Noble Missions for Change Initiative

OVC Programming Best Practices 2013

2013

http://www.noblemissions.org

CONTENT

INTRODUCTION

Noble Mission for Change Initiative (NMI) is committedly working towards achieving its vision which is to see a developed society where young people are empowered for quality living, free of social vices with enhanced productivity and wellbeing. Our Mission is to empower young people with relevant information, skills and support for healthy and productive livelihood. Our Goal is to work with young people to reduce their vulnerability and create an enabling environment for improved quality of life. Our Strategies are Service Delivery, Capacity Building, Advocacy and Campaigns Behavior Change Communication Outreach Researches. We believe in Integrity, Team work, Discipline, Commitment, Trust, Mutual Respect and volunteerism as Our Core Values.

The current project is another great step forward. The project is named: 'Compilation of Best Practice Programmes for Orphans and Vulnerable Children (OVC)'. The purpose of this project is to provide a complete manual of guidance to professionals, NGOs, and any other individual/organization who wishes to work for the empowerment of OVC and community development. This manual also provides insight on the situation of OVC around the world and enforces the increasing need to acknowledge the plight of these children and work towards giving them a better life, as these children are the world's future. The programmes being compiled under this project are not restricted to Africa only but cover programmes carried out across the globe.

The basic objectives of making this compiled manual are:

- To compile summaries of projects on OVC carried out in the past and at present on national and international level.
- To give an overview of the condition of OVC globally.
- To provide step-wise guidance, with examples, on effective OVC programming.

In order to accomplish this manual a team of volunteers under the guidance of NMI officials browsed the internet and other sources for OVC projects carried out across the world. From our search we came to conclusion that mostly the projects were African-based as this is where the OVC are concentrated mostly. Once the search was completed the projects were summarized in order to highlight the main and relevant features that could be of assistance to others. We hope that the following sections of this manual can be a great help for the ONGs and social policy workers.

The present manual would not have been compiled without the dedication and hard work of (in alphabetical order) Hema Senanayake, Hina Jaffery, Martina De Rivo and Rian Hulscher. In addition, we would like to thank Charles Omofomwan, Agnieszka Joanna Stolarczyk and the rest of NMI team for their valuable advices while working on the publication. We also want to encourage you to contact us in case you have any comments regarding the present publication (info@noblemissions.org).

KEYWORDS

AIDS (Acquired Immunodeficiency Syndrome): an advanced stage of infection with HIV. Without treatment, around 50% of the people infected with HIV develop AIDS within ten years. People with AIDS have weakened immune systems that make them vulnerable to selected conditions and infections.

Caregiver: a person who takes primary responsibility for the physical, mental and emotional needs of a child.

Child: a person who is below the age of 18 years.

Child protection: all activities associated with preventing and responding to anything that puts a child at risk.

Community: a group of people who share a common culture and are arranged in a social structure that allows them to have a common identity as a group, usually living in the same area.

FNS (Food and nutrition security): physical, social and economic access by all people at all times to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life.

Gender: socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for men and women.

Home based care: practical assistance to help people live as independently as possible in their own homes.

Household: a social unit (family or other group) composed of those living together in the same house.

HIV (human immunodeficiency virus): a lentivirus that causes acquired immunodeficiency syndrome (AIDS). HIV is transmitted primarily via unprotected sexual intercourse, contaminated blood transfusions, hypodermic needles and from mother to child during pregnancy, delivery or breastfeeding.

Income generation: activities aimed at increasing income at the family level such as access to credit, business skills training or improving market access.

Orphan: a child who has lost one parent or both parents.

Poverty: the inability of an individual, family or community to attain a minimum standard of living.

Psychosocial support: all activities that address the ongoing psychological and social problems that people face.

STI (Sexually transmitted infection)/ STD (Sexually transmitted disease): infections that are passed from one person to another during sexual contact.

Vulnerable: easily hurt or harmed physically, mentally or emotionally.

Vulnerable child: a child who, because of circumstances of birth or immediate environment, is prone to abuse or deprivation of basic needs, care, and protection and is thus disadvantaged relative to his or her peers.

CASE STUDIES

CÔTE D'IVOIRE

PROJECT	Legal Units Child Protection Support for Orphans and Vulnerable Children and Their Families in Côte d'Ivoire
COUNTRY	Côte d'Ivoire
NAME OF ORGANIZATION	USAID (AIDSTAR-One)
FOCUS AREAS	Legal Protection for OVC, psychological and social support to families and children.
AIMS & OBJECTIVES	• To provide legal help where required. • To increase public awareness about HIV/AIDS and human rights. • To facilitate vulnerable individuals/families however possible. • To facilitate ad reintegrate OVC into healthy lifestyle.
SUCCES RATE	Adequate
FINANCING	N/A

BACKGROUND OF TARGET POPULATION

This project targets the OVC and vulnerable families living in Côte d'Ivoire. The estimated numbers of OVC in this region are 540,000 with HIV prevalence of 4.7 (Institut National de la Statistique 2006). The target population comprises of women who face domestic violence, accusations of witchcraft and gender inequality, and children who are abused by their own families, who are orphans or rejected to be acknowledges by their birth parent/parents.

In this region birth and marriage certificates are of extreme importance, as without birth certificate a child cannot go to school and without marriage certificate claim to inheritance cannot be made. Also the traditional laws are much strongly implemented that the state law with the traditional laws being mostly gender-biased.

INTERVENTIONS USED

"A legal unit is a network of individuals and resources that can be tapped as needed to protect the rights of children and their families."

The basic mission of these units is solving problems of OVC and their families through prosecutions, mediation and awareness. The composition of units is dependent on the local needs. They mat comprise of doctors, judges, police, volunteers etc. The interventions that they use are:

1. Facilitating access to education by solving issues related to birth certificates or in some cases making the caretakers pay for the school fees.
2. Fighting child abuse by creating awareness, using legal processes/threats to responsible persons, providing psychological and medical care to required children.
3. Fighting gender-based violence by providing legal guidance and support.

4. Using formal and informal media to create awareness about HIV/AIDS and human rights.

CHALLEGES TO INTERVENTIONS

The challenges that these interventions face are:

1. Mostly people especially women, are not willing to speak against the accused persons through legal proceedings as they fear the consequences which include violence, accusation of witchcraft and absence of a bread earner for the family.
2. Traditional law practice is much stronger than state law therefore; the legal proceedings have a little value for the people who are unaware of their own rights.
3. Distrust amongst people for the legal system.
4. Lack of follow-up system.
5. Lack of specialized psychologists to victims of abuse and violence.
6. People do not share their experience which makes it difficult to help them.

RECOMENDATIONS FOR OVC PRACTITIONERS

- Study the customs and law of a place before starting any project.
- Involve the local people as much as possible help in better communication.
- Involve the government to support your intervention.
- When establishing legal units ensure the presence of medical and psychological practitioner.
- Provide regular training and a holiday at intervals to the practitioners so that they remain psychologically healthy.
- Prior to commencing the project create awareness about it through media so that word spreads about your project and people are curious to know. Also if there is any major issue with government or local bodies it will come to surface before the project starts.

REFERENCES

Castle, Sarah.(2011). *Legal Units Child Protection Support for Orphans and Vulnerable Children and Their Families in Côte d'Ivoire. Case Study Series*. Arlington, VA USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

ETHIOPIA

PROJECT	Coffee, Popcorn, Soup and HIV. Promoting Food and Nutrition Security for Children and Pregnant Women Living with HIV in Ethiopia
COUNTRY/CITY	Ethiopia/ Addis Ababa
NAME OF ORGANIZATION	Project Concern International (PCI)/ San Diego
FOCUS AREAS	HIV, Food and nutrition security (FNS), promotion of urban agriculture.
PARTNERSHIP	PCI in partnership with the Ethiopian Federal HIV/AIDS Prevention & Control Office (F-HAPCO), Addis Ababa HIV/AIDS Prevention & Control Office (AA-HAPCO) and the World Food Program (WFP).
AIMS AND OBJECTIVES	The project's overall aim is to reduce vulnerability to malnutrition and food insecurity among households affected by HIV.
FINANCING	PCI financed by the U.S. Agency for International Development's (USAID)

TARGET POPULATION

Activities target two groups in Addis Ababa:

1) Pregnant or lactating women living with HIV who are heads of households and attending a PMTCT program in one of the 16 participating health facilities in Addis; and

2) Parents and/or caregivers of children who are living with HIV, under the age of 12, and attending a pediatric ART program in one of the five participating hospitals in Addis.

BRIEF BACKGROUND OF TARGET POPULATION

In Addis Ababa the HIV prevalence rate is 9.2 percent (2.4 in Ethiopia), translating to more than 200,000 people living with HIV (Addis Ababa HIV/AIDS Prevention & Control Office 2010). Every day about 1,000 children under the age of 15 become infected with HIV globally, and in 2007, UNAIDS estimated there were 2 million children living with HIV, almost 90 percent of whom live in Africa. The vast majority of these children acquire HIV before they are born, during pregnancy or delivery, or when they are being breastfed (UNICEF 2007).

Despite the remarkable achievement in the area of HIV treatment in recent years, there is a widely held concern that prevention of mother-to-child transmission (PMTCT) activities have been lagging behind. In Ethiopia, from an estimated 84,189 pregnant women living with HIV in 2009, only 6,466 (eight percent) received antiretroviral prophylaxis (Federal HIV/AIDS Prevention & Control Office 2010). A total of 13,305 children were ever started on ART at the end of 2009, while 9,992 were currently on ART. ART coverage for children was 48.7 percent (Federal HIV/AIDS Prevention & Control Office 2010).

Chronic food insecurity compounds the problems posed by HIV. Ethiopia has one of the world's highest child malnutrition rates. According to a 2010 study from the National Nutrition Program of Ethiopia, among children 6 to 59 months of age, 38 percent were stunted, with higher levels among rural children.

Twelve percent of children 6 to 59 months of age were wasted, and 34 percent of children were underweight (Ethiopian Health and Nutrition Research Institute 2010). Children living with HIV frequently have low birth weight, so high quality nutrition interventions are essential to providing them with the best possible start in life.

Finally, strict adherence to ART for children living with HIV (as well as adults) is a global challenge. Individuals who start ART when malnourished suffer more severe side effects than those who are sufficiently nourished. Side effects, including nausea, taste changes, diarrhea, vomiting, and loss of appetite, threaten to reduce adherence to drug regimens and contribute to the development of drug-resistant strains of HIV. Sadly, of those individuals who are on treatment, the default rate is an alarming 20 to 25 percent (Banteyerga 2007).

ACTIVITIES

The project is an example of integrated HIV and food and nutrition security (FNS) programming, which combines distribution of highly nutritious soups, promotion of urban agriculture, and delivery of educational messages on issues related to HIV and FNS.

More specifically, the project is comprised of three components:

1) Distributing highly nutritious food to address short-term nutritional needs.
Two fortified, dehydrated soups (the Lentil Blend and the Harvest Pro Vegetable Blend) are distributed in order to supplement the existing food intake of the beneficiaries and to facilitate improved retention of women receiving PMTCT services and improved adherence for children enrolled in ART.

The method of soup distribution depends on the type of recipient. For children living with HIV receiving pediatric ART services, PCI delivers the commodity directly to the hospital staff at the five city hospitals. Mothers or caregivers receive the soup when they bring the child for monthly check- ups. During the same visit, either the counselor or home-based care volunteer briefs the caregiver on PCI's urban agriculture program and if they are interested, puts them in contact with the urban agricultural promotion officer. This initiates the transition from short-term assistance (the soup) to more sustainable FNS programming.

For mothers living with HIV attending PMTCT services, the system is slightly different. PCI stores and distributes the soup through AA-HAPCO and the World Food Programme (WFP), making use of their significantly larger food distribution systems. To increase efficiency, PCI delivers the commodities to AA-HAPCO's main warehouse. From there, WFP staff delivers them, along with their own commodities, to 10 sub city stores. Women receiving PMTCT services are scheduled one day each month to pick up the food. While the women are gathered, the storekeepers explain the ingredients of the soup blends describe various cooking methods and conduct a cooking demonstration. They also solicit interest in PCI's urban agriculture program.

Pregnant women living with HIV receive two kilograms per month and the children receive one kilogram.

2) Holding coffee ceremony discussions to provide emotional support and education around HIV and FNS.

The coffee ceremony is a central part of Ethiopian life and a sign, to those invited, of friendship and respect. In traditional village life, the coffee ceremony is the main social event in the village, a time to discuss current events, politics, and gossip. It is impolite to retire until you have consumed at least three cups, as the third round is said to bestow a blessing. The project's coffee ceremonies build on this tradition of friendship and information-sharing to deliver and reassert a variety of messages related to HIV and FNS.

Twenty to thirty women normally attend the monthly coffee ceremonies (while men are also invited - being caretakers of orphans and vulnerable children - few attend). Every ceremony routinely includes discussions on health, FNS, and their relationship to HIV and AIDS. As with other PCI programs, the familiar setting and ritual of coffee-drinking encourages participants to relax and talk openly about HIV, sex, illness, domestic abuse, rape, birth control, and other taboo topics that are normally difficult to discuss in this extremely traditional society. Given the traditional three-cup minimum, the ceremony provides enough time to delve into a wide array of issues; some ceremonies last up to two or three hours.

Session topics are planned in advance. There are usually four or five, and some are selected by the participants themselves to ensure relevance and a sense of ownership. The facilitators, trained by PCI, keep discussions focused. Often, facilitators launch a topic with the delivery of several key messages. They keep messages clear and succinct, and deliver them slowly and repeatedly, giving women of different education levels time to absorb the concepts. Sometimes, the ceremony will include a guest speaker; alternatively, the facilitator will invite some of the women from within the group to speak about their own experiences.

3) Promoting urban agriculture, including vegetable gardening and poultry rising, to address longer- term nutritional needs.

This project's component teaches women to meet their nutritional needs and those of their families by producing their own food (such as fresh vegetables, eggs, and meat) at home, which can also become a source of income for those who choose to produce more than they consume. Moreover, this activity also has a therapeutic value.

The urban garden training is conducted in groups of between 10 and 30 people over the course of one or two days. Most participants already have a basic knowledge of gardening, so the course is meant to strengthen their skills. The training covers such topics as preparing plots, improving the soil, handling seedlings, spacing plants, and intercropping with legumes. Participants also learn about organic pest control—creating a spray from the *dodinam* plant to control aphids—and making compost from chicken waste, ash, and vegetable scraps. Importantly, the curriculum also includes a nutrition component that reviews the benefits (i.e., vitamins and minerals) of fresh vegetables and their importance in fighting disease. The training stresses cooking vegetables lightly to kill germs, but cautions participants against overcooking, which reduces the nutritional value.

Participants choose one of two options direct soil gardening or container gardening (using plastic bags, pails, metal drums, and similar containers). They are offered a wide variety of seeds to get started, including kale, Swiss chard, lettuce, cabbage, tomato, green pepper, carrot, and beet. They also receive farming tools a pick axe, a hoe, and a watering can; those without their own land also receive containers.

The poultry production training likewise takes one to two days. Instruction covers basic poultry care, feeding, and disease management. Each participant receives two roosters, six laying hens, 50 kilograms of feed, and a cage.

SUCCESS RATE OF THE ACTIVITIES

1) Distributing highly nutritious food to address short-term nutritional needs.
People generally liked the taste of the soups, which could also easily be kept down by pregnant women.

A total of 2,441 children (1,193 boys and 1,248 girls) on ART and 1,915 mothers enrolled in the PMTCT program directly benefited from Breedlove supplementary soup in 2009. The total amount of commodity distributed equaled 74,998 kilograms (PCI 2009).

Linking monthly health care visits to food distribution has demonstrated to be an effective strategy for ensuring optimal uptake and retention of HIV and FNS services.

2) Holding coffee ceremony discussions to provide emotional support and education around HIV and FNS.
At the coffee ceremonies, women are engaged and extremely supportive of one another and comment on how much they learn especially from each other's experiences.

Effective facilitation demonstrated to be a very important aspect in order to guarantee attendance discussions must be kept fruitful, inclusive, and relevant to participants' lives.

The timing of ceremonies demonstrated to be a critical aspect due to the frequency of holidays and social events in the Ethiopian culture and the long duration of a coffee ceremony. For this reason, the date and time need to be carefully selected for optimal turnout.

3) Promoting urban agriculture, including vegetable gardening and poultry rising, to address longer- term nutritional needs.
More than 200 people have received training, seeds, and tools for home gardening, and about 60 received training and supplies for poultry production. Several participants have produced excess food and specialty crops, such as herbs, which brings in regular income (though this production has not been quantified yet). The vast majority of the participants in the urban agriculture program are mothers or caregivers of children on ART. However, PCI is trying to increase recruitment of women in the PMTCT program as well.

Organizational aspects
The partnership between F-HAPCO, AA-HAPCO, WFP, and the health facility staff has been programmatically effective and cost-effective. F-HAPCO ensured that the commodity was imported duty-free; AA-HAPCO and WFP managed the bulk of distributions; and health facility staff handled nutrition counseling and education, with technical support and training provided by PCI.

CHALLENGES

Widespread poverty.
While behavior change can result from acquiring new knowledge, the change must also be economically accessible. Dietary recommendations are often difficult to implement due to limited financial means, especially when people graduate from supplementary food support. With regards to the soup, the most common complaint is that the ration is not large enough. Two factors contribute to this problem the soup is not intended to serve as the main source of nourishment and the ration size is designed for individual use. Where household food insecurity is endemic, the ration is shared between households and serves as the main source of nourishment. The gardening and poultry programs facilitate more sustainable dietary changes, though to be effective; the programs would need to be expanded.

Stigma and discrimination.
Stigma and discrimination remain significant problems in Ethiopia and affect various aspects of the project women do not want PCI staff visiting them at home for fear that their neighbors and sometimes also their husbands suspect their status. For the same reason, they prefer to travel long distances to go to the central hospitals so that they will not be seen by neighbors and friends, but this is very time-consuming and expensive.

Lack of support for monitoring and evaluation (M&E).
The limited budget makes it difficult to establish a comprehensive M&E system. A quarterly review meeting takes place, as well as informal interviews with beneficiaries, but formal monitoring against indicators for the objectives of each project component is not done in a systematic or comprehensive manner.

Overburdened health care staff.
The scarcity of qualified health professionals is a systematic problem in Ethiopia and distributing the Bread love soup becomes and additional task for already stretched health workers at the distribution sites, who complain to be overworked and underpaid. This leads to an insufficient communication about the program.

ANALYSIS

- When organizing activities, take into consideration the cultural and social aspects of the target population, which could serve as a means of transmission of the project's instruments and goals. In this case, the coffee ceremony was a perfect occasion where to deliver messages.

- Do not underestimate the impact that stigma and discrimination can have on the project's activities even though an activity could appear positive, there is the possibility that it will not be accepted by the target group.

- The definition of the timing of the activities should take into consideration the cultural aspects of the target group, taking into account holidays and social events.

REPLICATING AND IMPLEMENTING THE SCALE

This project could be easily replicated in other contexts, both in urban and rural settings.

REFERENCES

- Addis Ababa HIV/AIDS Prevention & Control Office. 2010. AA-HAPCO Website. Available at http// aahapco.org/ (retrieved in August 2013).

- Banteyerga, H. 2007, *System Wide Effects of the Global Fund with Respect to ART Scale-up Evidence from Ethiopia*, PowerPoint presentation given at Health Systems 2020 conference, November 22, Dublin, Ireland.

- Central Statistical Agency (Ethiopia) and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia, and Calverton, MD Central Statistical Agency and ORC Macro. Available at www.measuredhs.com/pubs/pdf/FR179/ FR179.pdf (retrieved in August 2013).

- Ethiopian Health and Nutrition Research Institute. 2010. *Nutrition Baseline Survey Report for the National Nutrition Program of Ethiopia.* Addis Ababa Ethiopian Health and Nutrition Research Institute.

- Federal-HIV/AIDS Prevention & Control Office, Ethiopia. 2010. *Report on Progress Towards Implementation of the UN Declaration of Commitment on HIV/AIDS.* Available at http//data.unaids.org/pub/Report/2010/ethiopia_2010_country_ progress_report_en.pdf (retrieved in September 2013).

- Kara Greenblott. 2011. *Coffee, Popcorn, Soup, and HIV. Promoting Food and Nutrition Security for Children and Pregnant Women Living with HIV in Ethiopia*, AIDSTAR-One Case Study Series, USAID, Available at http//www.aidstar-one.com/sites/default/files/AIDSTAR-One_OVC_food_security_ethiopia.pdf (retrieved in May 2013).

- PCI. 2009. *Single Year Assistance Plan.* Final Results Report to USAID, Fiscal Year 2009.

- UNICEF. 2007. *UNICEF Website*. Available at www.unicef.org/aids/index_preventionMTCT.html (retrieved in September 2010).

NIGERIA

PROJECT	Community-Based Support (CUBS) Project for Orphans and Vulnerable Children in Nigeria Developing a Program Framework, Approach, and Activities to Address the Vulnerability of Girls, Young Women, and Female-Headed Households within the Context of OVC Service Delivery and HIV Risk Reduction
COUNTRY	Nigeria
NAME OF ORGANIZATION	Community-Based Support (CUBS) for OVC Project in Nigeria
FOCUS AREAS	Female adolescents, HIV risk reduction, female households.
AIMS & OBJECTIVES	• Identify ways in which the CUBS project could program to decrease the vulnerability (with particular attention to sexual vulnerability) of female adolescents and female household heads and also seek ways to provide safe spaces for these two groups. • Develop a program framework, approach, and activities to address the vulnerability of girls, young women, and female-headed households within the context of OVC service delivery and HIV risk reduction.
SUCCES RATE	Project is still running
PARTNERSHIP	US Agency for International Development (USAID) Management Sciences for Health
FINANCING	USAID

TARGET POPULATION

Orphans, vulnerable children and their caregivers are the target population. Specifically, this project was implemented in 11 of Nigeria's 36 states, aiming to make a difference in the lives of 50,000 OVC and 12,500 caregivers (there are more, but this was just for this project). They have a focus on an often neglected population, namely female (and male) adolescents who are often also the caregivers. The target population is very poor, lacking even basic life necessities. The prevalence rate of HIV in these states ranges from 1-9.7%.

BACKGROUND INFORMATION

The Community Based Support (CUBS) for Orphans and Vulnerable Children (OVC) project is being implemented by Management Sciences for Health and Africare in 11 of Nigeria's 36 states and will simultaneously strengthen the advocacy and coordination roles of the Federal Ministry of Women Affairs and Social Development (FMWASD). The 5-year CUBS for OVC project aims to make a difference by increasing their access to scarce but crucial resources while also taking into cognizance additional issues of gender, quality, and sustainability.

ACTIVITIES

The current report is an overview of just a part of a larger project. The focus was on only objective, namely to address gender-related issues in OVC programming, particularly the vulnerability of the girl-child, female-headed households, and the burden of care that rest on females. They had intervention at

three levels; individual, support networks and systems. The activities were based on that and on four platforms Education and vocational training, economic strengthening, psychosocial support and legal protection.

SUCCESS RATE OF THE ACTIVITIES

The success rate of the intervention has not been established yet as the project is still running. However, preliminary evaluations seem to be positive.

CHALLENGES

- ***Poverty.*** Many are in abject poverty deprived of even the basic necessities of life dignified and sustainable access to food and nutrition, acceptable living conditions, psychosocial resources critical to development and health, legal and social protection, educational resources, wages/income, and affordable health care.
- ***No support system.*** Extended family and community systems have become so weakened that they rarely provide the said safety nets. Government structures are also considered quite weak in terms of providing support for OVC.
- ***Gender inequity.*** Women and girls are largely powerless, voiceless, and undervalued. Despite the low value placed upon these females, the burden of care and nurture falls heavily on them.
- ***Age.*** Children become orphans at a young age and often also become the caregiver at a young age. Besides that, during adolescence they go through puberty, meaning they not only have to cope with their difficult situation, they are also very sensitive to their inner changes.
- ***Culture.*** Across the states, harmful traditional and gendered practices, which vary across regions, increase vulnerabilities of females. Also, marriage exposes girls and women to huge risk, especially with regard to practices that take place within marriage and within the backdrop of the secrecy and privacy that surrounds the institution (religion and culture position the marriage institution as a sanctified and sacred no-go area where a third party (even a program implementer or social worker) is considered an intruder).
- ***Terminal illness.*** The AIDS epidemic and its attendant problems served to worsen what was already a bad situation—increasing poverty and a mass rural-urban drift in search of greener pasture.
- ***Low level of education.*** Female orphans carry a disproportionate care-giving burden when family members become sick or die of AIDS. Thus, they tend to be deprived of school and educational opportunities.
- ***Lack of access to information.*** There is low access to reproductive health information at the household and community levels and low government commitment to reproductive health and gender issues. Although some of the CUBS states may have a number of active NGOs working individually, networking and coalition building around issues is limited, reducing overall impact.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

Due to the pervasiveness of the challenges facing female adolescents and heads of households and based on study findings, it is hereby recommended that the CUBS project intervene at three levels—individual, support network, and systems—to have an impact on orphans through four critical as well as strategic

intervention platforms (i.e., education, economic strengthening, psychosocial support, and legal protection).[i] Focusing on these three access points and addressing these four areas of need will have the greatest capacity to reduce the vulnerability of adolescent females and female heads of households and to affect other OVC groups including male adolescents.

Individual level

- Gender issues are often very subtle, so assessor must be observant.
- Probe to find out specific needs of adolescent girls in areas of priority for the gender components of the project education, psychosocial and legal support, and economic strengthening.
- Observe the living environment.
- Speak privately with the adolescent girl to find out specific needs and issues.
- Watch out for signs of abuse and if signs are present probe further and follow up with teachers or neighbors if necessary.
- Find out whether guardian would allow adolescent to attend a local drop-in center (to cater to girls' psychosocial, life skills, and counseling needs) if this was made available.

Support network

- Provide economic strengthening to households that are supporting OVC based on the needs of the OVC and the capacity of the household to meet those needs.

Systems

- Draw up state-level agenda and priority that feed into the national OVC response, taking cognizance of state situation and needs.
- With guidance from the national level, build competencies of key personnel to drive response at state level (in gender, OVC knowledge as well as critical policy and documents).
- Mobilize as well as document the key actors in the OVC landscape and their types of operations; establish an effective model for networking and coalition building.
- Collect state-level gender disaggregated data deriving from LGA-level monitoring.
- Provide technical assistance (TA) to strengthen LGA and community structures to be able to deliver.
- Are desk and M&E officers trained on gender and OVC issues and familiar with relevant policy documents? Are personnel acquainted with the specific state-level issues? Which legislation or enabling laws have been passed or not passed that could affect implementation?
- Has information been collected on relevant NGOs, CBOs, and FBOs working in the state and their specific roles and areas of strength?
- Are there strong women NGOs that the project could link with?

Education

- Provide school support (holistic), including secondary or vocational training. Provide funds for fees, transport, books, and uniforms.
- Provide family/caretaker support for girls to stay in school.
- Establish day care centers (to free girls and women to attend school or vocational centers).
- Employ affirmative action— free education, fee waivers, scholarships for girls.

[i] See sidebar Strategic Focus for Reducing Female Vulnerability.

- Establish a flexible school curriculum.
- Provide separate toilets for boys and girls.
- Support training, employment of female teachers.
- Support target schools to set up or strengthen access to life skills and sexuality and adolescent reproductive health (ARH) services (e.g., family life and HIV/AIDS education).
- Train teachers and relevant school authorities on the unique needs of male and female OVC.

Economic strengthening

- Strengthen caregivers/extended families through micro credit and income generation activities.
- Employ strategies to reduce the exposure of girls from economic activities such as hawking.
- Create household labor-saving devices to free the adolescent/caregiver to attend school or other vocational training.
- Use cash transfer programs.
- Provide incentive-driven conditional grants.
- Provide unconditional financial support in the best interest of the orphan.

Psychosocial support

- Provide safe social spaces for preadolescent and adolescent females through youth centers or kids' clubs.
- Provide toiletries to support feminine hygiene.
- Link girl heads of households to supportive local women's groups, faith-based programs or local NGOs for mentoring and support.

Legal access points

- Link adolescent OVC head of household to supportive, gender-sensitive local women's groups, faith-based programs.
- Remove child from source of abuse to safe place. Provide capacity-building for police and other law enforcement agencies to access more knowledge about women and gender issues.
- Establish gender desk in the police stations.
- Provide legal protection to OVC, including sensitization of family courts to gender issues.
- Provide advisory and training activities related to legal documentation including will-writing,
- Registration of births and issuance of birth certificates.
- Establish ward/village committees (community watch groups) to oversee welfare of OVCs.

Some additional strategies that are important are:

- High sensitivity to gender equity at all levels of interaction.
- Establishing effective referral links to other OVC service providers.
- Mass awareness-raising about the gender and OVC issues and promotion of behavior change.
- For OVC outside of families, linkages to resources for finding safe shelter should be provided. For OVC inside families, capacity-building should be targeted to ensure responsiveness to the different needs of boys and girls.
- Age-appropriate learning materials detailing nutritional needs of OVC should be provided to caregivers.

- Provide factual gender- and youth-friendly information to both male and female adolescents, especially in the areas of sexuality and sexual and reproductive health and rights.
- Provide basic facts about HIV and how to prevent infection.
- Referrals for female adolescent OVC living with HIV, disability, or sexual abuse to specialist care (e.g., post exposure prophylaxis).
- Mobilization for taking essential services to the communities and underserved (not waiting for them to access service).
- Mass de-worming.
- Functional referral systems and prevention of mother-to-child transmission (PMTCT).
- Free health care for children (0–5 years).
- Access to sustainable HIV care, treatment, and prevention.

REPLICATING AND IMPLEMENTING THE SCALE

It is a very broad project and most of their strategies are very useful for all vulnerable groups.

REFERENCES

CUBS (2010). Community-Based Support (CUBS) Project for Orphans and Vulnerable Children in Nigeria Developing a Program Framework, Approach, and Activities to Address the Vulnerability of Girls, Young Women, and Female-Headed Households within the Context of OVC Service Delivery and HIV Risk Reduction.

RWANDA

PROJECT	Psychosocial Benefits of a Mentoring Program for Youth-headed Households
COUNTRY	Rwanda
NAME OF ORGANIZATION	USAID & HORIZON
FOCUS AREAS	Psychosocial issues faced by youth-headed households.
AIMS & OBJECTIVES	To set up a mentoring program to teach youth who head their households in relation to psychosocial problems they face.
SUCCES RATE	N/A
FINANCING	N/A

BACKGROUND OF TARGET POPULATION

According to UNICEF survey 2006 about 16% of below 18 years of age children have lost either one or both parents in Rwanda resulting in almost 65,000 youth-headed households in which about 300,000 people live. These people if not stranded due to parental death, also include children who are left behind by their families or removed from family care due to any stigmatization. Increase in youth-headed households is mostly due to AIDS pandemic, shifts in cultural values, weak family structures and global socioeconomic environment.

The target population for this study was the rural province in southwestern Rwanda which is considered to be one of the poorest regions in the country. According to estimates calculated there are about 1000 youth-headed households in the region. These children who are subjected to support children when they themselves are at a tender age are more vulnerable to mental, physical, emotional and behavioral problems. However, they can have a positive impact on the other children under them if they are mentored properly.

INTERVENTIONS USED

This is a quasi-experimental study that was conducted to analyze the effect of adult mentorship on the psychosocial problems faced by the youth-headed households. The experimental study contained two groups. The first group contained the youth households in the district of Karaba and Nayamagabe, who were given the mentoring program as well as the basic needs program. The second group, which was considered the comparative group belonged to districts of Mudosomwa and Nyraguru, were given only the basic needs program.

Initially, a thorough screening led to 156 volunteers being selected and trained to mentor the target population. These volunteers then started their regular visits to the homes of the affected people and developed and stable relationship with them once a cordial relationship was developed they taught the youth how to cope with different problems that they faced on regular basis. These volunteers were asked to provide the basic need training and also extra mentoring to the allotted group of people.

In the next step a cross-sectional survey was conducted to measure the impact of the mentoring program and the experiences that the youth went through in relation with them. The baseline survey was also

followed by another survey two years later to see the long-term effects of the program. These surveys were followed by interviews of those youth who gave their informed consent for it. The interviews also focused on their experiences before and after the mentoring problems, the psychosocial issues they face and other kind of additional program that may be deteriorating their situation. The volunteers hired for conducting the interview were carefully trained for discussing sensitive issues and identifying people's need individually and deal with their problem in the most efficient manner.

KEY FINDINGS OF THE STUDY

In order to find the results analysis was done using STATA, which explored linkages between exposure to intervention and the following 5 psychosocial outcomes:

1) Perceptions of adult support.
2) Marginalization.
3) Grief.
4) Maltreatment.
5) Symptoms of depression.

Initial analyses assessed comparative change between the two groups. If a difference was found, regression analyses were conducted to assess whether the difference persisted after controlling for the following background variables age, sex, living alone, parent killed in the genocide, highest grade completed, health status, assets index, and number of meals eaten per day.

The main findings of this study were as follows:

1. Youth heads of households who participated in the mentorship program perceived a significant increase in adult support.
2. Intervention participants reported a significant decrease in feelings of marginalization.
3. Youth who did not participate in the intervention reported a significant increase in feelings of grief.
4. Youth who participated in the intervention reported a significant decrease in maltreatment.
5. Intervention participants reported a significant decrease in depressive symptoms.
6. A higher frequency of mentor visits was associated with more positive perceptions of the mentor-youth relationship.
7. Other children living in the households were minimally impacted by the mentorship program.

RECOMMENDATIONS FOR OVC PRACTITIONERS

- The mentorship program is a scalable approach to improving psychosocial outcomes among vulnerable youth.
- Females may need additional assistance to overcome depressive symptoms and reduce maltreatment.
- Programs need to be realistic about what aspects of psychosocial distress a mentoring program can alleviate.
- The mentorship approach increased community participation in the care of vulnerable youth.
- The frequency of mentor visits is important.

REFERENCES

Brown, Lisanne, Janet Rice, Neil, Boris, Tonya Thurman, Leslie Snider, Joseph Ntaganira,, Laetitia Nyirazinyoye, Edward Kalisa, and Emmanuel Nshizirungu. 2007, *Psychosocial benefits of a mentoring program for youth-headed households in Rwanda*, Horizons Research Summary. Washington, DC Population Council.

SOUTH AFRICA (1)

PROJECT	ARK-Project
COUNTRY	South Africa
NAME OF ORGANIZATION	Nurturing Orphans of AIDS for Humanity (NOAH)
FOCUS AREAS	Community, network, support, HIV/AIDS, OVC.
AIMS & OBJECTIVES	Reaching many OVC with minimal resources by setting up networks (Arks) that can provide support for OVC in their community.
SUCCES RATE	Very successful in creating the Arks; in 2007 they had over 110 functioning Arks.
PARTNERSHIP	N/A
FINANCING	PEPFAR (PACT SA), ARK SA, Deutsche Bank Foundation Deutsche Bank Securities, Department of Social Development Hay House, Finlay, Old Mutual, JSE, Barloworld, Nedbank Foundation, OTIS, Rockefeller Brothers Fund, ABI, The Kiawah Trust, Zenprop, Pareto

TARGET POPULATION

Their direct target population is the communities, focusing on driven individuals that are motivated to work with OVC. Secondary, the Arks they created through this approach help orphans and other vulnerable children in South Africa (and, with the highest prevalence of HIV in the world, this is a big group). By 2015, it is predicted that there will be 2 million OVC (orphans and vulnerable children) in South Africa and an OVC is defined as a child who has lost either one of their parents, or who has both parents but those parents are incapable of taking care of their child.

BACKGROUND INFORMATION

NOAH has created a10-step program through which enthused, driven and accountable individuals from a given community are mentored to set up their own community network to care for orphans and vulnerable children (OVC). This is called an Ark. It is a community-based model that uses minimal resources to work with communities to empower them to support and care for the children in their community.

ACTIVITIES

NOAH empowers communities with the knowledge, skills, strategies and self-confidence to care for their own orphans and vulnerable children through the building and maintaining of Arks.
Its primary objectives are to:

- Facilitate community volunteers at NOAH's Arks to effectively deliver core NOAH services to OVC in a holistic and consistent manner.
- Increase the number of community volunteers at individual Ark projects.
- Maintain volunteers' commitment.

Arks comprise community leaders and trained volunteers who provide the following services:

- Registration.

- Home visits.
- Accessing grants.
- Starting food gardens.
- Feeding.

Sometimes Arks also have centers, which makes them able to provide daycare or aftercare.

SUCCESS RATE OF THE ACTIVITIES

The project was very successful. They were able to expand their services to 110 functioning Arks, across Gauteng, KwaZulu-Natal and the North West provinces and so doing, expand NOAH services to communities and children. The Arks were compromised of 826 committee member, 1010 volunteers, 498 staff. Together, they registered 33541 of the approximately 1 million orphaned and vulnerable children in South Africa. During the month of September alone, Arks provided 27 599 children with meals and food parcels, 2 593 children were in daycare and 14 877 were in aftercare programs. Volunteers across the country had provided more than 8 443 home visits and a total of 11 204 children and families have received grants from government.

REPLICATING AND IMPLEMENTING THE SCALE

This is a project that can be implemented anywhere in the world, for many different target groups. The way they get communities involved is amazing.

REFERENCES

- ARK (2007). Annual review: A celebration of the progress shown in 2006/2007.
- ARK (2007). Annual review: It's in giving that we receive.
- ARK (2007). Annual review: Annual financial statements 2007.
- ARK (2007). Annual review: Annual Report for the Period 1 March 2006 to the End of February 2007.

SOUTH AFRICA (2)

PROJECT	Center for Positive Care
COUNTRY	South Africa
NAME OF ORGANIZATION	Center for Positive Care
FOCUS AREAS	HIV, AIDS, STI's, home-based care, orphan support, counseling, peer education, income generation projects.
AIMS & OBJECTIVES	• Reduce infection rates of STIs and HIV. • Improve the quality of life for people living with and affected by HIV and AIDS.
SUCCES RATE	Effective but to continue growing more professional staff is necessary.
PARTNERSHIP	Save the Children (UK) Khulisa Management Services
FINANCING	Save the Children (UK), USAID, PEPFAR, Department of Home Affairs (DoHA), Department of Social Development (DoSD), Department of Education (DoE), Department of Agriculture (DoA)

TARGET POPULATION

People with STIs and HIV and the communities that are affected by these illnesses. With an estimated 5.5 million people living with HIV in South Africa, the AIDS epidemic is creating large numbers of children growing up without adult protection, nurturing, or financial support. Of South Africa's 18 million children, nearly 21% (about 3.8 million children) have lost one or both parents. More than 668,000 children have lost both parents, while 122,000 children are estimated to live in child-headed households.

BACKGROUND INFORMATION

The vision of CPC is to reduce the infection rates of STIs and HIV and to improve the quality of life for people living with and affected by HIV and AIDS. The approach of the CPC is to enable people in communities to create community-based projects that offer prevention, HBC and OVC services. CPC provides ongoing technical and financial support to approximately fifty (50) such community projects. The main services offered through the projects include peer education and lay counseling; home-based care; OVC support and income generation activities. Partnerships and networking are key to the approach used by CPC.

ACTIVITIES

- Training provision: CPC is well regarded as a training provider in home-based care and counseling skills. The CPC has well established training programs of an informal and formal nature. Accreditation with the Health and Welfare SETA should further secure their training role.
- Home visits and Child Care Forums: Identify OVC, ensure these children and their parents/guardians access government services and grants and community-based services, monitor the wellbeing of OVC, taking into account different needs according to age and gender as well as the well-being of their parents/guardians.

- Partnership and Linkages with Local Institutions: Mobilize community support for OVC and their parents/guardians in the ward and actively support community initiatives for OVC and to raise issues related to service delivery for OVC and their parents/guardians with the relevant authorities.

SUCCESS RATE OF THE ACTIVITIES

Center for Positive Care was effective in changing the attitude of volunteers, creating a strong commitment, more respect for volunteers, a reduction of stigma associated with HIV and AIDS, improved access to social services, a better access to communities and clients, increased knowledge and awareness level regarding STI and HIV in the community and more gender equity. For children and adolescents to project helped improving their self-esteem and school performance as well as raising their awareness of the importance of a healthy lifestyle. For the family and community the coordination between the government and the community improved and community participation in OVC increased. However, the project would improve if there was more professional staff and basic resources to support these activities.

CHALLENGES

- Discrimination from the community: contact with the volunteers of the organization may lead to discrimination of the community.
- There is a high number of cases where children, especially orphans, are abused or neglected. This presents as physical, sexual and emotional abuse, as well as misuse of grants intended to improve the quality of life of the orphans.
- Poverty: The community need for food, water and shelter seems a higher priority.
- Delayed government service: The process of obtaining government services is difficult for both OVC and their guardians when uncooperative officials and bureaucratic systems often hinder CPC's efforts.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

Benefits of integration: Integrating prevention and care has not only been effective, but has empowered volunteers. Volunteers have gained in confidence and self-esteem, as they feel that they are providing valuable and quality service to their clients and community. They are taking more responsibility for their own health and the health of their family members, and are more aware of reproductive health issues. The project expected some volunteers to experience burn-out as a result of increased workload, but they have handled their new roles well and demonstrated a high degree of resilience and motivation.

Commitment: When the site coordinators of each of the four projects were asked what will happen to the project if the donor were to pull out, with a single unified voice, each of them stated their clear intention to continue to serve the community with or without compensation. The integrated service has infused a strong spirit of volunteerism amongst volunteers.

Gender issues: One of the biggest challenges for the four project sites has been the recruitment of male Volunteers and access to male patients. Of the 121 total Volunteers at the four sites, only five are men.

Very few men have come forward to volunteer their services. This has been an obstacle to reaching out to male patients, some of whom do not wish to be cared for by female volunteers.

REPLICATING AND IMPLEMENTING THE SCALE

Replication is possible, especially with regards to the community involvement.

REFERENCES

- Byenkya, T. & Njaramba, P. (2008). Center for Positive Care; A Case Study.
- Center for Positive Care (2005). *Integrating Prevention and Care to Mitigate the Impact of HIV and AIDS.*
- Rendall-Mkosi K., & Phohole M. (2005). *Integrating paediatric palliative care into home-based care: an evaluation of 3home-based care projects.* Durban: Health Systems Trust.

SUB-SAHARIAN AFRICA

PROJECT	Orphan and Vulnerable Children-Information Note.
COUNTRY	Sub-Saharan Africa
NAME OF ORGANIZATION	The Global Fund
FOCUS AREAS	Funding for OVC
AIMS & OBJECTIVES	To guide on type of information on OVC to be included for fund proposals.
SUCCES RATE	N/A
FINANCING	N/A

BACKGROUND INFORMATION

UNAIDS, UNICEF and PEPFAR define the following terminologies as:

"An orphan is a child under 18 whose mother (maternal orphan), father (paternal orphan) or both parents (double orphan) have died."

"Orphans and vulnerable children (OVC) are defined as affected by HIV and AIDS by virtue of, among others, living in a household where one or more people are ill, dying or deceased, or which fosters orphans, and children whose caregivers are too ill or old to continue to care for them."

"Children affected by HIV and AIDS (CABA) are defined as children living with HIV, and children whose well-being or development is threatened by HIV and AIDS in their families or communities."

AIDS increases family poverty and distress through loss of livelihood, increased mobility and additional health care costs which adversely affect children's health, nutrition, mental health and education, and may force some children to become target of exploitation, HIV-related stigma and discrimination, keeping them out of school, friendship networks, and health and social services.

In concentrated epidemics the children and adolescents are excluded from services of any kind sue to stigmatization of their parents' or their own involvement in sex work, drugs or any other kind of illegal activities. In such a scenario, the most effective programs for consideration in Global Fund proposals may include advocacy, legal protection, community and outreach services, peer support and education, financial assistance, and access to health, education and welfare services for children and families.

In generalized epidemics, increased mortality causes the children to live with surviving parents and extended families. Analyses show that poor outcomes for children include malnutrition, incomplete schooling and sexual risk-taking which are associated with orphan status vulnerability, poverty, low education levels, minority status, disability and residence in under-served areas among caregivers. The youngest children are the most vulnerable over the long-term because their bodies, brains, social relations and self-confidence develop rapidly during early childhood. Any interruptions and delays in young children's developmental potential are difficult to recover in later years; especially when children continue to live under difficult conditions Community-based early childhood development activities can provide such support and care, especially when parents are also engaged in livelihood activities. Girls are especially vulnerable to infection, as they face a risk of sexual violence and rape, both inside and

outside of marriage, due to gender disparities and sexual and social norms. Community programs, peer education and health services addressing the needs of vulnerable adolescents should be delivered through sex- and age-appropriate interventions aimed at increasing support and reducing risk.

OVC IN GLOBAL FUND PROPOSALS

The Global Fund supports evidence-based interventions and activities that provide details of assessments in order to justify the interventions that have been included, as well as details of how Global Fund grants will complement funding from other international and national sources in order to provide comprehensive care and support for OVC.

For every proposal accurate and adequate situation analysis should be carried out with specific importance to the cost of the intervention. There are five basic OVC related areas which should be targeted in any OVC proposal. These are:

1. Strengthening families of OVC.
2. Encourage community-based child care.
3. Security of health, education and birth registration should be ensured.
4. Government should have active participation in the project.
5. Provide various effective awareness campaigns.

Proposal applicants should also take care that the interventions should be HV sensitive rather than HIV specific in order to avoid stigmatization of the affected children and adolescents. Supportive family environment should be ensured along with community based awareness. Thorough analysis should provide the answer to the question whether the program should be started at small-scale or large scale. Proper monitoring and evaluation should be done at each step that is, input, activities, output and impact.

RECCOMENDATIONS FOR OVC PRACTITIONERS

- Pre-situation analysis with respect to cost is necessary for any intervention in order to decide the scale on which it should be launched and also to make contingency plans in any worst case scenario.
- Social issues like stigmatization, health care, education, gender-based violence and inequality are areas that will have to be targeted in any OVC intervention.
- Monitoring is extremely essential at all stages to ensure whether the intervention is moving in right direction or causing more problems that cure.

REFERENCES

Global Fund Information Note OVC (August 2011), http://www.iattcaba.org/. Retrieved on September 30, 2013.

TANZANIA

PROJECT	Looking Within. Creating Community Safety Nets for Vulnerable Youth in Dar-es-Salaam, Tanzania
COUNTRY/ CITY	Tanzania/ Dar-es-Salaam
NAME OF ORGANIZATION	Project Concern International (PCI)
FOCUS AREAS	Education, sustainable development.
AIMS AND OBJECTIVES	Help children and youth protect their access to education, including primary and secondary education, as well as vocational training.
TYPE AND LOCATION OF ORGANIZATION	Youth Alive Tanzania Youth and Parents Crisis Counseling Center (YOPAC) - Tanzania
FINANCING	YOPAC financed by the U.S. Agency for International Development's (USAID)

BRIEF BACKGROUND OF TARGET POPULATION

In Tanzania, as in many countries affected by the HIV pandemic, one of the most common household coping strategies for dealing with the effects of food insecurity, illness, and household poverty is to remove children and youth from school. Families cannot afford costs related to school, and they also need their children to earn income, or be at home to care for those who are sick or too young to care for themselves. For many families, sending their children to school is seen as a luxury, not an essential practice.

An important point is that, in 2003, food aid and other foreign assistance programs ended their work in many of the districts of Dar-es-Salaam, leaving a huge gap in support for families with few apparent resources of their own and endangering education prospects for many young people, especially OVC. Many families had taken in orphaned children over years and, without the NGOs' support they were accustomed to, were deeply worried about how they would have continued to pay for the children's needs. In addition, in Dar-es-Salaam HIV in pandemic HIV prevalence rate is estimated at 9.3 percent, and the national prevalence is 5.7 percent (Tanzania Commission for AIDS et al. 2008).

ACTIVITIES

The YOPAC program works in partnership with vulnerable families, helping caregivers and families facing adversity making better use of their own resources and expand their access to family and community resources so that a young person can stay in school.

Once potential resources are identified, YOPAC works to forge and formalize the commitments of the individuals who form the youth's support network, monitoring agreements over time and intervening when necessary to avoid gaps in support. The community-enforced agreement, much like a memorandum of understanding (MOU), binds all of those involved—the young person, the family, community members, and a local government representative—to the agreed terms.

The process is simple, transparent, and easily replicable in many contexts. The strategy can be used in isolation, as a way to help individual families in crisis mobilize community resources to support OVC, or it can be used as part of an exit strategy, to ensure that families have a safety net in place before the phase-out of external assistance.

YOPAC uses its referral network to target children and youth who need help. Some youth are referred through the schools (teachers know who is most vulnerable), and others come to YOPAC through peer educators who work on HIV awareness and education programming. Some are referred by local municipal administrators, while others come to YOPAC on their own initiative. In all cases, YOPAC investigates the situation of the youth and his or her family, interviewing family members, teachers, and neighbors to determine that they are indeed vulnerable and in need of the program's support.

In December 2010, 75 OVC received an education through the YOPAC program 34 in public primary and second school and 41 in vocational training— a minute portion of the youth in Dar-es-Salaam who need support.

YOPAC works with a Five-step process:

1) Identify Needs YOPAC's staff sit down with the family with the purpose of identifying all the unmet needs of the vulnerable young person and of the family that is supporting him or her, making sure the list is comprehensive and then prioritizing the needs individuated.

2) Identify Existing Resources, Gaps, and Potential Providers the starting point is always the youth and the families themselves, and their contribution to meeting their own needs. The youth and the family always play an active role in the process and make some contribution, which sometime is tangible and sometime is less tangible contributions like a shelter, some meals, love, good grades at school and hard work, should be counted.

Once the needs are individuated, YOPAC's staff together with the family determines the gap applying the formula *total needs* minus *existing resources*. The basic idea is to get members of the community to share responsibility for this gap and to contribute to fill it in ways they are able to. Potential providers could be extended family members, friends, neighbors, teachers, lawyers, members of parliament, counselors, community development officers, business people, NGOs, municipal or regional government, etc. YOPAC also has a small amount of resources that it contributes in some cases. Ideally, families will receive reliable support from a diverse range of sources, so that if one fails to materialize, they are not left completely stranded.

3) Plan How to Approach Potential Providers sometimes the family approaches the provider directly, and other times YOPAC facilitates the connection or makes it on behalf of the family or young person. One of the biggest difficulties in this step is the shame and stigma attached to asking for help YOPAC reminds everyone that is their responsibility to help those in need and that, as we are social beings, we all need one another.

4**) Sign Agreement and Implement** YOPAC uses a form, the community-enforced agreement, that works like a memorandum of understanding it documents the needs of the young person, his or her commitment to the process, the commitment of the family, and the commitments of relatives,

community members and YOPAC. A signing ceremony celebrates the agreement and copies of it are held by YOPAC, the family, and the municipal representative. The obligated resources are then delivered directly to the young person or the head of the family in order to ensure that a relationship will be built.

5) Monitoring and Follow-up periodic visits to the youth and its family are made in order to compare the agreed contribution to the actual receipt of support. In cases when obligations are not being met, an investigation will assess the reason. In some cases, pressure may be applied by the municipal government representative, a church leader or the most effective subject. In other cases, the circumstances of the provider have changed and he or she is simply no longer able to contribute in the way agreed in the MOU either a new arrangement based on the changed circumstances can be signed, or the provider can be absolved of its commitment and YOPAC goes back to the family to re-visit the list of potential providers.

SUCCESS RATE OF THE ACTIVITIES

1) Counseling skills are extremely useful in helping families overcome difficult situations relating to HIV- and poverty- related shame and stigma, and in resolving conflicts among youth, family members, and resource providers.

2) Addressing stigma associated with HIV and poverty is still a significant problem in these communities. YOPAC assures the family that their HIV statuses will remain confidential and that the primary aim is to work together to ensure that their needs are met. Community members report that stigma associated with HIV has declined as a result of this program, and that community sensitivity and involvement in caring for people living with HIV and OVC have increased. By promoting positive interactions between the families and resource providers, the latter (and the community at large) gain a better understanding of and greater empathy for families facing adversity.

3) Creating connections where possible, getting families to approach resource providers directly can be greatly empowering. Family members feel like they are actively solving their own problems, and in the process they are improving their networking and self-advocacy skills. Similarly, the process works best when support is delivered directly to the youth and family, rather than through YOPAC. Ultimately, the process establishes (or grows) a network of supportive relationships across the community. This is the basis for a community safety net.

CHALLENGES

MOU defaulters

Often the community members genuinely want to help, but when it comes to actually making the contributions, they find out it is beyond their means and they default on their obligation, undermining the arrangement. Sometimes they can be encouraged to fulfill their obligation, other times the arrangements should be modified. A step-by-step process for enforcing the agreements has yet to be developed.

Poverty
The YOPAC approach relies on the existence of resources within the community. But within the context of urban poverty, aggravated by the consequences of high HIV prevalence, families who were previously in positions of relative comfort are often barely able to meet their own needs, let alone those of a more vulnerable family member. A change in circumstances can also become an issue for those who make a commitment to help. This challenge does not necessarily mean a failure of the approach but rather illustrates that no solution is permanent and that follow-up and adjustment to change are necessary parts of the process. Ultimately, poverty- reduction strategies for the community as a whole provide the best way for the YOPAC approach to be consistently effective.

Staffing
Staffing is a serious constraint for YOPAC and should be carefully considered by any agency undertaking this approach. Follow-up, in particular, can be time-consuming and difficult, but is absolutely essential.

Sustainable programming
The YOPAC team was struck by the extent to which the families had become dependent on international and local NGOs and their unpredictable sources of assistance. When YOPAC began using the community-enforced agreements, families initially complained that YOPAC was complicating the process by using the MOU instead of just delivering the contributions "like a gift", the way other NGOs had done in the past.

Chronically ill and elderly caregivers
In communities with high HIV prevalence, children and youth are often under the care of a chronically ill parent or an elderly grandparent. With the untimely passing of their own children due to HIV-related illnesses, elderly caregivers now find themselves once again performing parenting duties in their final years of life. Applying the YOPAC approach becomes difficult when the primary caregiver for the vulnerable youth is also vulnerable and in need of care, due to illness or age. YOPAC has begun presenting these cases to the new "street AIDS committees," small prayer groups, and other support groups that offer support to families, in the hope that perhaps they could engage in the process on behalf of the primary caregiver. To date, it is still unclear whether these groups are adequately equipped to assume the familial responsibilities laid out in the MOU.

ANALYSIS

- Staff with good counseling skills and in-depth knowledge of the target community is fundamental.
- It is fundamental not to under valuate the importance of stigma and discrimination.
- The community itself should have sufficient resources to provide ongoing support. This could not be realistic in communities that have recently experienced large-scale crises.
- Consider the presence of strong community leaders and structures (such as religious institutions or government/community committees) that can support and "enforce" the process.

REPLICATING AND IMPLEMENTING THE SCALE

This project could be easily replicated in other contexts, both in urban and rural settings, unless the

community does not have resources to provide support, which could be the case in communities that have recently experienced large-scale crises.

REFERENCES

- Castleman, Tony. 2008. *Nutrition, Food Security, and HIV A Compendium of Promising Practices.* Washington, DC FANTA/Academy for Educational Development. Available at http//www.pronutrition. org/files/fsHIV_compendium2008.pdf (retrieved in March 2010)

- Greenblott, Kara. 2010. *Looking Within Creating Community Safety Nets for Vulnerable Youth in Dar-es-Salaam, Tanzania.* Case Study Series. Arlington, VA USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

- Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Dar es Salaam, Tanzania TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.

UGANDA

PROJECT	Integrated Care for Orphans and Other Vulnerable Children A Toolkit for Community Service Providers. Kampala. Uganda. Ministry of Gender, Labor and Social Development. 2005.
COUNTRY	The Republic of Uganda
NAME OF ORGANIZATION	Ministry of Gender, Labor and Social Development
FOCUS AREAS	Improving services for OVC.
AIMS & OBJECTIVES	The core objective is to develop a toolkit for the use of service providers for OVC.
SUCCES RATE	Good
PARTNERSHIP	Action for Children, AIM, Christian Children's Fund, Core Initiative Uganda, Hope for African Children Initiative, Kampala City Council, Ministry of Education and Sports, Ministry of Health, NACWOLA, Save the Children in Uganda, UNICEF, UPHOLD, USAID, UWESO, World Vision.
FINANCING	USAID

DESCRIPTION OF THE PROJECT

Many organizations have involved and have found innovative ways to support OVCs, ofeten with very few resources in Uganda. This project was to develop a sort of "Toolkit" to share practical ideas that worked in the field in Uganda and around the world. It includes step-by-step guides, sample documents, assessment checklists, monitoring and evaluation indicators, programme models, behaviour change messages, and suggestions for further resources. Such tools are meant to be used by service providers for OVC to improve their effectiveness and support for OVC.

TARGET POPULATION

The Toolkit is designed for OVC service providers at the community level, including community-based organizations (CBO), faith-based organizations (FBO) and non-governmental organizations (NGO). It can also be used by people providing technical assistance and support to these organizations, such as district Community Development Officers (CDO) or Probation and Social Welfare Officers (PSWO). Therefore the project targets the service providers for OVC and by improving their effectiveness the project indirectly cater to the OVC at large.

The Situation Analysis of Orphans in Uganda (MGLSD/UAC 2002) estimates that there are more than 2 million orphans in Uganda. One of every five children is orphaned, and most are between 6 and 15 years of age. One in four households in Uganda includes at least one orphan. With the added burdens of poverty, HIV/AIDS and armed conflict, many communities are facing a crisis situation.

Various groups use different definitions to identify orphans. The definition used in this paper is that an orphan is a person below the age of 18 years who has lost one or both parents.

Similarly the definition used to identify a vulnerable child is that a vulnerable child is a person below the age of 18 living in a situation that exposes him or her to significant physical, emotional or mental harm. There was no statistics provided in regard to the OVC with HIV/AIDS.

BRIEF BACKGROUND OF TARGET POPULATION

The OVC Secretariat of the Ministry of Gender, Labor and Social Development (MGLSD) of Uganda had observed that there were many non-governmental organizations involved in helping OVC in Uganda. Those organizations have been using their own methods in assessing, analyzing and making intervention in different OVC situations. Therefore the Ministry viewed that it would be best to develop a something known as a toolkit for the use of those who provide assistance to OVC.

So, the obvious objective was that OVC service providers could use the Toolkit to:
1) Improve existing OVC services.
2) Plan new activities.
3) Work more effectively with communities, volunteers and OVC.
4) Monitor and evaluate their OVC services.
5) Learn about and apply the National OVC Policy that guides OVC programmes around the country.

Accordingly the Toolkit was developed by the OVC Secretariat of the Ministry of Gender, Labor and Social Development (MGLSD) with support from the AIDS/HIV Integrated Model (AIM) District Programme. It was developed collaboratively with thematic working groups composed of OVC programme implementers and other stakeholders, and with the Technical Resource Committee of the MGLSD OVC Secretariat.

In Ugandan culture, the extended family and community have traditionally taken care of orphans. However, the orphan crisis has now overburdened households, and many communities are finding it too difficult to give orphans the care and support they need.

With the added burdens of poverty, HIV/AIDS and armed conflict, many communities are facing a crisis situation. The Government of Uganda and its partners are working to help households meet the financial, social, psychological, educational, and health needs of the children they support. That is why effective intervention is required to support OVC.

ACTIVITIES

The main activity was to identify the “Core programme areas of OVC support”. Subsequently step by step details of activities of each of the core programme area are spelled out. In addition, as is usually required a criterion has been developed for choosing OVC assistance and for choosing the most vulnerable households; this is important to deliver optimum support out of the limited resources available. The study had identified eight core programme areas of OVC support. Those are:

1) Socioeconomic security for OVC.
2) Food security and nutrition.
3) Urgent care and support for OVC.
4) Reducing the impact of conflict on OVC.

5) Education for OVC.
6) Psychological support for OVC.
7) Health for OVC.
8) Child Protection and legal support for OVC.

The project has made a commendable effort to define each core programme objectively even though there could be subjective speculation on the part of service provider. For an example in regard to the programme area of "Socioeconomic security for OVC" the study had first defined what it meant by socioeconomic security and any deviation from that definition requires the support of a service provider to ensure the socioeconomic security for OVC. But such definitions sometimes lead to make subjective assessment by the service provider if definitions are not backed by a quantifiable criterion.

However the uniformity of presenting details under each core programme area would help the service provider to innovate their own approaches when working with OVC. A system call "triple A" approach was used in the study. Tripple A means, Assess – Analyze – Act. This approach is reflected in the description of each core programme area.

Another major strength in this study is that they added additional value to their basic approach of triple "A". That means they got the participation of all possible stakeholders in carrying out the study. So, instead of simple triple "A" they used "Assess together" – Analyze together" – "Act together" approach.

Accordingly under each programme area mentioned above, many "tools" have been explained to improve the effectiveness of the activities carried out by field level service providers for OVC.

SUCCESS RATE OF THE ACTIVITIES

There is no directly measurable success rate in this study. Since the study aims to empower the service providers for OVC by identifying core progrmme areas and what definitive activities must be carried out under each programme area, the study has developed a practical "toolkit" for the use of service providers for OVC. By that measure the success rate is good because the job was done and has produced a document that can be used by service providers.

CHALLENGES

Basically there were no considerable challenges in carrying out this study as the study was implemented by the Ministry of Gender, Labour and Social Development of the government of Uganda.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

Perhaps the work could have been improved if the definitions are done minimizing the room for speculation by the practical service provider. Also one might argue the definition of OVC itself, is not consensual. This is important to separate normal cases of child poverty from poverty in vulnerable homes. Therefore, if this kind of study is to be carried out by any particular country in future, paying attention to similar aspects might be highly useful.

REPLICATING AND IMPLEMENTING THE SCALE

This project can be replicated in other countries. Similar study would provide guidance for any service provider or service provider organization for OVC. Yet certain definitions must be of international definitions. This is important to separate normal cases of child poverty from poverty in vulnerable homes. However compilation of a national level manual must be useful as it spell out the policy priorities of the government and core programme areas for OVC.

REFERENCES

- Uganda. Ministry of Gender, Labour and Social Development, and The Uganda AIDS Commission. 2002. *Situational Analysis of Orphans in Uganda, Orphans and their households Caring for their future*. Kampala Government of Uganda.

- Roles in Supporting OVC UNICEF, UNAIDS, and USAID 2004. Children on the Brink 2004, a Joint Report of New Orphan Estimates and a Framework for Action, http//www.unicef.org/publications/cob_layout6-013.pdf (retrieved in October 2013).

- THE TRIPLE 'A' APPROACH
  Cook, M. 1998. *Starting from Strengths Community Care for Orphaned Children, A Training Manual Supporting the Community Care of Vulnerable Orphans.* Malawi, http//www.ovcsupport.net (retrieved in October 2013).

- Cook. M.R. (2001), *Filling the Gaps, Using a Rights-based Approach to Address HIV/AIDS and its Affects on South African Children, Youth and Families*. Canada. The Institute for Child Rights and Development and The Interagency Coalition on AIDS and Development. http//www.iicrd.org/cap/files/filling%20the%20gaps.pdf (retrieved in September 2013).

- Child Protection Society, Zimbabwe. 1999. *Approaches to Community-Based care, A Guide for Groups and Organizations Wishing to Assist Orphans and Other Children in Distress (Draft Report)*, http//www.womenchildrenhiv.org/pdf/p09-of/of-03-05.pdf (retrieved in October 2013).

- Regional Centre for Quality of Health Care. 2003. *Nutrition and HIV/AIDS, A Training Manual.* Kampala Institute of Public Health, Makerere University, FANTA Project, and USAID.

- Canadian Foodgrains Bank. *Selecting Beneficiaries for Food Aid, Technical Information Put Simply, Infosheet 403*, http//www.foodgrainsbank.ca/programming/proposal_guide/tips/tips403.pdf (retrieved in October 2013).

- United Nations General Assembly. 51st Session, 26th August 1996. *Promotion and Protection of the Rights of Children; Impact of Armed Conflict on Children*, Note by the Secretary General. New York.

- De Lay, B. 2004. *Mobility Mapping and Flow Diagrams Tools for Family Tracing and Social Reintegration Work with Separated Children,* http//pdf.dec.org/pdf_docs/PNACS219.pdf (retrieved in September 2013).

- Ministry of Education and Sports. Mid-term Review of the Education Strategic Investment Plan (ESIP) in Uganda, A Consultancy Report. Kampala.

- Uganda. Ministry of Health, and UPHOLD. Draft 2005. Community Involvement in Education Kit. Kampala.

- Action for the Rights of Children. 2001. Critical Issues Disability, http//www.unhcr.ch (retrieved in September 2013).

- Advocates for Youth for the Centers for Disease Control and Prevention. 2000. Parent-Child Communication Basics A Lifelong Dialogue A Workplace Program to Enhance Parent-Child Communication, www.advocatesforyouth.org/ publications/pccbasics/introduction.htm (retrieved in October 2013).

- *Big Brothers Big Sisters of Durham & Orange Counties*, Inc. 2000. Volunteer Training Manual. Durham North Carolina, http//campusy. unc.edu/heyyou/committees/bigbuddy/manual/volunteer%20training%20manual%5B1%5D.doc (retrieved in September 2013).

- The CHANGE Project. 2004. *Understanding and Challenging HIV Stigma Toolkit for Action*. Academy for Educational Development, www.changeproject.org/technical/hivaids/stigma.html (retrieved in August 2013).

- Regional Centre for Quality Health Care (2004). *Nutrition for People Living with HIV/AIDS Counselling Cards.* Kampala Makerere University Medical School and Regional Centre for Quality Health Care, http//www.fantaproject.org/downloads/ pdfs/Uganda_Counseling_Cards.pdf (retrieved in September 2013).

- Centers for Disease Control and Prevention. 2003. Safe water systems for the Developing World A Handbook for implementing Household-Based Water Treatment and Safe Storage Projects. CARE/CDC Health Initiative, http//www.cdc.gov/safewater/manual/sws_manual.pdf (retrieved in October 2013).

- Uganda. Ministry of Health. *Community Owned Resource Persons Trainer's Manual on Improving Key Family Practices, Improving Child Health in the Community*. Kampala, http://health.go.ug/mohweb/ (retrieved in November 2013).

- International HIV/AIDS Alliance, *A facilitators' guide to participatory workshops with NGOs/CBOs responding to HIV/AIDS*, www.aidsalliance.org/_res/training/ Guides/Facilitators%20%20(Eng).pdf (retrieved in August 2013).

UNITED STATES (1)

PROJECT	Community-based Early Childhood Development Centers For Reaching Orphans And Vulnerable Children Considerations And Challenges, Issue Paper- February, 2012.
COUNTRY	Initiated in USA
NAME OF ORGANIZATION	AIDSTAR-One, Arlington, VA 22209 USA
FOCUS AREAS	Improving services for OVC by helping program managers to establish ECD centers.
AIMS & OBJECTIVES	The core objective is to develop a documentation to facilitate the program managers to establish and run good ECD centers to serve OVC.
SUCCES RATE	Good
PARTNERSHIP	A few scientific and research organizations have partnered.
FINANCING	USAID

DESCRIPTION OF THE PROJECT

This "ISSUE PAPER" has been compiled to assist the program managers to enable them to develop effective community-based early childhood development centers in order to reach and provide services to OVC. In that sense this paper provides information to program managers as to how they should plan, set up and operate an Early Childhood Development (ECD) Center to serve OVC.

TARGET POPULATION

The target population is OVC but indirectly through the motivation of the program managers to set up ECD centers to serve OVC.

BRIEF BACKGROUND OF TARGET POPULATION

Early childhood development programs aim to meet the cognitive, physical, and emotional health and developmental needs of children from age 0 to primary school-aged. Quality ECD programs integrate health, nutrition, education, and child protection; build on community strengths; support caregiver education; provide equitable access for children and their caregivers; and use various approaches that support diversity, address the needs of both boys and girls, involve multiple generations, and ensure ongoing monitoring and quality improvement. Community-based ECD centers incorporate the best of family-based and center-based ECD programs.

As program managers know, implementing high-quality ECD programs is often difficult or even impossible. However such difficulties might be overcome to a certain practically required level if the program managers themselves upgrade their knowledge, identify priorities, know the challenges and the resources available nationally and internationally.

Therefore, it is important, however, that program managers understand the elements of a quality ECD program toward which their programs can strive, and integrate those components as possible. One

approach is to focus on small, doable actions, taking into account the most cost-effective intervention that suits the environment.

This paper is intended to provide OVC program managers with examples of best practices in quality community-based ECD center programming from which to draw in order to meet the ECD needs of the children they serve.

The methodology used is to discuss and analyses selected four case studies. Sometimes studying cases is very important because they are not hypothetical examples but real world examples of successes and failures. Hence four case studies are provided as examples of how OVC programs have integrated aspects of community-based ECD. There is also a list of considerations when planning for quality community-based ECD centers.

ACTIVITIES

The main activity was to impart knowledge for the program managers to plan, establish and operate ECD centers so as to serve best for OVC.
The study expects/suggests that effective community-based ECD centers provide:
• A stimulating and healthy childcare environment that promotes physical, cognitive, and socio-emotional development; and inclusive learning that builds on children's strengths and attends to their health and safety.
• A curriculum that focuses on physical, cognitive, language, and socio-emotional development; allows children to be active and engaged; has clear goals shared by all stakeholders; is gender-sensitive and evidence-based; structures learning through investigation, play, and focused, intentional teaching; and builds on prior learning and experience.
• Psychosocial programs and referrals that are age and status appropriate.
• Reduced or no fees for young children in communities highly affected by HIV.
• Services that combine the provision of resources and materials with education, training, counseling, and other support.
• Centers located near primary schools so older children, particularly girls, who are caregivers can attend school while the younger children are cared for.
• Partnerships with nearby health facilities that can receive referrals or make regular visits to the center.
• Teachers who are committed to ECD and receive frequent training (both preservice and in-service) that improves knowledge, acceptable financial rewards, and opportunities for professional growth and networking.
• Processes by which quality is recognized (through systems such as certification, regulation and accreditation); and group size and adult–child ratios appropriate to the children's ages and overall cultural context.
• Complementary outreach programs that provide female and male caregivers with culturally appropriate information on how to nurture and promote equal development of both male and female children.
• Food supplies for OVC and their families to address food insecurity such as through food donation programs or vegetable and fruit gardens and permaculture at the center.

SUCCESS RATE OF THE ACTIVITIES

There is no directly measurable success rate in this study. Since the study aims to empower the program managers to establish ECD centers appropriately the success should be measured by determining whether the said objective is achieved or not. By that measure the success rate is good because the study has produced a document that can be used by program managers.

CHALLENGES

The study has listed a few important challenges that Orphans and Vulnerable Children program managers considering ECD programs should be aware of. Those challenges include the following:

• A dilemma for OVC program managers who want to include community-based ECD centers in their programs is whether to target children living with or orphaned by HIV, rather than enrolling all eligible children in the community (noting that many children may be negatively affected by HIV, although this is not recognized or known by the larger community). While OVC are more likely to lack access to the support needed for healthy development, ECD centers that exclusively serve, prioritize, or favor OVC can lead to further stigma and discrimination. Guidance from PEPFAR on OVC programming says, "Programs must implement effective measures to prevent gender inequity, avoid further degradation of family structures, reduce stigma, avoid social marginalization, and that do not generate jealousy and conflict for beneficiaries. Services need to be designed to reduce stigma, not increase it" (OGAC 2006, 4). The 2009 PEPFAR Next Generation Indicators Reference Guide further states "Individuals eligible for preventive and support service. Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS who live in households made increasingly vulnerable because of HIV/AIDS. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of [the] HIV epidemic" (PEPFAR 2009, 125).

• Quality community-based ECD centers require sufficient resources. Limited resources can result in services being uneven from one site to another, being overcrowded, having too few or inadequately trained staff, and being incapable of providing the care needed by the children, and instead just a place where they will be passively watched for much of the day. One of the ways to be cost-effective is to engage the community and build on existing resources. For example, rather than build a new structure, programs can borrow space from community centers or renovate unused buildings. Instead of taking children to specialized services, programs can bring one or two professionals to the center itself. Rather than purchasing teaching aids, programs can teach staff and caregivers to make their own. Making linkages to the donor community is another approach, as well as working with donors to support certain activities and/or inputs. For example, feeding programs such as the World Food Programme may donate food, and a local or international nongovernmental organization may provide health care services. Another option is to engage the community, beginning with advocacy so they understand the importance of ECD, and working with the community on activities such as rotating cooking for schools, or the donation of land for schools or community buildings for ECD classes. It may also be possible to identify local organizations that will sponsor ECD centers.

• Fees for ECD centers can be prohibitive for families struggling with HIV. Depending on the particular context, there are some ways to address the burden of fees. One option is establishing partial or full

scholarships for OVC through a government bursary system or advocating to local or national education agencies to provide support for underserved schools. Governments may compensate centers that waive fees for OVC. Using volunteer community teachers is another approach, limiting the need for fees that serve to pay teachers so that children can attend free of charge or for a nominal fee. Of course, there may be challenges retaining teachers who are not paid, and this may reduce the quality of teaching.

• Teacher salaries and staff turnover can be an issue for ECD centers. If ECD staff is employed by the host government, they may not have opportunities for refresher training, may face human resources constraints, and may be rotated in and out of the center, affecting the quality of the childcare provided. It is important not to place too much burden on staff. For example, in one ECD center in Malawi, staff is responsible for cooking the children's food, which takes time away from their focus on the children.

• National-level HIV policies and interventions are generally not designed to address the developmental needs of young OVC. For example, ministries of education often focus on school-aged children and provide schooling and health education, while ministries of health may focus more on the medical aspects of prevention and treatment and less on mitigation efforts for young children. This leaves a gap in policies and programs targeting the ECD needs of preschool-aged children and makes it difficult for projects to achieve the scale of coverage required to effectively address the needs of this growing group of children. Key national planning documents such as the Poverty Reduction Strategy Papers, HIV national strategic plans and frameworks, and national OVC policies need to include the specific needs of young children as development priorities. Efforts to mainstream ECD within HIV policies should not compete with the OVC agenda, but rather strengthen it. These agenda pursue the same objective the well-being of OVC.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

This paper provides essential basic information as to the establishment of ECD centers to serve OVC. Also it discusses a few important challenges that should be aware of by program mangers even before planning ECD centers. Since the knowledge imparted by this paper is based on selected case-studies, that information is real not theoretical. Hence it would be better if program managers could arm themselves with the kind issues and challenges that discussed in this ISSUE PAPER.

REPLICATING AND IMPLEMENTING THE SCALE

It seems inappropriate to replicate a similar study but this could be perhaps kept on upgrading as and when new opportunities and challenges propped up.

REFERENCES

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)- *Guidance For Orphans And Vulnerable Children Programming*, 2012, http://www.pepfar.gov/documents/organization/195702.pdf (retrieved in September 2013).

UNITED STATES (2)

PROJECT	Early Childhood Development For Orphans And Vulnerable Children Key Considerations Technical Brief – March 2011.
COUNTRY	Initiated by USA
NAME OF ORGANIZATION	AIDSTAR-One, Arlington, VA 22209
FOCUS AREAS	Preparing program managers in designing ECD programs to serve for OVC.
AIMS & OBJECTIVES	The core objective is to prepare a technical documentation to be used by the program managers of ECD programs.
SUCCES RATE	Good
PARTNERSHIP	In collaboration with a few scientific and research organizations.
FINANCING	USAID

DESCRIPTION OF THE PROJECT

This technical brief gives an overview of critical ECD elements and existing evidence for program managers who are interested in implementing ECD programs, or incorporating ECD elements within existing programs to support OVC. The brief describes the three critical elements of ECD, summarizes key findings from program evaluations and literature on ECD, and answers commonly asked questions about developing ECD programs for OVC.

TARGET POPULATION

The target population is OVC but indirectly. The target is to empower program managers in designing and implementing strong, comprehensive ECD programs by focusing on the basic principles of child wellness and development. By incorporating best practices gleaned from worldwide research on ECD in a range of settings, program managers can develop effective OVc programs aimed at very young children.

BRIEF BACKGROUND OF TARGET POPULATION

Early childhood development (ECD) interventions— those targeting children from birth to age five (and/ or age upon entry into school)—are among the most cost-effective approaches for improving outcomes for vulnerable and at-risk children. Recent reviews of ECD programs demonstrate that the benefits of early intervention for all children are far-reaching and lead to reduced instances of stunting, heart disease, and mental illness; increased school attendance; improved social and gender equality; and enhanced prospects for income generation throughout life.
Mostly, OVC programming does not prioritize very young children. U.S. Government OVC resources largely focus on school-aged OVC. Though some OVC programs include very young children in their activities, they rarely model their practices on ECD research or best practices. Nor do they distinguish among the profoundly different stages marked by infancy, toddlerhood, preschool, and primary school.

In view of above, this technical brief gives an overview of critical ECD elements and existing evidence for program managers who are interested in implementing ECD programs, or incorporating ECD

elements within existing programs to support OVC. The brief describes the three critical elements of ECD, summarizes key findings from program evaluations and literature on ECD, and answers commonly asked questions about developing ECD programs for OVC.

ACTIVITIES

The main activity was to impart knowledge for the program managers in designing and implementing ECD programs for OVC. In this regard the technical brief has listed a several important questions for program managers to answer by themselves before initiating an ECD program. The list of questions has been produced by the World Bank. Since the objective of this technical brief is to prepare program managers in designing and implementing ECD programs I would be appropriate to the questionnaire below.

World Bank Getting Started Check-list:

• Can I explain and discuss what is meant by "early childhood," "child care," and "child development"?
• Can I explain the program implications of the definitions adopted?
• Can I explain to a skeptical colleague why it is worthwhile to invest in ECD?
• Do I know the basic approaches to ECD, and which interventions are complementary?
• Can I make intelligent suggestions about programs and understand where projects or components fit into the larger health and education picture?
• Have I obtained information about the status of children in the country:
  – Survival, health, and nutrition
  – Cognitive, psychosocial, and emotional child development
  – Progress and performance in primary school?
• Have I obtained information about childrearing practices in the country?
• Have I obtained information about the economic, social, cultural, demographic, and political context?
• Have I identified projects in the country that should be coordinated with an ECD project or attached as a sub-project?
• Have I checked with other child and ECD organizations to find out what ECD activities they are supporting in the country and what people and organizations might be available there for consultancies?
• Does a national plan of action for children exist? Have relevant social policy statements been identified?
• Have relevant stakeholders been identified and consulted in order to locate levels of interest, different perceptions of problems, and possible conflicts?
• Has an institutional analysis been carried out? What resources are available or lacking?
• Has a central problem been identified and agreed on?
• Has a project objective been formulated and agreed on that is clearly stated and associated with indicators (of quantity, quality, and time) that can be used to assess its attainment?
• Have the project approach and the project outputs/activities been agreed on that are clearly stated and associated with indicators (of quantity, quality, and time) that can be used to assess attainment? (Source the World Bank (2011)).

SUCCESS RATE OF THE ACTIVITIES

There is no directly measurable success rate in this study. Since the study aims to empower the program managers in designing and implementing ECD programs, it has been observed that the said objective is basically achieved. By that measure the success rate is good.

CHALLENGES

No significant challenge in this nature of studies.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

This paper insists the importance of ECD programing. It observes that such programming is much more cost effective in serving OVC in compared to the programs targeted for the school going age OVC. Hence it would be better if program managers could proactively prepare themselves in designing ECD programs. In this regard this technical brief would be useful for them.

REPLICATING AND IMPLEMENTING THE SCALE

It seems inappropriate to replicate a similar study.

REFERENCES

A lengthy list of references has been provided. As a similar study is not proposed to replicate the list of references is not reproduced here.

UNITED STATES (3)

PROJECT	PEPFAR expert meeting on clinical post-rape care for children in primary health care centers that provide HIV care.
COUNTRY/CITY	United States, Washington DC
NAME OF ORGANIZATION	AIDSTAR-one
FOCUS AREAS	(Medico-legal) post-rape care for minors, HIV
AIMS & OBJECTIVES	• Develop key recommendations for the delivery of post-rape care in primary health centers (that also provide HIV care) for minors. • Review and build upon existing guidelines and documents, including the ECSA-HC guidelines and the adult-focused WHO guidelines for medico-legal care for victims of sexual violence. • Develop technical considerations on delivery of post-rape care in primary health centers for minors, specifically to inform PEPFAR, and for use by other partners and implementers more broadly.
SUCCES RATE	Effective in creating guidelines, no mention of practical implication and how successful they were.
PARTNERSHIP	PEPFAR Gender, Orphans and Vulnerable Children, and Pediatric Treatment Technical Working Groups Together for Girls
FINANCING	U.S. Agency for International Development (USAID)

TARGET POPULATION

(Health care providers of) minors that experienced sexual violence in HIV affected areas.

BACKGROUND INFORMATION

Both the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Health Initiative have made monitoring and responding to gender-based violence a key focus, particularly with regard to strengthening post-rape care services. However, there is limited guidance on provision of post-rape care services for persons less than 18 years of age. The East, Central, and Southern African Health Community (ECSA-HC) released guidelines for the clinical management of child sexual abuse in July 2011. Although the World Health Organization (WHO) Africa Regional Office was involved in the development of the ECSA-HC guidelines, to date, WHO has not produced its own clinical guidelines specifically for children. While there are many examples of local institutions that are addressing post-rape care for children and adolescents—for example, in Kenya, South Africa, Zambia, and Zimbabwe—PEPFAR has not provided systematic information or guidance to its implementing partners on this issue. In response to this gap, the PEPFAR Gender, Orphans and Vulnerable Children, and Pediatric Treatment Technical Working Groups, in coordination with the Together for Girls partnership, convened a one-day expert meeting in Washington, DC, on April 26, 2012, to develop technical considerations on post-rape care for persons under 18 years of age in primary health centers that also provide HIV care.

ACTIVITIES

The technical meeting brought together 28 people including PEPFAR U.S. Government and Together for Girls representatives, as well as experienced providers. During the meeting they discussed how to

establish a comprehensive document on how to treat minors that experienced sexual violence in HIV affected areas.

SUCCESS RATE OF THE ACTIVITIES

An evaluation of the project; did they reach the target group, how effective were they in reaching their aims with the activities? Were there things that were not useful or effective? What aspects did seem to be of great importance to the project? Also include the evaluation of the organizational aspects when possible (how did the cooperation go, was it cost-effective, etc.)

CHALLENGES

- A lack of consistent protocols.
- A lack of training for health providers and frequent turnover of the few staff who are trained.
- Need to strengthen capacity, comfort, and understanding around the specific unique needs of children.
- Weak links between the medical and legal sector, particularly with regard to national reporting requirements and local laws.
- Inconsistent definitions of what it means to provide child-friendly services.
- A disconnect between sexual trauma and HIV/sexually transmitted infection testing and follow-up.
- Poor referral systems and continuum of care.
- Low community awareness of care and treatment options for survivors.
- Drug shortages resulting in provision of substandard care.
- Gaps in psychosocial support.

ANALYSIS/RECOMMENDATION TO OVC PRACTICIONERS

- ***Medical care as part of a comprehensive response system*** the document should clearly articulate how the medical component is implemented and linked to a comprehensive response system.
- ***Clear and consistent use of appropriate terminology*** a robust discussion ensued about the use of certain terms such as “survivor” versus “victim,” and “sexual violence” versus “child sexual abuse” versus “rape.” Participants shared varied opinions that reflected the challenges in addressing such a complex issue as violence against children. It was also noted that the divergent opinions about terminology are mirrored in the larger child protection/gender-based violence community.
- ***Obtaining consent from children*** it was recommended that the document include guidance on how to handle specific circumstances, such as:
    - How to obtain consent if the caregiver is suspected of being the perpetrator of the abuse
    - Determining when it is necessary to obtain consent from a caregiver and when a child’s consent is sufficient.
    - What to do if a child presents at the clinic on his/her own without being accompanied by a caregiver, and what to do if the child is accompanied by another minor.
    - How to obtain consent from children with disabilities.

- ***Tailoring care for children based on age and development level.*** Age differentiation was particularly relevant for sections on obtaining consent from children, identifying physical and behavioral signs and symptoms of sexual violence in children, and communicating with children and taking their history.
- ***Special considerations for extremely vulnerable populations.*** Participants acknowledged the absence of language about the special needs of particularly vulnerable populations, such as mentally and physically disabled children, refugee and displaced children, children who have been trafficked, and migrants. A recommendation was made to mainstream and incorporate specific language on these circumstances throughout the document.
- ***Linkages between sexual violence and other forms of violence.*** Participants noted that if a child has experienced one form of violence (sexual, physical, or emotional), it can often be an indicator that other violence has occurred as well. Participants agreed that medical providers are not trained on this important issue and recommended adding a section on identifying physical abuse into the document.
- ***Follow-up care and linkages between medical providers and community services.*** It was recommended that the document highlight the linkages between medical services (e.g., clinics) and community support structures and the specific roles both medical providers and communities play in follow-up care for children who have experienced sexual violence.

REPLICATING AND IMPLEMENTING THE SCALE

The meeting itself can be replicated, maybe in order to update the document that is (being) made. The end result, which is a comprehensive document of guidelines, can be implemented everywhere.

REFERENCES

Weber, Stephanie. 2012. PEPFAR Expert Meeting on Clinical Post-Rape Care for Children in Primary Health Care Centers that Provide HIV Care. Arlington, VA USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Other: Literature Review on Program Strategies and Models of Continuity of HIV/Maternal, Newborn, and Child Healthcare for HIV+ Mothers and their HIV+/ Exposed children.

PROJECT	Literature Review on Program Strategies and Models of Continuity of HIV/Maternal, Newborn, and Child Healthcare for HIV+ Mothers and their HIV+/ Exposed children.
COUNTRY/CITY	-
NAME OF ORGANIZATION	USAID (AIDSTAR-One)
FOCUS AREAS	Health and Social services required in an integrated model for HIV+/exposed infants and women.
AIMS & OBJECTIVES	• Provide summaries of existing literature on integrated models on HIV+. • Provide an overview on important aspects and limitations of integrated models.
SUCCES RATE	Good
FINANCING	N/A

BACKGROUND INFORMATION

World Health Organization (2008) defines integrations as:

"The organization and management of health services so that the people get the care they need, when they need it, and in ways that are user friendly, achieved the desired results, and provide value for money."

Briggs and Garner (2006) in their systematic report on five studies remark that the evidence on integration is inconclusive. They also hint that better child outcomes might be possible through integration, however no evidence is provided. Both and Roosemalen (2010) are of the opinion that in case of PMCT (Prevention of Mother to Child Transmission) programmes, semi-integrated provisions are much more suitable especially in case of maternal health care services. Adding to this conclusion, Dudley and Garner (2011) also conclude that complex integrations have very few, if any effects on health services.

Overall the factors encouraging effective integration are:

- Qualified and experienced staff.
- Training and transfer of skills.
- Less cost.
- Interest of stakeholders.
- Integrated electronic patents note across services.
- Male partner involvement.
- Client not being discouraged from crowded clinics.

Some of the inhibiting factors towards integration are as follows:

- Limited resources especially financial.

- Negative perceptions and fears of HIV+ pregnant women.
- Lack of support from male partner.
- Costs of contraceptives.
- Staff unwilling to discuss sexual issues with clients.
- High staff turnover.

INTERVENTIONS & THEIR FINDINGS

Systematic reviews and search strategy was used to find relevant studies. Studies that were included were the ones that had proper research design, quantitative data, some form of integration and were related to child and mother outcomes. Of the 112 studies analyzed only 22 qualified for data abstraction. 7 were included in Group 1 and 15 in Group 2.

GROUP-1 STUDIES

STUDY	INTEGRATION DESCRPITION	EFFECTS ON CHILD	EFFECT ON MOTHER
Chabikuli et al. 2009	PMTCT, family planning, HIV clinic. Pre-and post-retrospective review.		Significant improvements in uptake of contraceptives & improved male participation
Futterman et al. 2010	PMTCT plus cognitive behavioral intervention (eight sessions) plus mentor mother (HIV-positive, recently delivered, coping positively, trained). Comparison group gets routine care.	Higher rate of clinic visits for intervention.	Antiretroviral use, testing the baby and exclusive infant feeding are high in both groups. Well-being improved. Better informed on HIV, social support access, healthy living, and self-care.
Killam et al. 2010	Stepped wedge design comparing antiretroviral therapy (ART) referral and antenatal care integrated service for ART provision to HIV-positive mothers.		More initiated ART while pregnant in intervention
Megazzini et al. 2010	Prevention of mother-to-child transmission (PMTCT) plus HIV testing, treatment, and adherence. Cluster randomized controlled trial of 12 labor wards.		Increased Nevirapine coverage in five of six clinics. Adherence increased Nevirapine coverage
Palombi et al. 2007	DREAM package. Comparing DREAM plus water filters and formula with DREAM plus highly active antiretroviral therapy (HAART) plus breastfeeding option.	Reduced gastrointestinal problems with water filters, lower rates of anemia and malnutrition.	80% retention.
Simba et al. 2008	Study of impact of integration of PMTCT with reproductive and child health on workload in cross-sectional study of over 50 facilities	.	

Van't Hoog et al. 2005	Two time periods of evaluation, before integration and after integration. N = 8,231 (4,012 pre- and 4,089 post-introduction service).	Nevirapine uptake was higher in the second period	Significantly increased pre-test counseling, acceptance of test, pick-up of HIV-positive patients.

GROUP-2 STUDIES

STUDY	INTEGRATION DESCRPITION	EFFECTS ON CHILD	EFFECT ON MOTHER
Braun et al. 2011	PMTCT, early infant diagnosis, and pediatric ART services.	Only 29% of HIV-positive children enrolled in services. High mortality.	
Cervantes et al. 2003	Women who use drugs/Hispanic, three-phase multicomponent program.		Drug use, alcohol, risk behavior, and mental health benefits.
Chi et al. 2007	Descriptive study of 680 pregnant women examining simple integration of antenatal and ART services.		High attrition along the cascade of visits. One-third of women failed to follow up, of whom 43% eligible for treatment.
Chinkonde et al. 2010	PMTCT plus voluntary counseling and testing with some pediatric referral for HIV-positive children. Qualitative interviews with providers.		
de Koning et al. 2005	Descriptive account of providers' views of integration of HIV-related care in the maternal and child health setting.		
Evjen-Olsen, Olsen, and Kvåle 2009	Program integration description looking at integrated service provision		
Ginsburg et al. 2007	PMTCT services are integrated into maternal and child health services, but adult and pediatric care and treatment programs often function independently, without coordination or linkages.	Infants return for immunizations but are not identified as HIV-exposed unless mother brings for antenatal care or is specifically asked. Loss to follow-up of HIV-exposed babies is common.	Significant loss to follow-up.
Mazia et al. 2009	Seven sites, quasi-experimental pre- and post-test. Aspects of antenatal care, labor and delivery, family planning, PMTCT, and HIV care and treatment are included as well as postnatal care and women's health.	Significant increase in the proportion of HIV-positive mothers and their exposed infants who had started cotrimoxazole prophylaxis as recommended.	20-fold increase in postnatal visits within three days. Significant increase in observed breastfeeding before discharge (from 28% to 80%). Infant feeding advice 35% to 63%. Increase in HIV testing for postpartum mothers and their partners
Nyandiko et al. 2010	PMTCT, ART treatment, and feeding counseling. Mother/child visits not combined.	Benefits of treatment. High loss to follow-up, <50%	

		infant testing.	
Otieno et al. 2010	Descriptive account of benefits of integrating HIV into maternal and child health clinic		
Potter et al. 2008	Pre- and post-retrospective account of integration of sexually transmitted infection screening in PMTCT provision (syphilis screening). There were 5,801 first visits to 22 antenatal clinics from 1997 to 2004 in Lusaka		
Rollins et al. 2007	Integration of HIV into immunization clinics.	Over 7% of 6-week-old infants attending immunization and 20% born to mothers with HIV are infected with HIV.	
Rutenberg and Baek 2005			
Torpey et al. 2010	38 sites—baseline and follow-up data 2005 to 2008. PMTCT expanded into existing maternal and child health structures.		Increased inflow into the cascade, enhanced uptake of testing, collection of results, and utilization of interventions.
Welty et al. 2005	Pre- and post-study. PMTCT, nevirapine, and counseling.		High level need

CHALLEGES TO INTERVENTIONS

The challenges these interventions face are:

1. Lack of support for combined services.
2. Inadequate integration in some cases.
3. No infant outcome data is available.
4. No resources for training the required staff.
5. Discouragement in the form of already established social stigmas.

RECCOMENDATIONS FOR OVC PRACTITIONERS

- Study the social taboos of the society and work towards removing them through knowledge.
- Work on victims as well as their bread earners so that support could be provided to the victims by their families.
- Try to gather as much data as possible. If data not available observe the surroundings and carry out project at small scale first to see its response and feasibility.
- Try to have available sponsors for projects so that shortage of resources does not occur once the project starts.
- Provide training to your own team before providing it to the affected people.

REFERENCES

Sherr, Lorraine. (2012). Literature Review on Program Strategies and Models of Continuity of HIV/Maternal, Newborn, and Child Health Care for HIV-Positive Mothers and Their HIV-Positive/-Exposed Children. Arlington, VA USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

CONTACT

Noble Missions for Change Initiative

Noble Missions for Change Initiative,
C/O LIFI, Suite 4, Wing A, 2nd Floor,
Deo-Gratias Plaza, Op Utako Market, Utako.
P. O. Box 8901, Wuse 2,
Abuja, Nigeria

How can you help us:

Donations are welcome by:

Bank transfer to the address: Noble Missions for Change Initiative, 0023649861, Guaranty trust bank

Direct deposit to: Noble Missions for Change Initiative, 0023649861, Guaranty Trust Bank

Cheque in our name: Noble Missions for Change Initiative

Information for accounts for foreign currencies:

Account name: Noble Missions for Change Initiative

Account numbers:

Naira (#):0023649861, USD($): 0119745895, GBP(£): 0119745905, EUR(€): 0119745912

Swift Code: GTBINGLA, bank

Address: GTB, Lagos, Nigeria

Noble Missions for Change Initiative

T: +(234) 8181688336
info@noblemissions.org
www.noblemissions.org
Twitter: @noble_missions
www.facebook.com/noblemissions