community care givers	Weekly	0 (167)	0	7 (145)	5	0 (34)	0	46 (331)	14	0 (174)	0	1 (107)	1	0 (10)	0	29 (804)	4	0 (341)	0	8 (252)	3	0 (44)	0	75 (1135)	7											
	Monthly	90 (167)	54	22 (145)	15	28 (34)	82	85 (331)	26	81 (174)	47	1 (107)	1	3 (10)	30	30 (804)	4	171 (341)	50	23 (252)	9	31 (44)	70	115 (1135)	10											
	Longer than a month	2 (167)	1	8 (145)	6	2 (34)	6	26 (331)	8	0 (174)	0	1 (107)	1	0 (10)	0	5 (804)	1	2 (341)	1	9 (252)	4	2 (44)	5	31 (1135)	3											
Nutrition	Once only	0 (167)	0	0 (145)	0	0 (34)	0	0 (331)	0	0 (174)	0	0 (107)	0	0 (10)	0	0 (804)	0	0 (341)	0	0 (252)	0	0 (44)	0	0 (1135)	0											
	Never	75 (167)	45	108 (145)	74	4 (34)	12	174 (331)	52	93 (174)	53	104 (107)	97	7 (10)	70	740 (804)	91	168 (341)	49	212 (252)	84	11 (44)	25	914 (1135)	80											
	Total	11 (82)	13	55 (61)	90	20 (22)	91	471 (596)	79	6 (97)	6	33 (75)	44	8 (10)	80	269 (428)	63	17 (179)	10	88 (136)	65	28 (32)	88	740 (1024)	72											
Basic material needs	Girls	8 (82)	10	75 (86)	87	14 (14)	100	414 (470)	88	7 (90)	8	36 (82)	44	2 (3)	67	296 (454)	65	15 (172)	9	111 (168)	66	16 (17)	94	710 (924)	77											
	Boys	19 (164)	12	130 (147)	88	34 (36)	94	885 (1066)	83	13 (187)	7	69 (157)	44	10 (13)	77	565 (882)	64	32 (351)	9	199 (304)	65	44 (49)	90	1450 (1948)	74											
	Total	0 (76)	0	12 (55)	22	1 (27)	4	121 (421)	29	0 (98)	0	13 (69)	19	3 (11)	27	112 (360)	31	0 (174)	0	25 (124)	20	4 (38)	11	233 (781)	30											
Households receiving external support	Girls	0 (79)	0	22 (78)	28	5 (18)	28	117 (390)	30	0 (89)	0	19 (81)	23	0 (2)	0	80 (335)	24	0 (168)	0	41 (159)	26	5 (20)	25	197 (725)	27											
	Boys	0 (115)	0	34 (133)	26	6 (45)	9	238 (811)	29	0 (187)	0	32 (150)	21	3 (13)	23	192 (695)	28	0 (342)	0	66 (283)	23	9 (58)	16	430 (1506)	29											
	Total	5 (61)	8	88 (143)	62					10 (58)	17	107 (175)	61					15 (119)	13	195 (318)	61															
Birth registration	School/medical or other support	56 (61)	92	55 (143)	38					48 (58)	83	68 (175)	39					104 (119)	87	123 (318)	39															
	No support	12 (154)	8	55 (73)	75	18 (46)	39	529 (718)	74	25 (189)	13	78 (153)	51	1 (11)	9	510 (805)	63	37 (243)	11	133 (226)	59	19 (57)	33	1039 (1523)	68											
	Total	12 (154)	8	55 (73)	75	18 (46)	39	529 (718)	74	25 (189)	13	78 (153)	51	1 (11)	9	510 (805)	63	37 (243)	11	133 (226)	59	19 (57)	33	1039 (1523)	68											

Appendix 4: Survey results for Uganda, 2005 & 2010

	ADP						Adjacent community						Combined total												
	OVC			Non-OVC			OVC			Non-OVC			OVC			Non-OVC									
	2005	2010	%	2005	2010	%	2005	2010	%	2005	2010	%	2005	2010	%	2005	2010	%							
	#	#	%	#	#	%	#	#	%	#	#	%	#	#	%	#	#	%							
School attendance 7-14 years	Girls	70 (72)	97	73 (75)	97	74 (77)	96	42 (44)	96	67 (79)	85	51 (54)	94	77 (77)	100	53 (55)	96	137 (151)	90	124 (129)	96	151 (154)	98	95 (99)	96
	Boys	77 (79)	97	57 (58)	98	67 (70)	96	55 (60)	92	78 (94)	83	62 (63)	98	103 (105)	98	49 (52)	94	155 (173)	90	119 (121)	98	170 (175)	97	104 (112)	93
	Total	147 (151)	97	130 (133)	98	141 (147)	96	97 (104)	93	145 (173)	84	113 (117)	97	180 (182)	99	102 (107)	95	292 (324)	90	243 (250)	97	318 (329)	97	199 (211)	94
Access to medical treatment	Girls	47 (59)	80	23 (24)	96	52 (54)	96	20 (20)	100	37 (37)	100	24 (24)	100	30 (33)	91	21 (21)	100	84 (96)	88	47 (48)	98	82 (86)	95	41 (41)	100
	Boys	49 (51)	96	29 (29)	100	44 (45)	98	25 (27)	93	40 (40)	100	28 (29)	97	33 (35)	94	17 (17)	100	89 (90)	99	57 (58)	98	77 (79)	97	42 (44)	96
	Total	96 (110)	87	52 (53)	98	96 (99)	97	45 (47)	96	77 (77)	100	52 (53)	98	63 (68)	93	38 (38)	100	173 (186)	93	104 (106)	98	159 (165)	96	83 (85)	98
Counselling from community care givers	Weekly	10 (170)	6	12 (100)	12					0 (152)	0	5 (100)	5					10 (322)	3	17 (200)	9				
	Monthly	42 (170)	25	40 (100)	40					9 (152)	6	12 (100)	12					51 (322)	16	52 (200)	26				
	Longer than a month	28 (170)	16	20 (100)	20					4 (152)	3	11 (100)	11					32 (322)	10	31 (200)	15				
Nutrition	Once only	17 (170)	10	-	-					22 (152)	14	-	-					39 (322)	12	-	-				
	Never	73 (170)	43	28 (100)	28					117 (152)	77	72 (100)	72					190 (322)	59	100 (200)	50				
	Girls	75 (99)	76	101 (128)	79	130 (137)	95	65 (91)	71	75 (117)	64	76 (110)	69	122 (132)	92	63 (94)	67	150 (216)	69	177 (238)	74	252 (269)	94	128 (185)	69
Basic material needs	Boys	102 (120)	85	95 (128)	74	110 (124)	89	70 (98)	71	68 (122)	56	90 (118)	76	153 (167)	92	68 (102)	67	170 (242)	70	185 (246)	75	263 (291)	90	138 (200)	69
	Total	177 (219)	81	196 (256)	77	239 (261)	92	135 (189)	71	143 (239)	60	166 (228)	73	275 (299)	92	131 (197)	67	320 (458)	70	362 (484)	75	515 (560)	92	266 (385)	69
	Girls	39 (124)	31	34 (125)	27	90 (130)	69	9 (88)	10	14 (121)	12	20 (109)	18	80 (139)	58	0 (93)	0	53 (236)	22	54 (234)	23	170 (269)	63	9 (181)	5
Households receiving external support	Boys	39 (120)	33	44 (127)	35	70 (122)	57	8 (96)	8	15 (120)	13	26 (117)	22	112 (164)	68	3 (102)	3	54 (240)	23	70 (244)	29	182 (286)	64	11 (198)	6
	Total	78 (244)	32	78 (252)	31	160 (252)	63	17 (184)	9	29 (241)	12	46 (226)	20	192 (303)	63	3 (195)	2	107 (476)	22	124 (478)	26	352 (555)	63	20 (379)	5
	School	18 (50)	36	15 (100)	15					8 (50)	16	2 (100)	2					26 (100)	26	17 (200)	9				
Birth registration	Medical	17 (50)	34	46 (100)	46					1 (50)	2	43 (100)	43					18 (100)	18	89 (200)	45				
	School & medical	-	-	16 (100)	16					-	-	2 (100)	2					-	-	18 (200)	9				
	Other	13 (50)	26	-	-					2 (50)	4	-	-					15 (100)	15	-	-				
Total	23 (50)	46	77 (100)	77						10 (50)	20	47 (100)	47					33 (100)	33	124 (200)	62				
	129 (250)	52	104 (256)	41	155 (251)	62	37 (189)	20	49 (228)	21	58 (228)	25	80 (292)	27	38 (196)	19	178 (478)	37	162 (484)	33	238 (543)	44	75 (385)	19	



Grandmother Mary in Zambia cares for four double-orphaned children, including four year-old Isaiah.

photo: Jon Warren/World Vision



World Vision

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. We are a federal partnership and work in almost 100 countries worldwide, serving 100 million people.

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This material has been funded by UKaid from the Department for International Development, however the views expressed do not necessarily reflect the department's official policies.