Future imperfect: protecting children on the brink

a discussion paper prepared by
Mbulawa Mugabe, Mark Stirling and Alan Whiteside for the
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I. Introduction

The scale of the spread of HIV is staggering. Since researchers first identified HIV/AIDS nearly 20 years ago, some 60 million people have been infected and more than 20 million people around the world have died from HIV/AIDS. Today, an estimated 40 million people, including almost 3 million children under 15 are living with HIV/AIDS.

Sub-Saharan Africa has been hit the hardest, where 28.5 million people are infected, and in 2001 alone, 2.2 million people died from AIDS. In Botswana, it is estimated that 38.8 percent of adults aged 15 to 49 are infected. More than 30 percent of adults 15 to 49 years of age are living with HIV/AIDS in Lesotho, Swaziland and Zimbabwe, and over 20 per cent of adults are living with HIV/AIDS in Namibia, South Africa and Zambia. In East Africa, HIV prevalence ranges from 8 to 15 percent. In central and West Africa rates are generally below 10 percent.

With infection rates still rising, the world is facing a catastrophic increase in illness and death that has the potential to undermine economic and social development on a massive scale. In countries hardest hit, AIDS is already undermining economic growth, the ability of health systems to cope with increasing demands for care, and the ability of schools to cope with teacher illness and death.

And it is leaving a sea of orphans in its wake. Today, more than 14 million children under 15 years of age - 11 million of them in sub-Saharan Africa - have lost one or both parents to AIDS. The numbers seem unbelievable. Predictions a decade ago were for an epidemic half this size.

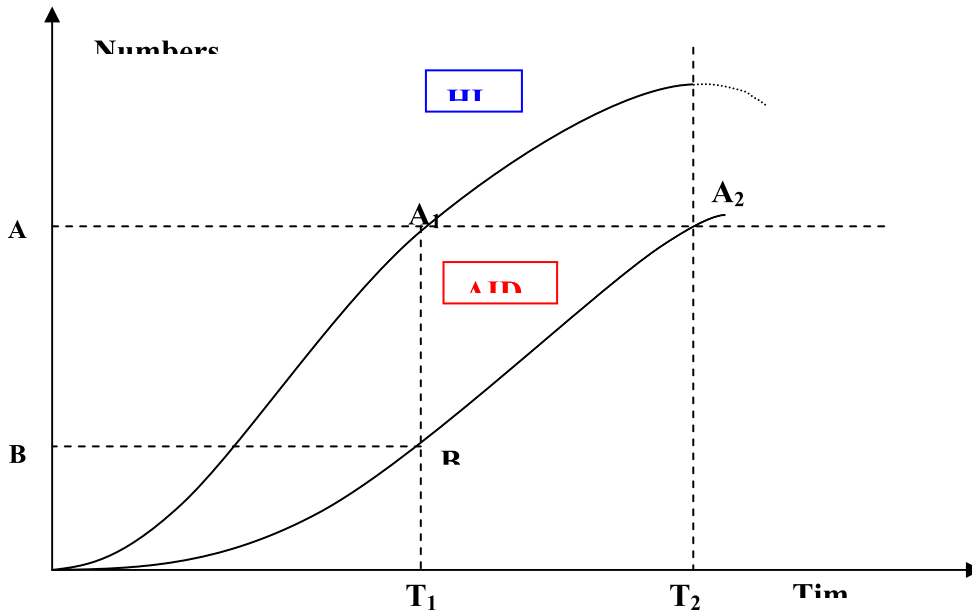
As rising numbers of adults continue to die, the orphan ranks will continue to swell, leaving massive numbers of children and young people to grow up without parental supervision, support or care. Many will grow up without an education, depressed, and alienated from society. The implications are enormous, yet nations have been slow, and perhaps reluctant, to respond. The crisis has begun. The challenge now is to avoid a catastrophe.

II. Understanding the dynamics of HIV/AIDS

There is no single HIV/AIDS epidemic – there are several. There is the silent HIV epidemic, which spreads through a population without people knowing they're being infected. There is the epidemic that is measured by the number of AIDS cases and deaths. Finally, there is the devastating impact of these deaths on society, including the widespread rise in orphans and increasing poverty. Responding to the orphan crisis, requires an understanding of these multiple epidemics and how they evolve; and a recognition that emerging epidemics, sometimes not so apparent, need to be anticipated and prepared for.

The dynamics of these epidemic are shown in the two curves in Figure 1. The HIV curve show the virus spreading through a population. This is tracked using surveys, most commonly of pregnant women attending antenatal clinics. The challenge of prevention is to stop HIV incidence from rising – making sure there are no new infections. Computer modeling can predict the second curve – the number of AIDS cases. Yet while data on HIV infection is available, there is no information on AIDS cases and deaths. In the absence of a cure, however, AIDS cases and deaths will inevitably occur. Additional curves can be added – for example cumulative AIDS deaths and numbers of orphans. Each is to the left of the AIDS case curve.

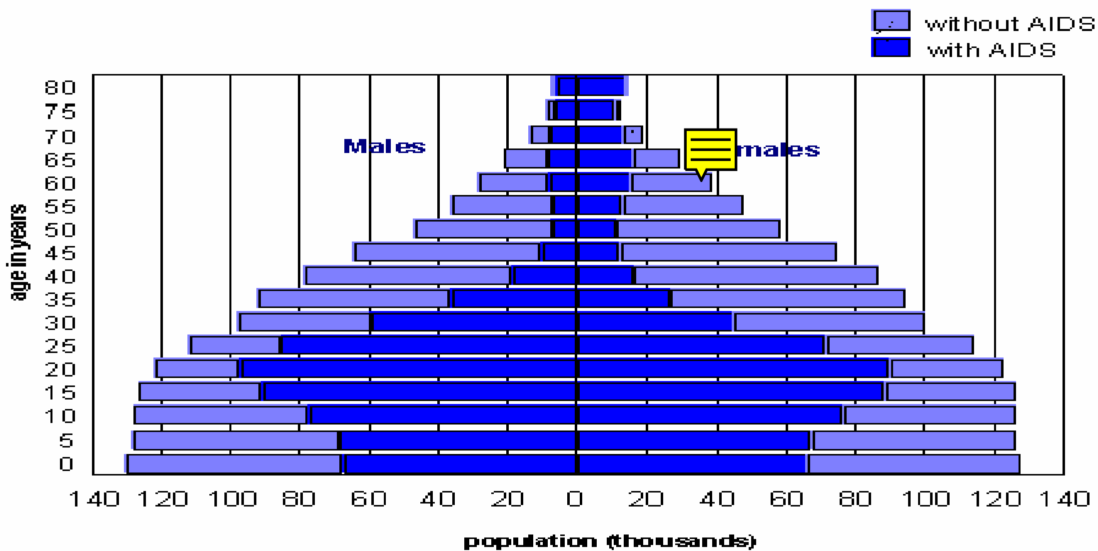
Figure 1. The Dynamics of HIV/AIDS



Devastating demographic consequences

The majority of HIV/AIDS infections occur in young adults - people who have completed their education and started their families. In South Africa, for example, the highest mortality among women is among those aged 25 to 29 and among men, those aged 30 to 34 .[i] The result is that in many countries, life expectancy will drop to below 40 years and population structures will change dramatically. The social and political consequence of changing population structures across the region have yet to be fully appreciated or understood. However, it is clear that the premature death of so many adults will result in labour shortages - affecting household incomes and welfare, the productive sectors, and the provision of essential services - especially education, health, local administration, justice and security. Such will also affect household capacities to care for children and older people. AIDS' effect on population structures is shown in Figure 3.

Fig 3: Projected population structure with and without the AIDS epidemic, Botswana, 2020[ii]



Key messages

- 70% (28.5 million) of the world's population of people living with HIV and AIDS live in sub saharan Africa
- HIV infection rates in SSA are high and continue to rise.
- Time lags between HIV infection, AIDS deaths and orphaning tend to mask (hide) the full impacts of the HIV/AIDS epidemic on children.
- The medium term demographic shocks of AIDS are heavy and inevitable.
- Even if HIV infection rates were to be substantively reduced, immediately, the demographic impact of this will not be felt for another 7-10 years

III. The consequences for children

The impact of the HIV/AIDS pandemic is most profoundly mirrored in the lives of children. In 2001, 12 percent of sub-Saharan African children under 15 years of age were orphans – almost double the proportion in Asia (6%). Although the orphan population varies significantly across the sub-continent, data from the Multiple Indicator Cluster Surveys (MICS)[iii] supported by UNICEF (1999-2001) indicate that around 50% of orphans in sub-Saharan Africa are between 11 to 18 years of age, some 30% are aged between 6-10 years and 18% are under the age of five years. The mean age of orphaning is 6.2 years.

Unlike other illnesses, when a parent dies of HIV/AIDS, the probability that the spouse is HIV positive is quite high. This means a child will likely lose both parents in a relatively short period of time. In 2001, there were 5.5 million double orphans from all causes, with two thirds of them losing at least one parent to AIDS. By 2010, that figure is expected to jump to nearly 8 million.

When parents get sick and eventually die, their children's survival, development and care are severely compromised. Survival chances are poorest for children of HIV positive mothers and those whose mothers died of AIDS when compared to children of mothers who are alive or have died of other causes[iv] . MICS data show that the illness and death of parents affects the nutritional status of young children. In Lesotho, for example, the proportion of underweight orphaned children aged 0-4 years is almost double that of non-orphaned children.

When parents are no longer around to provide protection, their children also become more vulnerable to exploitation, abuse and discrimination. Surveys show that teenage orphans are sexually active and that most of them have unprotected sex. Girls who are orphaned are at an increased risk of being sexually exploited. Compared to children with both parents, orphans who have lost both parents are more likely to stop attending school for a variety of reasons. And girls are more likely than boys to drop out or miss school.

MICS data from across most of sub-Sahara Africa found that the proportion of children aged 5-14 years working more than 40 hours a week was highest among children who have lost either one or both parents when compared to children whose parents were alive. Early loss of parents is also associated with depressive disorders and there is growing evidence (e.g Malawi) of social segregation where orphans mix only with other orphans and not with non-orphans.

The impact of HIV/AIDS begins when illness enters a family. It continues through the death of parents, orphaning of children and potentially affects the next generation. Grandparents are responding as caregivers. 32 percent of caregivers in Uganda are grandparents, 43 percent of those caring for

orphans in Tanzania are grandparents, and in Zambia, that figure is 38 percent. Many of these children are therefore orphaned a second time, and some, more.

HIV/AIDS is placing huge burdens on families who take in orphans. African tradition is strong and relatives often take in many children, but receiving an orphan into a household severely depletes a household's resources. Indirectly, through orphanhood and fostering, HIV/AIDS reduces income, savings, investment, and human capital accumulation, even for those not directly affected by the disease.

The complex way in which the disease affects families and multiple generations can best be illustrated by the hypothetical scenario of the Mamba Family in Swaziland.

The number of orphans will continue to rise for at least the next decade. In general, it takes about 10 years between HIV infection and death from AIDS. So today's prevalence rates will largely determine the pattern of orphaning for the next decade. Because of the ten year lag in infection and death, even in a country where HIV prevalence has declined, the numbers of orphans will continue to remain high.

Key messages

- HIV infection rates are high and rising throughout most of SSA fuelling future adult AIDS deaths and a rapidly growing orphan population. Over 70% (28.5 million) of the world's population of PLWHA live in Africa.
- 34 million African children are orphans (12% of all African children) of which 11 million are due to AIDS. By 2010 this population will be over 42 million of which half will have been orphaned by AIDS.
- 70% of Africa's orphans are living in 12 countries most severely affected by HIV/AIDS. By 2010 orphans will account for 15-25% of all children in 12 African countries.
- Orphaned children are more likely to die and be malnourished, to suffer psycho-social problems, to drop out of school, to be abused and exploited, and are more vulnerable to HIV infection than other children.
- In the most affected countries, families and communities are not coping – desperation, vulnerability and disparity are increasing.

The Mamba Family: a scenario

Bheki Mamba was born in 1992. His father, a migrant miner, spent 11 months of the year away from home working in South Africa. When Bheki was 7, his father fell ill with TB and died.

By the time Bheki was 8, his two older sisters, Thandi and Nosipo, then aged 15 and 13 respectively, had been taken out of school and Bheki was only able to attend intermittently. His mother was frequently ill and the family depended on the meagre earnings of their grandmother who made handicrafts. In 2002, when Bheki was 10, his mother died. With only four years of education, Bheki was functionally illiterate. His sisters were sent to live with their maternal uncle who was employed as a security guard and lived on a homestead outside Manzini. The uncle, a traditional Swazi, had two wives and nine children, which meant that his small income had to stretch even further. Not only were the sisters not able to attend school, but their arrival in the kraal meant that the uncle's two youngest children had to be withdrawn from school.

Bheki remained with his grandmother but her ill health – diabetes and increasing senility– meant that caring for her was a full time job. When she died in 2005, Bheki was 'orphaned' for a second time, and went to live with his sisters.

By 2005, both girls had moved to peri-urban slums. Thandi (20 years old) worked at a textile factory and had one child who was thriving. Nosipo (18 years old) was unable to find employment and so depended on her boyfriend and the little cash she made through home brewing. She had two children; the youngest sick with thrush and constant diarrhoea. When she took the child to the hospital, the nurses said there was little they could do and sent her away without an explanation. The child died in 2008 and Nosipo and her boyfriend both died the following year. Thandi took in her sister's eldest child.

By 2010, Bheki was 18 years old, and, like his sister, he was HIV+, although he didn't know it. He made a living working as a conductor on buses and supplemented it with petty crime. He had many girlfriends and was contributing to the spread of HIV.

This story illustrates the widespread and long-term impact of HIV/AIDS. In this family, at least five premature deaths can be attributed to the infection (the youngest child, father, mother, daughter, daughter's child and possibly Nosipo's boyfriend). Three children grow up without an education, which means that their children are less likely to be sent to school. A young boy grows up without love and support, and as a result is alienated from society. And the impact of the disease is still being felt in 2010 as Bheki and his sisters' children continue to bear the burden. They will grow up in poverty and without both parents or if they are infected, they will fall ill and die. The future is also not bright for the uncle's children who grew up in a poor household that got even poorer and who had to leave school as a result

IV. The response considered

The inadequate response to date

The situation of orphans and other vulnerable children has reached crisis proportions, in large part, because of the failure of governments to recognise and respond to it. As a result, the response to the orphan crisis to date has been largely led by families, communities and NGOs. Despite their commitment to act on behalf of OVC, their efforts have often been overwhelmed by the scale and magnitude of the crisis. The result is that famyl and community coping capacities are over-stretched, inadequately supported, and beginning to fail. As a consequence of this lack of support, there is

increasing household poverty, increasing child mortality and malnutrition, declining school attendance, increasing proportions of child headed households, increasing number of children on streets, and increasing disparity between families who are affected by HIV/AIDS and those who are not.

In part, the failure to extend and expand community based support for HIV affected families, reflects the fact that national leaderships have not decried the crisis for what it is, and that only a few are speaking out on the needs of orphans and other vulnerable children. As a consequence the public sector response has been inadequate. In most countries, the crisis is regarded as the responsibility of Welfare Departments and their NGO partners. As a result, few countries have national goals and strategies for these children, fewer have integrated a response to the orphan crisis within national development strategies, and few have made explicit budget commitments. The orphan crisis has remained on the periphery – despite the fact that it will result in unprecedented restructuring of African societies.

The silence on orphans and other vulnerable children at country is also mirrored in regional and continental thinking. While the Africa Union and regional organisations (SADC, ECOWAS, ECAC) have made a number of commitments to act on HIV/AIDS – mobilizing leaderships, expanding prevention, treatment and care programmes, setting up AIDS councils, coordinating mechanisms and AIDS budgets, etc – these institutions are curiously silent on the plight and needs of Africa's orphans and the consequences for Africa's future development.

Perhaps what is most surprising is the failure to understand the consequences of AIDS for development in general. Attacking poverty is the goal that resonates best with governments and donors. It is clear that HIV/AIDS both fuels and is fuelled by poverty, and that no poverty reduction strategy in SSA can hope for success without addressing the determinants and impacts of the HIV/AIDS epidemic. Yet, despite this recognition, most national poverty reduction strategies of Africa are silent on HIV/AIDS, and particularly on its impacts on children – the future human capital of these nations. Existing development indicators do not reflect the impact of AIDS nor can they measure its complex adverse consequences. In most affected countries the Millennium Development Goals will be unachievable as a result of the epidemic.

Short-term, medium, and long-term responses needed

Why are the current responses to the impacts of HIV/AIDS piecemeal, uncoordinated and inadequate? In part, its hard for people to get their mind around the epidemic and its impacts. In many environments HIV is invisible and its future impact is inconceivable to policy makers and planners.

People working in the field of HIV/AIDS advocacy may be compared to the weather forecasters in Mozambique in 1999. Heavy rains had fallen in Malawi, Zambia, Zimbabwe, Botswana and South Africa, the catchments of the Zambezi, Limpopo and other rivers that flow through Mozambique's flood plains into the Indian Ocean. The floods were coming; they were inevitable and unstoppable. The only uncertainty was how bad they would be. There was only a short window of opportunity to warn those people at risk and evacuate them. But how do you persuade people to move when they have never experienced the type of disaster you are forecasting, and when it is not even raining where they are?

The problem is that HIV/AIDS is an emergency, but it is a long-term emergency that will require changes in thinking and acting if there is to be an effective response. As in an emergency response – such as the Mozambican floods – urgent and bold actions on clear priorities will signal the difference between effective and failed action. In emergencies there is need to:

- define the scale of the problem - which rivers are flooding, where and how bad will it be.
- warn people to leave for high ground (prevention).
- rescue people from the rising waters using a mixture of high-tech (helicopters mobilised from outside the country) and local resources (boats, rafts and canoes).

- prepare for short term impacts – food, water, shelter, clothing and blankets; and for the medium term – health care and education.

- prepare for longer term rehabilitation and development – helping people move back to their homes with the where-with-all to resume normal family and productive life (seeds, tools, household items, food support).

- set in place mechanisms to prevent the disaster happening again.

With most emergencies, there is an expected and defined endpoint and a return to normality – water recedes, wars end. But with AIDS and OVC the endpoint is unknown, so political motivation is not spurred by reaching an endpoint, which itself is a rallying cry and a means for politicians to appeal to a constituency – it is beyond their perceived 'sphere of influence'. At the same time, HIV/AIDS is fuelled by fundamental societal inequalities between men and women, rich and poor. The consequences require both resources and a rethinking of effective actions. It requires asking people to put their societies on a war footing when they cannot see the enemy, may not believe that it exists and may not actually care about the victims. It requires strong, broad based, sustained and caring leadership – from government, NGOs and civil society, from among and within communities.

Questioning paradigms and debunking myths

The myth of coping[v]

One of the arguments for inaction is that people are coping. The extended family takes in the orphans and other vulnerable children. Since hordes of children are not seen on the streets (though increasingly they are), communities must be caring for them. But the idea and language of "coping" has to be questioned in relation to HIV/AIDS and its impacts. There is a distinction between psychological coping and economic coping (managing resources to deal with a prolonged life event like orphanhood), and many families are not doing either.[vi]. Coping is often a myth because:

- Many households affected by HIV/AIDS do not cope. On the contrary, they break up and their members, orphans, widows and the elderly, join other households.

- It is not households that cope – rather it is individuals within them who manage to survive.

- There may be precious little in the way of developing "strategies" to manage crises. Rather the decisions merely reflect efforts to survive in the very short term.

- Short-term solutions to crises – sale of household assets, withdrawal of young girls from school to help with domestic and farm work - have medium and longer term negative effects and costs. These may include lower or no educational achievement, poor diet with associated stunting or wasting, lack of care, poor socialisation and the need to resort to crime or hazardous occupation to survive, etc.

- The impact of a large-scale events such as an HIV/AIDS epidemic has effects on wider social, economic and even environmental systems. For example, in a community or region that is hard hit, there are changes and costs at the levels of the farming system, social infrastructure and the maintenance of physical infrastructure. These all point to general impoverishment in many dimensions.

- The effects of "coping" are shouldered unequally between poorer and better-off households, men and women, generations, and different social groups and geographical regions.
- Finally people who are forced to sell their own clothes or the clothes of the dead to survive cannot be said to be coping.[vii]

Psychological coping is also a myth for children. Their trauma and stress are often not acknowledged and unaddressed, and they have to carry this burden, which they are often unequipped to handle, into

adulthood. Often these burdens, unresolved anxieties and tensions, play out in the form of anti-social behaviour, rebelliousness and a predisposition to crime.

In relation to HIV/AIDS, the story of coping mechanisms is really a part of the wider story of structural adjustment policies – before they began to be offered "with a human face". The idea of "coping" originates from the unwillingness of the rich or those in power to do anything more than apply a bandage to the wounds of national or global inequality when what has been required for a very long time is extensive and expensive surgery.

Timeframes and evolving needs

The impact of AIDS on children are complex and evolve through childhood and adolescence. Children are a lifetime commitment – their parent's lifetime – and the response to the needs of children in need is a long haul commitment. A child orphaned at 6 years of age (the average age of orphaning in Africa) needs care and support until at least 18 years and probably longer. This implies (obligates) a long term commitment, one which most governments are unable to afford, and most donors are not prepared to look beyond a 3-5 year commitment.

Sustainability

People understand sustainability to mean that when the core funding, be it government or donor, runs out, the local community or administration will be able to continue the project using their own resources. This may be a laudable target for many projects. It makes sense that communities should be asked to cover the recurrent cost of providing clean water and should manage this themselves. Micro-credit projects take pride in being self-sustaining. However, AIDS changes things and this is especially true for projects designed to assist people impacted by the disease. Furthermore, "sustainability", like "coping," is often another way of asking people to do more with less. Sustainability is not a blanket criterion that can be used to judge the viability of projects in AIDS affected areas. The epidemic means resources are being lost in communities and nations at the same time as demand rises. International solidarity – between rich and poor nations of the world – is therefore an essential condition for a response to the OVC crisis.

Key messages

- The response to date has been small in scale, fragmented, and has failed to address the magnitude of nature short and longer term consequences.
- Responses have been largely led and driven by families, communities and NGOs. In most countries government engagement has been limited – the OVC crisis has received little priority and attention.
- The factors underlying the inadequacy of the current response are many – AIDS denial, the "hidden" nature of the OVC problem, tendency to avoid an overwhelming and complex problem, etc. These factors must be addressed.
- Conventional development paradigms – such as reliance on coping mechanisms and the prerogatives of sustainability – need to be reconsidered in light of the impacts and consequences of HIV/AIDS. AIDS is not sustainable.

"We can't do everything for everyone"

The size and complexity of the crisis can be overwhelming and is often used as an excuse for inaction. The way to overcome this is to have a clear understanding of which children need to be reached, where they are located, and in what types of families and communities, they are living.

V. Promises made to children

At the UN Special Session on AIDS (June 2001) all African Governments affirmed a goal for OVC within their ***Declaration of Commitment*** (DoC). This goal was again reaffirmed at the UN Special Session for Children in May 2002 in their Declaration for a ***World Fit for Children*** (WFFC).

The DoC/WFFC goal is a good goal as it emphasizes the obligations of state actors to provide leadership and mobilise partnerships (with communities, NGOs, civil society, international community, etc) to ensure protection, care and services for children. It emphasizes the critical importance of reinforcing and building family and community capacities; in acting in the best interests of the child and ensuring non-discrimination; and in ensuring that actions must result in improved outcomes for children. The goal also spells out the priorities for action as: i.e. to ensure

- counseling and psychosocial support for children living in HIV/AIDS affected families.
- access to basic services on an equal basis with other children: especially basic education, shelter and clothing, food, health services
- protection from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

The WFFC and UNGAS DoC also specifies the immediate obligations of government. That is, governments agreed to:

- establish national orphans and other vulnerable children (OVC) policies and strategies by 2003
- ensure that these are under full implementation by 2005.
- report on implementation progress and adequacy of the OVC response annually.

The framework for action therefore exists

The OVC Goal

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2002, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

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

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

Source: UNGASS Declaration of Commitment, June 2001 & SSOC World Fit For Children, May 2002

Priorities for capacity building have been agreed upon and endorsed by governments, NGOs and development partners (see Children on the Brink – strategies to assist children). Such are focussed on strengthening and supporting capacity of families to protect and care for their children; mobilizing and supporting community based responses; strengthening the capacity of children and young people to meet their own needs; ensuring that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children; and raising the awareness within societies to create an environment that enables support for children affected by HIV/AIDS.

V. What must be done

Acting at scale on the OVC crisis is a challenge both conceptually and programmatically. It is a challenge because children's needs differ and evolve through their life cycle, and children's family and community contexts, values and capacities vary. Parenting recognises and responds to these circumstances, even if imperfectly. When a parent dies, however, " all things tend to fall apart" in the lives of children. Effective responses and support, therefore, must vary according to the needs and circumstances of children, and the communities within which they live. Scaling up, therefore, is not merely a matter of ensuring access to a prescribed shortlist of services, or the fulfillment of a set list of "minimum standards". Rather - as children are loved, nurtured and protected within families and communities, and as families and communities constitute the front line in the response to the OVC crisis - the challenge is to strengthen community-based capacities to care for OVC, and to do this at immediate and sustainable scale. In short, the challenge is to enable the scaling up of micro, family and community centred, responses. To lay the foundation for this four conditions need to be fulfilled.

- First, community based leaders, facilitators and mobilisers must be sensitised and their capacities strengthened to adequately respond to the needs of orphans and children living in vulnerable families.

- Second, the planning and provision of essential services (health, education, counseling, welfare, justice, etc) must be strengthened and adjusted to respond to the circumstances of OVC and ensure non-discrimination.

- Third, national leaders must make public their priority of acting for OVC, reflect this priority in national plans and budgets, and develop alliances with civil, society leaderships to act in common for children orphaned and made vulnerable by HIV/AIDS.

- And fourth, international partners must make the OVC crisis both an emergency and development priority and reflect this priority in their ODA decisionmaking.

There a number of interesting and innovative support programmes aimed at meeting these needs. Examples include keeping children in school through fee remission; providing school feeding and food to take home; surrogate mothers in the community; protection against abuse and neglect; support for disclosure and succession planning; expanding home based care to respond to the health needs of children living in families affected by HIV/AIDS; identification of foster parents and guardian; and protection of inheritance rights to name but a few. Each of these interventions addresses some of the needs, yet none address all. The challenge will be to bring all the interventions together in ways that will be cross-cutting, multisectoral and long term.

An emergency and development response

The OVC response – because it is a large, immediate and long-term crisis – requires both a developmental and an emergency response. This implies action on two fronts. Firstly, there is need to mainstream the needs of OVC within national development plans so that actions are defined which address the needs of OVC and ensure equity with other children. The objective is not to create exclusive programmes for OVC but rather to make sure that existing programmes are sensitive to the special needs and circumstances of OVC, and to ensure they are not excluded. Secondly, there is need for an emergency like response to ensure child access to essential services and community

based care and protection. Key actions for emergency attention would include ensuring: a) care & support for sick parents; b) that all orphaned children are safe and under adult protection and care; c) that basic needs - shelter, clothes, food – are fulfilled; d) continued attendance of basic education; d) protection from violence, exploitation and abuse; and e) actions to minimise the risk of HIV infection.

The bottom line – a choice of two paths

The bottom line is that a choice must be made. The first is to continue with the failure to address the OVC crisis, and to reap the immediate and longer term consequences of this. This path is not acceptable. The second, to re-invigorate and energize the OVC response to ensure the achievement of the UNGASS goals. To choose the 2nd path means making choices and doing business differently. There is need to overcome the current inertia and complacency, to escape the sense of being overwhelmed by the size, velocity and complexity of the OVC crisis. Vigorous, focussed, and sustained leadership, broader and united partnerships, greater community action at the grassroots, and significantly more resources are required to trigger a scaled and sustained response.

Key messages

- The DoC/WFFC OVC goal provides good guidance, a framework and accountability for a response to the OVC crisis.
- Curiously, however, African governments, regional and continental organisations have been silent on their concern and commitment to act with and for OVC.
- Strengthening and supporting capacities of families, communities, children themselves, service providers and national institutions is key to building effective short and longer term responses.
- Leaderships – in all sectors and at all levels – play a pivotal role in scaling up actions for OVC. Social mobilisation is key is key to scaling-up.
- Immediate action is proposed to: promote public awareness, sensitivity and solidarity; mobilise leaderships to act on the OVC priority; increase access to information about child care and protection; mobilise resources; strengthen monitoring and accountability; and deepen knowledge of the OVC situation, response and consequences

Some proposed actions

To crank up the OVC response – ensuring a quantum shift in sense of priority and action that touches the lives of children – the following actions are proposed for the coming 12 months.

Promote public awareness, sensitivity and solidarity

a. Promote public discussion of the impact of HIV/AIDS on children and the OVC crisis, of the special attention required by orphans and children made vulnerable by HIV/AIDS, and of actions that must be undertaken by families, communities, government and partners to protect and care for such children. Engage media (and children's champions – OVC Goodwill Ambassadors?) in local launches and discussion of Children on the Brink report and the UNGASS goals and investigative journalism/discussion on "Do we know what's happening with our orphaned children? Are we doing enough?"

Mobilise leaderships on OVC as a priority

b. Meet with national leaders (including heads of state in 12 most severely affected countries) to urge strong personal leadership for expanded OVC response and that OVC are given priority and mainstreamed within the national development agenda.

c. Advocate with heads of state and most senior government leaders to urge intensified action by governments to fulfil UNGASS/WFFC commitments on OVC. Specifically to urge all governments to (by end 2003):

    - Conduct situation analyses of the magnitude, scope and impacts of HIV/AIDS on children and young people, the adequacy of current responses and opportunities for expanded action.

    - Develop national strategies, action plans and budgets to respond to the OVC crisis. Such should include both immediate emergency and longer term developmental responses and be integrated within the national development plan (especially PRSPs, SWAPS, etc) with specific OVC related budget items clearly identifiable.

    - Review and revise laws, and orient systems that administer justice, to ensure non-discrimination (gender, HIV/AIDS, orphan status), protection from exploitation and abuse, and protection of children's and women's property and inheritance rights.

    - Establish national and sub-national coordination mechanisms to enable government and NGO's to share experience and coordinate efforts.

d. Assist parliaments to conduct special parliamentary sessions (during budget discussion) to discuss the OVC crisis: i.e. take stock of the situation of OVC, the adequacy of the response, and to define key actions/decisions to be taken by parliament to support the achievement of DoC/WFFC commitments.

e. Sensitise and mobilise local level leaderships (parliamentarians, mayors, local government officials, traditional and religious leaders, etc). Arrange leadership orientation/training for local leaderships with focus on:- sensitization to the OVC crisis, how to monitor welfare of children and organise community support for vulnerable children and families. Such orientation should seek to define what every local leader should know and do about children affected by HIV/AIDS.

f. Support formation and functioning of multi-religious working groups to mobilise, help coordinate and support the OVC work of religious organisations.

g. Advocate to ensure the inclusion of specific OVC commitments within NEPAD.

Increase access to information about child care and protection

h. Develop and implement communication strategies to provide child caretakers with essential information about child care and protection, and who to turn to when in need of help (use Facts for Life).

Mobilise resources

i. Commission rapid study to estimate the costs of an adequate OVC response within Africa. Agree methodology and calculate estimates of costs and resource requirements for an short and longer term OVC responses.

j. Support conduct of country, multi-country or regional round tables to mobilise additional resources for OVC response.

k. Assist governments (focus initially on most affected 12) to make OVC budget provisions within upcoming budgets.

Strengthen monitoring and accountability of OVC response

l. Urge and assist governments to report on the OVC response on an annual basis. Such reports should feed into i) annual reviews by parliament of OVC response; ii) national reports to the UNSG Report to EcoSoc on Follow up to the UNGASS Declaration of Commitment; iii) national reports to the Committee on the Convention on the Rights of the Child; iv) reports to the Africa Union (NEPAD implementation report), SADC and/or ECOWAS.

m. Assist the Africa Union to prepare an annual report on progress of African governments in acting on OVC goals as part of the annual review agreed as a follow up to the ADF and Abuja Conference. This report should be presented to and discussed at the annual AU Heads of State and Government meeting. (Need also to support NGO/civil society comment on such reports).

n. Convene biannual (two yearly) conferences – Africa wide and at regional level - to monitor progress and share experience. Conferences should be convened by AU, SADC & ECOWAS and bring governments, NGOs and international development partners together to report and assess progress, and share implementation experience.

o. Request the Committee on the Rights of the Child to require countries to report on the OVC situation and response as part of their country reports.

Deepen knowledge of the OVC situation, response and consequences

p. Support research to better define and understand the future (5 to 10 years from now) impacts and consequences (for children, societies, nations) of the demographic shocks being brought by AIDS for strategy development and development planning.

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[iv] Zaba, B. (2001) UNICEF Project: HIV and Child Mortality (Final Report on Phase 1)

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[vii] Mutangadura, G.B. (2000) 'Household Welfare Impacts of Adult Females in Zimbabwe: Implications for Policy and Program Development'. Paper
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