FOOD SECURITY AND NUTRITION:

MEETING THE NEEDS OF ORPHANS AND OTHER CHILDREN AFFECTED BY HIV AND AIDS IN AFRICA

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For WFP and UNICEF

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EXECUTIVE SUMMARY

Research for this paper included a review of 101 documents and interviews with 36 UN and NGO staff (both field and headquarters-based) and researchers. The aim was to document 'what we already know'; 'what more we could do'; and what 'promising practices' exist to serve 'orphans and other children affected by HIV and AIDS (denoted here as OVC -- see definition on page 8), with respect to food security and nutrition.

While the review identified an array of innovative ideas and good intentions, these were rarely supported with objective analysis of what has worked. Importantly, where reviews or evaluations were done, their conclusions often tended to be premature, rarely capturing the success (or failure) of beneficiary graduation and programme exit strategies – which would begin to provide insight to the longer-term outcomes and impacts of these interventions. Essentially, there remains a dearth of honest analysis and exposure of the lessons learned. Key findings from the literature review and interviews appear below:

Situation: Evidence of a generalized relationship between orphanhood and nutritional status remains tenuous, with some indication of greater food insecurity among households with multiple orphans. Overall, this study concludes that differing findings on food security and nutritional status across various settings and cultures are perfectly reasonable to expect since societies have varying abilities to protect and care for OVC. Further, we should accept global ambiguity and focus on improving our ability to characterize the situation *locally* in order to contribute to better programming. Initial steps towards this goal are to define terminology and understand where definitions of OVC must be common, and where they will justifiably vary.

Targeting: There was consensus throughout this review that vulnerability to food insecurity or malnutrition is a more useful basis for targeting than affiliation with HIV. Priority actions include: 1) enhance support to Prevention of Mother to Child Transmission (PMTCT)/PMTCT Plus to target not only mothers and babies, but by extension, fathers and other children at home; 2) seek out pediatric hospices/day-care facilities, transition and foster-care programmes; and 3) exploit and expand growth monitoring and promotion (GMP) and nutritional rehabilitation unit (NRU) services for early identification of HIV positive infants and children.

Programming: This section contains a resounding call for food assistance programming as an integral component of multi-sectoral responses that support children and their families. Priority actions include: 1) introduce or revitalize nutrition education as core strategy; 2) adapt growth monitoring and care programmes to respond to HIV; and 3) stimulate local market production of ready-to-use food (RUF) and ready-to-use therapeutic food (RUTF) products with subsidized pricing in order to improve access to these products.

Monitoring and Evaluation (M&E): Recognizing that food is one of many inputs to a comprehensive HIV care and protection package, M&E tools that measure child vulnerability in a holistic manner should be promoted. M&E for OVC should also seek to engage children, especially given discrimination and biases in intra-household distribution. Qualitative tools and anecdotal evidence should be further exploited given the significant limitations of quantitative approaches in measuring nutritional status and food security of OVC. Finally, investments in care and protection (including food and nutrition support) are long term in nature and the impact may not be visible until many years later. Opportunities for prolonged follow-up are urgently needed to see how events/interventions play out in terms helping young people to become healthy and productive adults (and parents).

In search of promising practices, the authors propose an in-depth review of various 'models' that seek to support nutritional status, food security and livelihoods of OVC. Research priorities generated from this work are also presented.

GLOSSARY OF ACRONYMS

ANC	Antenatal care
ART	antiretroviral treatment
CBO	community-based organization
CHH	child-headed household
CHS	Community and Household Surveillance
CRS	Catholic Relief Services
CSB	corn-soya blend
CSI	coping strategy index
CSM	corn-soya milk
CTC	community-based therapeutic care
CVI	child vulnerability index
DHS	Demographic and health survey
ECCD	early childhood care and development
EUM	end-use monitoring
FAO	Food and Agriculture Organization of the United Nations
FBO	faith-based organization
FCS	food consumption score
FFA	food for assets
FFT	food for training
FFW	food for work
FHI	Family Health International
GMP	growth monitoring and promotion
HBC	home-based care
ICRW	International Centre for Research on Women
IFPRI	International Food Policy Research Institute
IYCF	infant and young child feeding
JFFLS	Junior Farmer Field and Life Schools
M&E	monitoring and evaluation
MCH	mother and child health
MOAC	Ministry of Agriculture and Co-operatives
MTCT	Mother to child transmission
NERCHA	National Emergency Response Council on HIV and AIDS
NRU	nutritional rehabilitation unit
NGO	non-governmental organization
OGAC	Office of the US Global AIDS Coordinator
OVC	orphans and other children affected by HIV and AIDS
PDM	post-distribution monitoring
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	persons living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PRRO	Protracted Relief and Recovery Operation
RAAAP	Rapid Assessment, Analysis and Action Planning
RUF	ready-to-use food
RUTF	ready-to-use therapeutic food
THR	take-home rations
UN	United Nations
UPE	universal primary education
VCT	Voluntary counselling and testing
WHO	World Health Organization

1. INTRODUCTION

This research was undertaken in an effort to understand the complex issues of food security and nutrition faced by Africa's orphans and other children affected by HIV and AIDS, their families and communities, and to present a synopsis of where we stand today on programmatic issues including targeting, effective programming and monitoring and evaluation (M&E).

In short, the aim was to address:

- ✓ What empirical evidence exists that describes the food security and nutrition situation of orphaned and vulnerable children in Africa?
- ✓ What are the strategies, promising practices and models that are known to work?
- ✓ What guidance exists for frontline implementers and how well/easily is that guidance being utilized?
- ✓ What are the challenges facing implementers and how are they overcoming them?
- ✓ What more needs to be done?

Research for this report was carried out between July and October 2006. In the first phase of the study, a broad review of the literature was conducted, enhanced by personal and telephone interviews with individuals from a range of provider levels in UN agencies and non-governmental organizations (NGOs). After an initial synthesis of findings, an interim report was produced which created an opportunity to hone in on key aspects for follow-up. The second phase focused on investigation of selected issues through additional desk review, interviews, and follow-up email correspondence with key interview subjects and consultants. More than 100 documents, both published and grey literature (primarily documents produced by NGOs), were reviewed.

A total of 36 UN staff, NGO staff, consultants and researchers provided input, either in the form of interviews or reviewing aspects of the findings. A summary of recommendations is presented in Chapter 6.

Definitions

This paper deals with **'orphans and other children affected by HIV and AIDS'**. Definitions of this particular group vary, although efforts have been made to move towards a common definition. For the sake of brevity, the term **OVC** (Orphans and Other Vulnerable Children) is used in this paper to represent this category, with the following definitions in mind:

Orphan:
The *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS* uses the following definition for an orphan: An orphan is a child under 18 years of age whose mother, father or both parents have died from any cause. Orphans can be more specifically described as follows:

- Single orphan – a child who has lost one parent
- Double orphan – a child who has lost both parents
- Maternal orphan – a child whose mother has died (includes double orphans)
- Paternal orphan – a child whose father has died (includes double orphans)

HIV and AIDS Affectedness/Vulnerability:
Children 'affected by' HIV and AIDS, or 'made vulnerable' because of HIV and AIDS, may be defined as such for a variety of reasons. Children and youth may spend a large part of their day without adult guidance or supervision, perhaps even living outside of parental care, even when their parents are still alive. They may take on adult responsibilities when parents become ill, which may include providing physical care for ill parents, caring for younger siblings and generating income to meet the household's basic needs. Children may also be vulnerable due to their own illness or disability. Also, non-orphaned children living in the same household as orphaned children may be vulnerable to the same conditions. In many African languages the word that would be translated as 'orphan' in English includes all such vulnerable children. Various terms have been used in English to describe these children, such as 'virtual', 'social' or 'de facto' orphans. However, they are most commonly referred to as 'vulnerable children'.[1]

The February 2005 *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS* (UNICEF, UNAIDS, et al.) uses the following definition for 'a child made vulnerable by HIV/AIDS'.

A child who is below the age of 18 and:
- has lost one or both parents, or
- has a chronically ill parent (regardless of whether the parent lives in same household as the child), or
- lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or
- lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or
- lives outside of family care (i.e. lives in an institution or on the streets)

Note: Other definitions uncovered in this literature review were broader and included:
- ✓ Children who are HIV-positive
- ✓ Children whose parents are alive but who live with relatives or non-relatives under strained capacity
- ✓ Children living with their parents in fostering households, which may have recently taken in an orphaned child.

2. THE 'SITUATION' OF ORPHANS AND OTHER CHILDREN AFFECTED BY HIV AND AIDS

What We Know about the Situation

One of the objectives of this research was to explore the 'situation' of orphans and other children affected by HIV and AIDS with respect to their food security, nutritional status and discrimination.[2] This research used as a starting point a 2005 review by the International Food Policy Research Institute (IFPRI), which was commissioned by WFP and entitled *Child Vulnerability and HIV/AIDS in sub-Saharan Africa: What We Know and What Can Be Done*. That report reviewed a number of survey findings, including those drawn from a 2004 meta-analysis by Rivers, *et al.* of national nutrition and health surveys conducted in sub-Saharan Africa over the last five years.[3] This chapter reflects on the IFPRI overview, explores whether evidence gathered from grey literature, interviews and other more recent studies concurs with or disputes those findings, and begins to define the implications for practitioners of food-assisted programs for OVC.

Time constraints and a mandate to explore a variety of programmatic issues (in addition to the 'situation' of OVC), limited the consultants to examining 12 other surveys[4] (see Annex C). The findings from some of these studies are also summarized in Annex A. It is important to note that comparing the survey methodologies, data handling and analysis across these surveys would help to judge the comparability of results as well as the quality and reliability of the data. This was not done, as it was not within the scope of this review. Furthermore, it should be noted that information on food security status was more abundant than that of nutritional status. Some of the reasons for this are noted later in this section, and in the M&E section of this report.

1. Food security

As noted, data on food security were more plentiful than those on nutritional status, but predictably, the types of indicators used to measure food security status vary considerably across studies. Certain trends, however, do emerge:

Food Security and Orphan Households: The Community and Household Surveillance (CHS) system of six countries in southern Africa (C-SAFE/ WFP) found that orphan households were not more food-insecure than non-orphan households, but like many studies, this analysis did not distinguish between households with one orphan and households with multiple orphans. Both the Blantyre survey (covered in the meta-analysis) and the Catholic Relief Services (CRS) STRIVE data demonstrate that, with respect to the populations they represent, food insecurity is significantly greater for households with multiple orphans and progressively increases as the number of orphans in the household increases.

Food security in households with sick adults: A recent study of children in Soweto, South Africa[5] noted increased vulnerability to food insecurity for children residing in 'sick households' (households where at least one sick adult resides), as well as other indications of inadequate care and protection (deteriorating immunization record, reduced adult supervision and reports of abuse). The CRS project baseline from Malawi echoed similar sentiments, noting that the number of months a household could meet its food demand with the current harvest was correlated significantly with the presence of people living with HIV and AIDS (PLHA) in the household.[6] Further aggravating the situation of 'affected' children, a study conducted in Zimbabwe revealed that when a child experiences the illness of a significant adult *and* deteriorating food security, she (this occurs more frequently among girls than boys) is more likely than non-affected children to drop out of school.[7]

Finally, the CHS regional analysis used the Coping Strategy Index (CSI)[8] as one indicator of food insecurity, and found that the overall mean CSI for households with chronically ill members was

significantly higher (more severe coping strategies) than for households without chronically ill members. Interestingly, it should be noted that although coping strategies were more severe with the presence of chronic illness, the same report did not identify any significant difference in Food Consumption Score (FCS), suggesting that dietary diversity was the same for both households with and without chronically ill members.

Food security and OVC from a child's perspective: World Vision Hope Initiative broadens the analysis to orphans and children affected by HIV and AIDS (using the criteria for 'affectedness' recommended by the UNICEF/UNAIDS M&E guide[9]) for its 2005 baseline surveys in Uganda and Zambia. These surveys reveal more food insecurity among OVC than non-OVC and, importantly, include the children themselves in the interviews. This approach is similar to that applied by a large Cape Town University study,[10] which used a participatory methodology to better understand the life experience of orphans and vulnerable children in six South African communities. Children who participated in the Cape Town study consistently raised lack of food in the home, hunger and fear of hunger as primary concerns.

With the exception of these studies, there seems to be a dearth of data on the food security situation of OVC that takes into account the perspective of the child. Both the literature and interviewees pointed to the need for the children to participate in assessing their situation as it may be quite different from that of adults. As one source noted, "Children are more honest than adults, and have no hidden agenda. They speak to their situation as they see it." Another interviewee noted that household food security, as characterized by the head of household, does not often reflect the food security status of a vulnerable child within that household, especially where there is discrimination. The topic of gathering information from children is discussed further in the Chapter on M&E.

2. Nutrition

Orphanhood and nutritional status: Evidence to date has not established a clear relationship between orphanhood and nutritional status. The general conclusion of the Rivers, *et al.* meta-analysis was that, overall, there is no significant correlation. The 2005 Government of Zimbabwe/UNICEF OVC survey reviewed in this study, however, finds that "orphans, particularly maternal orphans, were more likely to be stunted than non-orphans."[11] Several other surveys noted in the IFPRI overview show correlations between orphanhood and malnutrition – e.g. Tanzania and Zambia (higher stunting rates) and Uganda (poorer nutritional status).

With regard to data on nutritional status, one interviewee noted that "Sample size is a huge problem. Since the vast majority of orphans are over five years of age, surveys that measure nutritional status of under-fives are not capturing a significant number of orphans. This makes it difficult to compare orphan to non-orphan data on nutritional status with much credibility. Further, we don't know enough about measuring the nutritional status of children *over* five[12] to get around the problem by measuring that cohort." This is discussed further in this document under M&E.

Key Point: Evidence of a generalized and globally consistent relationship between orphanhood and nutritional status remains tenuous. While there appear to be significant indications that OVC (as well as households caring for multiple orphans) demonstrate greater levels of food insecurity than those not affected, this does not necessarily mean that 'orphanhood' or the 'presence of orphans' are the most useful or appropriate proxy for establishing targeting criteria and selecting beneficiaries. In certain contexts, these indicators can be correlated with nutrition and food security status. However, **given extreme variations in caring practices/traditions across countries and cultural boundaries, it would be inappropriate to apply them on a generalized basis**.

One interviewee suggested, "We can't mix peri-urban and rural, and different tribes and cultures – each has specific caring practices that affect food security and nutritional status, and need to be considered within its own specific context." Another individual noted that "it is important to acknowledge that differing findings on issues related to nutrition and food security across settings is *perfectly reasonable* to expect given differing contexts. Some societies have greater ability to protect orphans (in the nutritional sense) than others. Some take them in, in others they become street children, etc..."

Type of orphan, length of orphanhood and living arrangements: The type of orphan is also often cited as a determining factor in the health and nutritional status of the child. And while it is generally accepted that maternal orphans are at greater risk than paternal for health problems due to the loss of their primary caregiver, a 2003 study in Kenya[13] found that children who had lost a father were more likely to be malnourished (suffer from wasting[14]) than non-orphans, indicating that loss of a father may be at least as significant as loss of a mother in some situations.

The Zimbabwe OVC baseline noted the extreme variability in living arrangements for orphans across districts, demonstrating how caring practices are not necessarily homogeneous even in the same country, and therefore generalized conclusions cannot be drawn for programme purposes. Data must be gathered and analysed to inform programmatic decisions on a localized basis.

In the majority of studies reviewed, findings related to the location of the child (household of extended family vs. foster home, institution, street, etc…) were noted as having an influence. It was also noted that the length of orphanhood is an important element. For example, one might assume that a single orphan who has recently lost his mother, but is still living with his father, may be better off than a double orphan who has moved on to a foster family some time ago. But in fact, the single orphan, who is still in the period of crisis, may be more vulnerable than the double orphan who has already had an opportunity to develop coping strategies.

"A person who isn't related to the child discriminates against him: if such a child is in a home not for relatives and given food, someone can come and say 'that child is sick. Why have you given him/her food on your plates?'

-- Female OVC caregivers, WV focus group participants in Uganda

"My suggestion is … we must get a solution by keeping these people who are already infected out of the community … throw them out. Because they are already dead."

--Secondary school teacher, focus group participant in Uganda, World Vision Hope Initiative, Uganda and Zambia Baseline

3. Discrimination

The literature and interviews consistently pointed to quantitative and qualitative evidence of discrimination of orphans and children affected by HIV and AIDS with respect to care and protection issues, including access to food (both in quantity and quality). Discrimination took various forms: 1) public ostracism by the community; 2) taking in of OVC for exploitative purposes; and 3) intra-household discrimination. There is some overlap in how each of these forms plays out and all were seen to have serious implications for programming.

Public ostracism: Children who have lost one or both parents to AIDS, or who are infected or affected by HIV in other ways, often experience discrimination and social exclusion from communities as a result of the stigma attached to the disease. This is still, at least in part, the result of ignorance and misunderstandings about transmission. In Sierra Leone, for example, where the prevalence rate is estimated at 2.9 percent, "many people were not happy to accept a child into their family if the parent died of AIDS because of fear of the disease spreading into their family."[15]

Secondary school teachers in Lesotho noted that the "characteristics of pupils are reported to change drastically for the worse after the death of one and both parents, or during the prolonged illness and

suffering of either or both parents,"[16] which increases their exposure to further ostracism.[17] Finally, although the prevalence of child-headed households (CHH) is still very low (less than 1 percent according to a recent UNICEF report),[18] one interviewee blamed public ostracism for their very existence, observing that these children are sometimes shunned and left to their own devices. She also expected the number of CHH to rise in the coming years due to the inevitable growth in the number of orphans and the diminishing ability of families to absorb and care for them.

Taking in orphans for exploitative purposes: Nearly all of the studies gave anecdotal evidence of households taking in orphans for the purpose of exploiting them, either as cheap sources of labour, or to appropriate any assets or entitlements (e.g. food rations for orphans) that they saw 'attached' to the child. Since orphaned/destitute children are not generally given the opportunity help decide their own welfare, they usually have little choice regarding where they are expected to live, irrespective of whether the adoptive family is genuinely concerned with their well-being.

In Lesotho it was noted that, "many a time, members of the extended family would not only harass and exploit these children for domestic labour, but also forcefully take away their property, which may include land, housing, materials and/or livestock, thus denying them their inheritance."[19] Focus groups also cited cases where caregivers wanted to adopt a child, but faced resistance from the orphan's relatives, who wanted the orphan to live with them so that they could benefit from donations that the orphan is entitled to, or because they wanted to use the child as a labourer.[20]

Intra-household discrimination: Focus groups conducted as part of the WFP Malawi Protracted Relief and Recovery Operation (PRRO) baseline similarly noted that OVC were not receiving sufficient food, and that this was magnified where household size was excessive and caretakers could not find alternative means of obtaining food. Some orphans noted that they lack food not because there was no food in the home, but because the children of their caretakers took priority. The focus groups revealed that caretakers generally did not treat orphan children the same as their own. This applied to paying school fees, assigning chores (heavier workloads went to orphans), and having to resort to casual labour (gardening in the fields, molding bricks, fetching water and washing clothes for other people) in order to generate income for food. (An analysis of 19 demographic and health surveys (DHS) in ten sub-Saharan African countries provides quantitative evidence of intra-household discrimination against orphans regarding investment in schooling, with orphans having lower enrolment rates than non-orphans in the same household.[21])

The Lesotho Rapid Assessment, Analysis and Action Planning (RAAAP[22]) also noted that "children who are orphaned as a result of AIDS face huge problems of poverty and stigma, and are often deprived of school fees, food, clothing and sometimes shelter by their 'guardians.'" Most foster parents considered the orphan a "burden that they could not run away from – they do it because they have to."[23] Many studies noted that the further the child is from his/her core family, the greater the likelihood of discrimination.

Overall, although discriminatory treatment was sometimes discussed in the context of outright exploitation and abuse, more often it was described the 'natural' result of parents prioritizing their biological children for food, schooling and other elements of care and protection, in the face of extremely constrained resources. According to interviewees and literature, **family capacity** – whether the head of household is a widowed parent, an elderly grandparent, or a young person – **represents the single most important constraint to building a caring and protective environment** for children who have lost their parents to AIDS-related causes. Finally, another report by UNICEF Lesotho expressed concern for the rights of orphans when households caring for them often cannot meet such basic needs as sufficient food, clothing or medical care for their own children. It suggests that we examine the shifting definition of 'family' in the wake of the HIV epidemic, and expresses concern that children are being integrated into the homes of increasingly more distant relatives or friends of the family. In these situations, children are further removed

from any obligations to or from nuclear families or communities of origin and placed at greater risk of neglect and abuse.

What More Can We Do?

> "We need to look at our situation locally, not globally. Many times what you get is anecdotal, not quantitative, but this is the basis to start programming. There's lots out of information out there but is this applicable to us here in Mozambique? We need localized information in order to make programmatic decisions for our OVC interventions."
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> *-- Interviewee from Mozambique*

1. Focus on the local situation

Some frustration was expressed by headquarters-based interviewees and researchers around the fact that not enough is known about the relationship between OVC, malnutrition and food security, and that often the evidence has mixed results. Field staff highlighted that identifying generalized, globally applicable relationships may not ever be feasible or appropriate. Instead, efforts should focus on how to characterize the specific, localized context in which emergency and development practitioners are working, and how to apply those findings to good programming on the ground.

As we've seen, the individual and aggregate consequences of HIV and AIDS play out differently in every country. A culturally specific situation analysis and ongoing contextual monitoring are essential to designing and implementing effective OVC interventions. Only when localized information is gathered and analysed and geographic and programmatic priorities have been identified can specific actions be recommended. Using the Family Health International (FHI)/IMPACT document entitled 'Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Guidelines and Tools' was recommended as a good place to start.

2. Understand whose situation we are trying to assess, and our purpose in defining the terms

Constructing definitive language to characterize the situation of orphans and other children affected by HIV and AIDS is a complex undertaking. A first step toward ensuring that we are comparing apples with apples is to define our terms, and to understand where definitions must be common, and where they will justifiably vary. As noted in the FHI/IMPACT Guidelines for 'Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV and AIDS':

> "The concepts of orphan and vulnerable child are social constructs that vary from one culture to another. In addition, these terms take on different definitions that can be at odds with one another depending on whether they were developed for the purpose of gathering and presenting quantitative data or for developing and implementing policies and programs. It is important to make this distinction and establish a 'firewall' between definitions developed for one purpose versus the other.
>
> Problems occur in the field when definitions established for quantitative [surveillance] purposes are picked up and used for program targeting or eligibility criteria in policy and program implementation. The quantitative process must have clear boundaries and allow for absolute distinctions. In contrast, developing and implementing policies and programs have to take into account local variations in what factors cause or constitute vulnerability. In the latter case, no one prescriptive notion will suffice for every occasion."

Establishing non-programme-specific baselines or tracking the well-being of children at the national or district levels requires objective definitions, which may focus specifically on HIV and AIDS. However,

defining targeting criteria for *programme beneficiaries* should not single out or prioritize children affected by HIV and AIDS over those who are vulnerable for other reasons.

Of equal importance, where baselines and final evaluations are implemented for an OVC intervention, those surveys should use the same criteria used for targeting. More than one of the organizations interviewed used definitions for their project baseline that were different from the ones they used for programme purposes, which makes translating baseline findings to programmatic decision complicated.

> "In the field this definition [the UNICEF/UNAIDS M&E Guide definition of OVC] has no relevance. It's likely to be useful for the global agenda on children and HIV/AIDS, but on the ground, for picking kids, it will always be open for interpretation. Since we are complementing other people's agendas with food, there are no strict definitions set by WFP. We cannot predetermine the criteria. We leave it to our partners to select who is most vulnerable. After all, the truth is that they know better than we do."
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> *-- Food Programming Staff Person*

3. TARGETING: IDENTIFYING THE MOST VULNERABLE CHILDREN

What We Know about Targeting

1. Targeting vulnerability, not orphanhood

Over the past several years, food assistance programmes have been actively engaged in the protection, care and nutritional rehabilitation of children and households affected by HIV and AIDS. In efforts to identify households experiencing food insecurity related to AIDS, proxy indicators were widely used. Households with chronically ill members or those looking after orphans, as well as those headed by elderly, youth or widows, were assumed to be potentially more vulnerable to food insecurity and consequently prioritized for assistance. Communities were called upon to identify these households, with varying degrees of success.

There is growing agreement that it is most useful to target vulnerability to food insecurity and/or malnutrition (depending on the intervention) rather than select children and families on the basis of their association with HIV.

With the exception of clinical interventions, which are appropriately targeted to individuals and groups on the basis of known/suspected HIV infection, there is no value in making a distinction between children from 'AIDS-affected households' and children from other households in need. For the purpose of delivering food security and/or nutrition interventions, and in the case of children in particular, current thinking is that it is not useful (and potentially harmful) to identify children for food security interventions in ways that label them as 'different' and set them apart.

Research to date informs us with increasing clarity that **targeting on the basis of orphanhood is at best problematic**. Clearly, not all orphans are food-insecure or even vulnerable; and as mentioned briefly in the previous section, one of the most vulnerable phases a child can experience occurs *during the illness of the parent*, prior to official orphanhood,[24] and in the first year following the death of a parent.

Defining Vulnerability

Vulnerability is the *exposure* and *sensitivity* to food insecurity, malnutrition or disruption in livelihoods, depending on the topic of concern.

The degree of vulnerability depends on the characteristics of the **risk (*exposure*)** and a household's **ability to respond to risk (*sensitivity*)**

Vulnerability (to food insecurity for example) is a forward-looking concept. The question that vulnerability analysis poses is: ***How prone is this individual, household or community to acute loss in their ability to acquire food?***

-- adapted from the Developmental Relief Competency Based Curriculum, TANGO International 2006

Disparities in food security reported between orphans and non-orphans (as well as orphan households and non-orphan households) do not necessarily imply that 'orphanhood' or the 'presence of orphans' *per se* is the disadvantaging factor.

-- CRS STRIVE survey report

The evidence in the previous section demonstrated the numerous factors influencing an orphaned child's vulnerability to food and nutrition insecurity. Furthermore, how each of these factors influences vulnerability is not necessarily the same across cultural, economic or political contexts, making it impossible to apply global norms when 'orphanhood' is the basis for targeting. The consensus from this research is therefore that targeting 'orphans' in an effort to identify food-insecure children is also likely to cause errors of both inclusion and exclusion – inclusion of orphaned children in food secure households, and exclusion of food-insecure children whose parents are still alive.

In order to identify vulnerable children, **the clearest indicators arise from household wealth/asset assessments**; neither 'household caring for orphans' nor 'dependency ratio' is accurate proxies for food insecurity or child vulnerability on their own.[25] The CHS regional analysis[26] demonstrated this clearly, implying that asset ownership is a more reliable targeting criterion than socio-demographic criteria, or should at a minimum be used in combination with those criteria.[27] This resonated with one M&E specialist who characterized orphanhood as a 'distant' indicator of food insecurity or malnutrition, much the same as 'the presence of chronic illness', and asked: "If we have to use 'distant' indicators, why not use poverty indicators, which are more accurate proxies for food insecurity and malnutrition?"

Multiple, weighted indicators can assist with documentation and validation of targeting decisions, but in reality, interviewees expressed the view that community-based organizations that are already actively engaged with their vulnerable members are best placed to select and apply criteria. This is especially true in rural communities that are historically interdependent and close-knit, where illness or other crises in neighbouring households are visible to all. Much less is known about community-based targeting in urban settings. Unfortunately, there is no 'one size fits all' answer to targeting dilemmas.

2. The implications of targeting labels

It is important to consider the language of targeting. There is continued concern, for instance, about the effects of using the 'orphan' label as a criterion for vulnerability. In fact, "to some extent, it appears that the term 'orphan', and especially 'AIDS orphan', can do more harm than good by contributing significantly to the stigma and abuse experienced by these children."[28] This is particularly significant in African culture where the word 'orphan' is not necessarily associated with the loss of a biological parent but is more often interpreted as having been abandoned, having no one to care for you, and having no one to *provide* for your needs. The idea of 'single orphan' can be particularly insulting to the surviving parent who is providing support and care. In no other context is a child with a surviving parent referred to or categorized as an orphan. As noted earlier, when these parents need assistance, it is often because of poverty or lack of empowerment, NOT because the child is 'an orphan'.

> By linking orphans directly to material resources that are not generally accessible to others, we stand to 'commodify' them, placing them at risk of further vulnerability in contexts of poverty. A school principal expressed this poignantly: "People," he said, "are taking kids [orphans] like they're keeping cattle."
>
> *-- Giese et al, 2003*

Children labeled 'AIDS orphans', in addition to enduring the generally negative connotations around orphanhood, are often (erroneously) believed to be HIV-positive, on the basis that their parents were infected. In fact, an informal survey showed that teachers, nurses, etc. in high-prevalence countries attribute a far higher HIV infection rate to 'AIDS orphans' than what genuine data would actually reveal.[29]

In addition, care must be taken to avoid having children made *more* vulnerable by being targeted, especially given evidence of cases (noted in the previous section) where children fall prey to unscrupulous relatives who use the child's 'orphan' status to gain access to resources which are never shared with the child. Thus targeting becomes an exercise in understanding the roots and manifestations of vulnerability rather than simple socio-demographic categorization.

The idea of targeting based on vulnerability to food insecurity is supported by those in the field who have experienced social disharmony in communities where 'orphan households' or 'AIDS-affected households' were prioritized over other needy (sometimes more needy) households. As well as avoiding situations where beneficiaries feel stigmatized, it is important that targeting doesn't perpetuate or contribute to stigma by associating AIDS with 'helplessness'. It requires a delicate touch: our role is not simply to observe and acknowledge the influence of stigma, but to actively seek to diminish it. Thus it will be beneficial when planning and implementing projects to 'normalize' the existence of HIV and AIDS in

communities. Strategies for normalization include engaging those infected and affected by HIV and AIDS in meaningful roles in all stages of the project, and encouraging open dialogue. In this regard, the GIPA declaration[30] provides a useful framework for inclusion and normalization but is generally underutilized.

3. The costs of targeting

Several interviewees expressed concern about the cost of targeting, especially with the shift away from the very simple 'orphan' criterion to the more complex targeting around general vulnerability. Staff often find sophisticated targeting methodologies that examine coping strategies, household assets, dietary diversity, degree of chronic illness, etc. too complicated, labour-intensive, expensive and time-consuming. One interviewee expressed the concern that there is no overarching agreement between key stakeholders about the identification of vulnerable children for food assistance, relative to the targeting required for other interventions, concluding that "if we were actually part of a multi-sectoral response, we wouldn't have to spend so much money to do all this targeting just to deliver the food – our problem is that we are working in isolation!" Another noted that the funds spent on targeting and verification exercises would be better utilized by the community-based organizations (CBOs) and faith-based organizations (FBOs) that are actually providing OVC services, stating "they know who the most vulnerable children are, and they need this money just to maintain the services they provide. If they can't afford to keep their doors open, then we're back to square one, providing food in isolation of other services…"

Note! There is some concern that moving away from the 'orphan' target may have negative ramifications on funding levels. The level to which donor resources have been tied to 'orphans' has influenced targeting, monitoring and reporting, and reality dictates that unless the focus shifts to 'vulnerable children' and brings with it an equivalent or greater resource pipeline, this much-needed updating of targeting strategies will not be implemented.

Targeting exercises over the past several years are now blamed for the increasingly common use of the label 'AIDS orphan', and for raising unrealistic expectations in communities, especially when the food pipeline is insufficient to meet the demands once targeting has been completed. In southern Africa, some NGO staff describe a phenomenon of constantly 'raising the bar' (i.e. increasing the criteria), making it harder and harder for communities to place beneficiaries on the distribution list in an effort to stretch inadequate resources. As one interviewee stated, "The need simply far outstrips the apparent resources of UN agencies and bilateral donors." These dilemmas point to the need not only for bolstering funding, but also for capacity building and support mechanisms that assist front-line staff to cope with the challenges.

4. Targeting mechanisms that work: using existing structures

For any form of ration allocated to households, it is agreed that the identification of vulnerable children is most successful when **communities themselves establish the selection criteria and identify children/households** for inclusion, although admittedly, the process is more suited to rural communities than urban ones. Because the factors that affect children's vulnerability vary from one context to another and are often dynamic, and because orphans and vulnerable children are not a homogeneous group, food programming must work through and depend on established community systems to effectively and efficiently target beneficiaries who are in greatest need. While it is becoming clearer *who* and *how* to most effectively target the most vulnerable children, the practical implications of getting the job done properly in the real world – and with real-world funding levels – remain challenging.

Leading examples demonstrate that an in-depth understanding of the context of vulnerability should be specific to each community, implying that long-standing relationships with the communities are required.[31] Interviewees described a process of identifying geographical areas of intersection between high food

insecurity and high HIV prevalence as the initial lens for deployment of food assistance. From there, they rely on the strength of local partnerships to appropriately attach food to programmes that are already running. The critical decision in planning a food assistance intervention, then, becomes **'who to partner with'** (rather than 'how to target individual beneficiaries') **and who can use food as an effective complement to their existing package of services to vulnerable children**.

On-site feeding for school-going children. This continues to be the most straightforward mechanism for targeting vulnerable children on a large scale. It is generally designed to protect and improve OVC access to education, school feeding targets young (6-12 years) in-school children in geographical areas where high levels of food insecurity, high HIV prevalence and low school enrollment/retention rates co-exist. However, while the literature and interviewees acknowledge the role of school feeding in keeping children from dropping out, there is concern about the growing number of children that school feeding fails to reach. These are the 'most vulnerable' children, who were not in school to begin with because of issues not related to food (distance to school, money for uniforms/school fees, cynicism about the value of education, etc…).

Take-home rations (THR). While THR programming has a number of strengths (described in Chapter 4, Programming), targeting is the most difficult aspect and must be undertaken with care and in close collaboration with key community stakeholders. Ideally, it is preferable to provide THR to *all* children in a school that has been identified as located in a food-insecure area. Where resources are limited, however, using school systems to target *particular* children for THR is fraught with challenges and the danger of stigmatizing the children in front of their peers.[32] It can be difficult to reach consensus with the community about which children should be selected, and even more difficult to achieve compliance with the criteria. While teachers are in an excellent position to identify children at risk, they need the support of a functioning referral network through which services (including food assistance) can be obtained. When teachers are engaged in the identification of the school's most vulnerable children, the most useful information stems from the their observation of the child's behaviour (coming to school hungry, falling asleep in class, unable to concentrate) and physical appearance rather than on demographic information or assumptions about 'orphanhood'.

Prevention of Mother to Child Transmission (PMTCT). The targeting potential of PMTCT programmes is vastly under-exploited. The complete PMTCT Plus package (anti retroviral therapy (ART), nutritional support, family planning and reproductive health services, counseling and supportive care, and treatment of other diseases such as malaria and tuberculosis) presents several opportunities to reduce both infant HIV infection and orphaning. There are many successful examples of integrating food assistance with Maternal Child Health/Antenatal Care (MCH/ANC) and PMTCT programmes. These models expand access to comprehensive HIV service delivery to mothers, infants and other family members in the following ways:

- ✓ Maternal HIV counseling and testing encourages partner testing, regardless of outcome;
- ✓ HIV-negative mothers are informed of the importance of avoiding HIV infection during pregnancy and lactation, and risk-reduction counseling is provided;
- ✓ Food assistance for mothers (regardless of HIV status) improves nutritional status, reduces stress related to food insecurity and leads to improved maternal-child outcomes;
- ✓ Short-term antiretroviral (ARV) treatment of HIV-positive mothers and HIV-exposed newborns diminishes prenatal and intrapartum mother-to-child transmission (MTCT) ;
- ✓ Post-test counseling of HIV-positive mothers encourages not only partner testing, but testing of existing children;
- ✓ Post-test counseling of HIV-positive mothers includes nutrition counseling and cotrimoxazole prophylaxis as well as appropriate referrals to livelihoods and agriculture services;

- ✓ HIV-positive mothers receive counseling and support for appropriate infant feeding decisions;
- ✓ HIV-positive mothers with low CD4 counts and/or low BMI are prioritized for nutrition support and where possible, referred for long-term antiretroviral therapy (ART);
- ✓ HIV-exposed infants are closely monitored especially during accelerated weaning and until they are successfully established on solid food;
- ✓ Follow-up of HIV-exposed infants ensures infant HIV testing, bringing HIV-positive infants into care and treatment at the opportune time, thus reducing infant mortality.

Home-based care (HBC) networks. HBC networks were noted as an increasingly effective entry point for identifying vulnerable children, including those in need of treatment for HIV. Ideally, HBC workers are part of a multidisciplinary team that provides access to the diverse service needs of patients and families. Food is often attached to HBC programming in the form of household or supplementary rations. Identification and appropriate referral of children and youth in need is an integral part of the HBC provider's mandate. There are many successful examples of programmes that train HBC volunteers to ensure that children and families are appropriately referred to services, including food security and livelihood programmes or trainings within their communities.

What More Can We Do to Improve Targeting?

1. Exploit and expand Growth and Monitoring Promotion (GMP) and Nutritional Rehabilitation Unit (NRU) services

Growth monitoring, promotion and care programmes are under-utilized as entry points for identification of HIV-positive children. Significant anecdotal evidence demonstrates that the lives of HIV-positive children can be extended through improved nutrition and basic health care interventions even in the absence of ART. It is, therefore, critical to acknowledge the role of nutrition, and to fully utilize existing mechanisms in the management of HIV illness in children as we wait for the rollout of pediatric formulations to gain momentum.

2. Seek out pediatric hospices/day-care facilities, transition and foster care programmes

There continues to be a reluctance to capitalize on existing (institutional) mechanisms for children who are sick or in transition, based on concerns about perpetuating or appearing to condone long-term institutional care of children, and a failure to differentiate between different kinds of 'institutional' (as opposed to 'home-based') mechanisms. Where home-based care

"Even though the window of opportunity is relatively narrow, PMTCT programmes offer the opportunity to prevent primary HIV transmission within the family, improve the care and treatment for family members who are HIV-infected, and ultimately strengthen child survival and well being."

Theo Smart, HIV & AIDS Treatment in Practice #70

Mothers2Mothers help prevent MTCT

The potential for such a high level of impact provides a clear case for channeling food assistance resources through MCH and PMTCT mechanisms.

Mothers2Mothers is an innovative, community-based education and mentoring programme for HIV-positive pregnant women and new mothers. Based in South Africa, this programme identifies HIV-positive mothers who have been successful with pregnancy, delivery, exclusive breastfeeding and accelerated weaning, matching them with small groups of HIV-positive women in their communities to provide peer support and a bridge with clinical care.

'Mentor Mothers' teach and counsel pregnant women about the science of HIV infection and ART, behaviours to help prevent MTCT, safer feeding options for infants, strategies to help in disclosing their status, tactics for negotiating safer sexual practices, and nutritional guidelines for women living with HIV and for their infants. Food support is used to strengthen Mothers2Mothers activities such as daily gatherings for nutritious lunches and nutritional education.

programmes are affiliated with an adult community hospice, day-care facilities for sick children (such as Jon Hospice in Zambia, or South Africa's Hope Worldwide Siyawela community child care, or Tumelong Hospice/Lekegema Orphan Haven) are emerging to support parents and caregivers who are struggling to provide care for an ill child during the day. Programmes like these, as well as transition facilities and foster care programmes, are excellent points of entry for nutrition education and food assistance, and are likely to have the positive effect of freeing up scarce cash resources for other high-priority expenditures such as medication and transportation.

3. Support PMTCT and PMTCT Plus

PMTCT programmes are under-utilized for targeting vulnerable mothers and children for additional assistance, including food. Pregnant women can be targeted with relative ease, not only to gain access to mother-infant pairs but as an entry point to children and families in general. Innovative programmes are using food assistance and nutrition programming to increase uptake by some of the most vulnerable women, children and families.

4. PROGRAMMING: BALANCING COMPLEXITY AND PRACTICALITY

What We Know about What Works in Programming

1. Food as an integral component of a comprehensive package

Overwhelmingly, interviews and reviews of the current literature reaffirmed the broad agreement that food-based interventions for OVC cannot stand alone – that where food assistance is required, it should be **part of a multi-sectoral approach** in which food is one element of an integrated package. Best practice in OVC programming now demands an intentional effort to coordinate and collaborate across programmatic areas (agriculture, health, emergency, education, social protection and others), a standard that applies equally to NGOs, UN agencies, governments and donors. Food security and nutrition are essential components of this effort, but must be programmed in deliberate partnership with other OVC service providers. **Failure to intentionally link these (traditionally) separate and distinct funding and programming streams seriously limits the potential for impact and fails to make the best use of the scarce and time-limited resource envelop attached to either area.**[33]

Yet experience to date demonstrates that, in spite of best intentions, integration is more easily said than done. Interviewees from several agencies, and from all levels of deployment, repeatedly noted that HIV/OVC programming and food-based programmes continue to work in isolation, often in separate buildings or locations, reporting to different managers, and rarely crossing paths. Field-based interviewees conveyed expressions of frustration: "We all know we need to build programming that is long-range, multi-sectoral and seamlessly integrated. But we're still trapped by funding silos, sectoral boundaries and bureaucracy. And we're all going flat out, so busy 'doing' that we don't take the time to learn how to do things differently."

> "Integration means ensuring that children and families have access to health systems and services that provide quality care and support, and that girls and orphans stay in school and learn how to protect themselves. It means providing good nutrition for children affected by AIDS and securing safe water and basic sanitation for AIDS-affected households. It means empowering women to make decisions with their own health and the best interests of their children and families in mind."
>
> *UNICEF (2007). Children and AIDS: A stocktaking report*

At the root of this frustration was that aggregate-level (geographic) targeting and commodity management systems do not easily meld with country-wide OVC approaches, nor do they adequately support a continuum of household-level care. Individuals with HIV move in and out of illness as their disease progresses, and thus the needs of their households (and the children in them) are not static – they are dynamic, with every member experiencing HIV in their own way, at their own pace. Their circumstances also change in response to climatic/environmental shocks, seasonal food shortages, shifts in the local economy and bouts of illness. Implementers struggle to respond in a timely and practical manner. Traditional food programming mechanisms are simply too sluggish and inflexible to deliver in this environment.

In contrast to a short-term, population-level emergency food assistance response, the current context (especially in high-prevalence countries) requires long-range commitment (10-15 years) and approaches to food security and improved nutrition that respond to evolving needs on a household-by household basis. Interviewees reiterated that the social safety net systems built today for children and families *need to last at least a generation* – they must be envisioned as permanent rather than temporary or makeshift. The consensus is simply that we must maximize every opportunity to serve the children in our care by linking with other service providers.

> "If food programming is used as an entry point, it must be just that – the *entry point* – not an end unto itself."
>
> *--- Interviewee from southern Africa*

Finally, there is a clear call for **food programming to go beyond simply improving *access* to food; it must also influence food *utilization*** through supporting better hygiene practices, facilitating access to de-worming and sharing information about infant/young child feeding and care practices, good nutrition and food preparation. There was also mention of the importance of children's access to safe drinking water (as part of the nutrition package), implying that programming to ensure the nutrition security of children should include activities such as drilling boreholes, and training in management of water points and water purification. While these have long been core components of child survival programming, there is a sense of increased urgency where children are becoming increasingly more vulnerable to malnutrition, disease and poverty associated with high HIV prevalence.

2. Forming and supporting viable partnerships

As noted in Chapter 3, during the process of conceptualizing any food assistance intervention with OVC, one of the first steps is to assess the potential for viable partnerships.[34] While increased funding for HIV and AIDS-related initiatives has prompted a many actors to become involved in this field, this is sensitive work and there are critical shortfalls in the management and technical skills required. There is an urgent need to build capacity of local organizations to undertake meaningful assessments of community needs, design effective context-specific programmes, implement them efficiently and evaluate their success. This is not only key to effective implementation but also to the development of long-term strategies through which communities become self-sufficient. Interviewees spoke of the need to put time and resources into partner sensitization and training before initiating tangible activities. They also expressed their frustration with the high turnover and professional mobility of key individuals at all levels. They described the pace of food programme implementation as painfully slow and the constant need for retraining, re-orientating and backstopping as exasperating.

Another source of frustration is the **reliance on volunteers** to provide child-related services, and the challenge of addressing ongoing attrition and re-training. Burnout rates can be high especially where the work is both physically and psychologically demanding. Volunteers are often expected to provide services along the continuum of care, responding to needs of infected and affected children in a variety of settings, without receiving either stipends or incentives, even though they are often as poor as, or poorer than, the people they are assisting. The use of food packages as an incentive for volunteers (especially those involved directly with providing food assistance) is still controversial in light of the many other services being provided (for free) by volunteers. Field-based interviewees asked for guidance, for instance, on whether to continue providing rations to HBC providers who carry food packages to their clients (when those who don't deliver food assistance, but provide HBC, go without), knowing that these volunteers all come from food-insecure and HIV-affected households. Lessons learned from experiments in Mozambique and other countries where financial and other incentives have been tested need to be shared with countries like Zambia, Zimbabwe and Malawi where the 'volunteerism' debate is extremely contentious.

Stigma remains an important influence on all programming where a relationship exists (or is assumed to exist) between the service/benefit and the beneficiary. It is important that WFP, UNICEF and co-operating partners continue to learn how stigma interacts with targeting, uptake and effectiveness. While it is important to design interventions that are 'sensitive' to stigma and discrimination, it is also important understand and acknowledge where stigma may actually be diminishing. Where communities are talking about and acknowledging HIV and AIDS openly and individuals are coming forth to demand services, we need to avoid *perpetuating* stigma by assuming that it still exists. Programme designers should avoid creating

unnecessarily convoluted mechanisms to ensure anonymity of beneficiaries, such as targeting by proxy, unless it is clear that the community still requires it. There is some evidence that provision of food in highly food-insecure communities affected by HIV and AIDS actually helps break down stigma – when people need the service, they will come forward.

3. School-based feeding: an intervention that works in reaching OVC

In addition to its efficiency in targeting on a large scale (see Chapter 3), there are also specific programmatic advantages of school feeding in reaching OVC. It is clear that educating children, especially girls, is critical to mitigating the effects of the epidemic and to reducing vulnerability to infection.[35] With the global push on Universal Primary Education (UPE), WFP is uniquely placed to work with governments as they put UPE in place. This serves a strategy for addressing both HIV prevention and impact mitigation, and with its underpinnings in Millennium Development Goal #2,[36] it provides a springboard for influence on school health and nutrition, and the inclusion of locally adapted agriculture and livelihood interventions as well.

> "We don't want children to grow up thinking food only arrives on a lorry."
>
> *-- Patrick Nganzi, Concern Worldwide, Malawi*

There were several insistent voices, in both the literature and interviews, for long-range (15-year) school feeding commitments in high-HIV-prevalence countries. If food security is a right, not a privilege, then children should be able to depend on it as an integral (not on-again, off-again) component of a social protection response to chronic food insecurity and vulnerability. **Long-range planning (capturing at least a single generation) would encourage a truly developmental approach to child nutrition** through which to integrate new patterns of growing, harvesting, preparing, eating, storing and preserving food that would influence generations to come. While this requires re-visioning of how food assistance is resourced, a stabilized, predictable food pipeline is more cost-effective to implement than multiple reactive 'bursts' and (with local purchase arrangements, for instance) can be managed in such a way as to not disrupt trade and local economies.

Interviews and literature also repeatedly suggested that **agencies that implement food programmes should investigate the potential of food-assisted nutrition training for teachers and community health volunteers**. Offered in conjunction with school gardens and applied agriculture, the produce grown could help support dietary diversification in school feeding programmes.[37] Community health volunteers could be trained in optimal nutrition, food handling and preservation, food preparation for special needs and context-specific infant feeding. While these approaches have an immediate impact on child nutrition, they also have longer-term benefits related to healthy food choices and effective food management. There were also several calls that WFP take a stronger stand on the regular use of de-worming medicine to ensure that children receive maximum nutrition from any food provided at the schools.

This review found several inspiring examples of stratified interventions (that build upon and complement each other) using school feeding as an entry point to other food security interventions, including THR, community day care/early childhood education centres, after-school care, community gardens and food bursaries.[38] The effectiveness of THR as a method of raising levels of school enrolment and attendance is well documented. **Provision of household THR, either as supplementary food or as income transfer, is generally supported by interviewees, although attaching conditionality was controversial.** Practitioners fear that some of the most disadvantaged children would fail to qualify for reasons beyond their control, thus this mechanism would contribute to marginalization.

As mentioned in Chapter 3, there is general agreement that the school system has an important role in identifying children at risk and referring them for a more comprehensive assessment of the needs of the

family and appropriate support systems. If food assistance were required, rations would be collected by families rather than disbursed to targeted children at school. Many have advocated for a re-conceptualization of the school as a multi-purpose community development and welfare centre where assistance (including food) to families becomes an integral part of a school's operations.[39] This idea advocates for the management of social safety net support through school-based community committees, (rather than hospitals and clinics, for instance) where a non-sectarian focus on wellness, learning and the future of the community as a whole can capitalize on the community's natural interest and investment in children.

As noted earlier, the obvious shortcoming of school-based interventions is that they generally don't reach the children who are not in school, and who may be the most vulnerable of all**. Food for Listening (Zambia)** uses interactive radio to deliver critical components of primary school curricula, along with HIV awareness and prevention messages, to reach out-of-school and community school children. Food is delivered to child participants and adult facilitators as they gather in small 'classes' to listen to broadcasted lessons, and can also be provided as a THR, much like school feeding does. WFP also provides food assistance to drop-in centres that offer learning opportunities and educational

Early Childhood Care and Development (ECCD) refers to a wide range of interventions that support children's survival, growth, development and learning in the period between birth and primary school age. ECCD programmes often include parenting programmes and formal pre-primary education. Interventions such as nutritional supplements, iron supplements, de-worming and psychosocial stimulation of malnourished children have been identified as having a major impact on outcomes such as attention and language development.[40] ECCD has particular potential for children with HIV, who suffer common childhood diseases more than other children. Affordable, community-based ECCD programmes can positively influence the health and nutritional status of vulnerable young children through the early diagnosis of HIV, access to food assistance and nutrition education, appropriate immunizations, treatment for common childhood infections and ART adherence. ECCD programmes have traditionally resided in the private sector, serving middle/upper-class families who could afford the fees. More recently, however, similar initiatives have surfaced in response to needs identified in poorer communities, offering vast potential for mechanisms that provide food and nutrition support.

4. Supporting the households that care for vulnerable children

In Chapter 1, it was acknowledged that *family capacity* represents the single most important constraint to building a caring and protective environment for children. Therefore, the primary thrust of any OVC intervention must be **the provision of support and information to the households where children live,** either with parents who are struggling to manage HIV infection or with relatives who have taken in the children after their primary households dissolved. Interviewees called for more flexible access to food (or cash to buy food) that could be programmed on an ongoing, reliable, individualized and quick-response basis. They reiterated several times that food (or the means to procure it) is an essential component of a network of referral and protection services available to families in crisis and children in need. Interviewees called for more responsive mechanisms that allow for earlier intervention especially in high-prevalence areas, before household assets are irrevocably depleted and/or the child has left school.

5. Caring for children not found in households

In spite of the disruptions wrought by HIV and poverty, most of Africa's vulnerable children are still educated, protected, mentored, counseled and observed by the adults in their core or extended families and communities. However, an increasing number of children are found, for a large part of their day, in risky environments without the protection or supervision of an adult. One prominent OVC expert differentiates between children *of* the street (who live, work, eat and sleep on the street) and children *on* the

street (children who work on the street but go home to their family at the end of the day).[41] Regardless of how they come to be 'without supervision' – whether they have run away, or have been abandoned, formally relinquished, placed in temporary care or apprehended by child welfare officials – many of these children are eventually cared for in some form of institutional setting.

While there is solid evidence that long-term institutionalized or residential (the classic 'orphanage' model) care for children should be avoided,[42] there are **several examples of 'transition facility' and 'group home' initiatives that require support to provide food to children.** These temporary arrangements are often necessary while family re-unification efforts are carried out; when re-unification is not possible, community fostering or formal foster-care should be sought. There are also excellent examples of programmes running short-term courses in life-skills development and psychosocial support (e.g. Masiye Camp in Zimbabwe). Children are generally referred by OVC programmes for these specialized short-term residential courses, where food serves as an excellent complement to services already provided, reaching an exceptionally vulnerable group of children. It is also clear that there are some children (severely disabled and some HIV-positive) for whom efforts to make family-based arrangements will inevitably fail and where the level of care required is more sophisticated than a typical home-based setting can provide. These children may need to be cared for in a more institution-like setting and WFP food support may be an appropriate intervention.

In providing food to children living in settings other than 'home', one of the greatest challenges is identifying which commodity and ration size is most appropriate. Literature on good child-care practice informs us that the basic care package should include the provision of a nutritional diet that matches local cultural norms. However, where poverty is rife, 'normal' household standards may not be nutritionally adequate and the dietary standards of organized childcare may be higher than those of the local community. This situation "creates a tension which could encourage parents or children to seek a placement within a non-family care service, thus separating them from their families." [43] Viable childcare service providers must have (and must adhere to) explicit referral and admission processes. Therefore, there is need for careful investigation of operations before embarking on a partnership arrangement and deployment of food assistance.

There is agreement that food can be usefully deployed to support the care of children living in settings other than 'home', through programmes that:

- ✓ Are mandated to provide short-term transition shelter and family re-integration services;
- ✓ Promote formal foster-care as an effective means of preventing or reversing the institutionalization of infants and children when re-integration is not possible; and
- ✓ Adhere to national or international standards for the provision of quality care to children.

Raising the Standards Quality Childcare provision in East and Central Africa – Save the Children UK

6. Reaching OVC through livelihoods and life-skills training

There are some promising examples of food-assisted programmes promoting agricultural knowledge/skills, life-skills training and other support to livelihoods. Programmes designed to build the capacity of children and young people to meet their own needs are increasingly recognized as important. The FAO/WFP Junior Farmer Field and Life Schools (JFFLS) and Mobile Farm Schools (run by several NGOs) are two such examples that combine training in agricultural practices with life skills and HIV awareness and prevention. In some cases the JFFLS programme is linked to schools (e.g. Swaziland and Kenya), whereas in other cases the programme also targets out-of-school youth (e.g. Mozambique). Regardless of the targeting mechanism, the programme seeks to fill the intergenerational knowledge and skills gap left by the premature death of parents with AIDS. Early reviews of these programmes show that careful targeting, well-qualified staff specifically cultivated to meet the needs of the curriculum, and the inclusion of sound graduation strategies are critical to their success. A thorough and critical analysis of

these projects (and others like them) would help to inform those interested in replication. Special attention should be paid to post-project monitoring (including graduation and exit strategy monitoring), and should consider whether graduates of the training have gone on to: secure employment; access land and apply the agricultural (or other vocational) skills that they acquired; remain HIV-free; and pursue viable livelihood strategies.

The recently launched Strategic UN and Partners' Alliance on OVC, Sustainable Livelihoods and Social Protection, spearheaded by FAO, is a strategic and operational partnership among UN agencies, governments, civil society organizations and NGOs. The Alliance seeks to jointly address food security and nutrition needs of OVC in the immediate, medium and long term using the sustainable livelihood model underpinned by social protection. The aim is to strengthen support for the livelihoods of children and families affected by HIV and AIDS. Serving and linking countries in southern Africa, the Alliance 'provides a clear opportunity to capitalize on the synergies, support and partnerships that the UN system can provide'.[44]

7. The complex challenge of safer and more nutritious feeding options for HIV-exposed infants

Safer infant feeding in the context of HIV is a growing problem in desperate need of a solution. Interviewees appreciated that the current WHO/UNICEF guidelines are well-intentioned and formulated with the most current technical information, but complained that they were impractical to implement. In spite of the guidelines, there is still a significant level of confusion on the ground about whether HIV-positive women should breastfeed at all. Of equal concern is the massive gap in human resource capacity (at both clinic and community levels) to support mothers as they make and carry out decisions that will protect their babies not only from HIV infection but from *all* risks associated with infant feeding.

It is exceptionally difficult to meet nutritional requirements in weaning-aged children who are on cereal-based diets even when they are breastfed. Especially as they grow, infants need a range of foods (fruits, vegetables, protein sources) which are often not sufficiently available in cereal-centric cultures. With HIV positive mothers weaning their infants from breastmilk to solid food at six months (which is recommended to avoid HIV infection) there is indeed a need for a 'therapeutic approach' to ensure safe and adequate nutrition.[45] In order to support HIV-positive mothers to safely (and completely) stop breastfeeding their babies at 6 months of age, technical guidance must be supported by access to nutritionally adequate commodities. At present, diets commonly available to non-breastfed infants in resource-constrained environments are poorly constructed and nutritionally inadequate. Among the WHO's Guiding Principles for feeding non-breastfed children 6 to 24 months of age, we find that "meat, poultry, fish or eggs should be eaten daily, or as often as possible, because they are rich sources of many key nutrients such as iron and zinc. Milk products are rich sources of calcium and several other nutrients. Diets that do not contain animal-source foods (meat, poultry, fish, or eggs, plus milk products) cannot meet all nutrient needs at this age unless fortified products or nutrient supplements are used."[46]

We have never before faced a situation that requires mothers in resource-limited settings to wean their infants at six months. Unfortunately, when breastmilk is removed from the equation for infants 6-24 months, we are left with very few options with which to build suitable infant and young child feeding (IYCF) programmes. In the context of HIV and poverty at an unprecedented scale, we now face the challenges of ICYF on a completely different playing field.

There is an urgent need for an affordable, nutritionally appropriate, ready-to-use product that will help mothers through accelerated weaning and protect the nutritional status of infants until they are fully established on solid foods. One field-based staff member described an unsuccessful effort to incorporate corn-soya milk (CSM), which was abandoned because of confusion at government level about

how to authorize its use, while many of those interviewed didn't even know CSM existed. The more ubiquitous corn-soya blend (CSB) is often used as a complementary infant food, but for 6- to 24-month-old infants weaned from breastmilk altogether, it is not nutritionally adequate unless the animal-source foods are somehow added. On a more positive note, a number of products and strategies are being tested at the moment and results are expected within the coming year.[47]

8. Adapting growth monitoring and promotion (GMP) for early identification HIV-positive children

There is a pressing need to train and sensitize growth monitoring and promotion (GMP) volunteers and nutritional rehabilitation unit (NRU) staff to recognize and appropriately refer infants and children for HIV testing and treatment. Growth failure is one of the most common signs of HIV infection in children. Once the growth of HIV-positive children has faltered, it generally takes them longer to recover than their HIV-negative peers. Interviewees noted that without strong growth monitoring and promotion for early identification of HIV-positive children (especially among early weaning/post breast-fed children), they will continue to elude much-needed early intervention for both nutrition and initiation of ART. This point was exemplified by the high prevalence of HIV found among children admitted to NRUs in three countries :

- Mozambique 2006: HIV prevalence among children admitted to the malnutrition ward ranged from 31.5 to 54.5 percent between January and June.[48]
- Northern Uganda 2005: HIV prevalence among children admitted to the nutrition ward was 23.9 percent. HIV-infection was most common in children less than three years of age.[49]
- Malawi 2006: HIV prevalence amongst malnourished children admitted to NRUs was, on average, 21.9 percent (urban areas 34.8 percent; rural areas 13.5 percent).[50]

Given these somewhat shocking findings, expansion of GMP efforts along with guidance on how it can be adapted to a high HIV-prevalence context was suggested by two experts as an urgent need. It is encouraging to note that integrating voluntary counseling and testing (VCT) into the management of malnutrition has been shown in Malawi to have a significant positive impact on children's access to prevention, treatment and support services.[51]

While it has long been acknowledged that NRUs are a potentially risky environment for sick children because of the exposure to the infections that inevitably abound, this becomes especially relevant in high HIV prevalence settings. Community-based Therapeutic Care[52] (CTC) for the treatment of malnutrition offers another entry point for improved case-finding and recovery of vulnerable children (including those who are HIV-positive). Bridging prevention and treatment, a decentralized CTC model has the potential to be greatly influential in the early identification and treatment of HIV-positive children at risk.[53] Community-based forms of ready-to-use, therapeutic take-home rations have added value in this context not only by reducing cross-infection risks but by easing the burden on caregivers.

9. Dependency and sustainability

Concerns about resource limitations and dependency have provoked a call for longer-term interventions that support community coping mechanisms and encourage the ongoing productive activities of households. Experience in southern Africa is showing that **recovery and development programming is best delivered *alongside* safety net programming to ensure a continuum of care for children as their situations evolve.** Where HIV and chronic food insecurity co-exist, there is agreement that short-term food assistance is a crucial component of a comprehensive social protection framework that allows households to stabilize and avoid dissolution. There is also tremendous potential in Food for Work (FFW), Food for Assets (FFA) and Food for Training (FFT) to build community capacity and improve the human resource base while preventing households from resorting to negative coping strategies.[54]

Ensuring food security for the household in which the vulnerable child resides is an important key to reducing or delaying orphanhood,[55] which is a sustainability strategy in itself. Many child-focused programmes, such as SCOPE-OVC (CARE Zambia) and STRIVE (CRS Zimbabwe), have worked closely with partners and sub-grantees (local CBOs working with children and families) to facilitate their access to food resources through WFP or C-SAFE. Neighborhood Care Points (UNICEF/WFP Swaziland) and Community Care Coalitions (World Vision Zambia and Uganda) also provide concrete examples of how community-based targeting, referral, service delivery and monitoring functions can be merged into a seamless model of care.

The National Emergency Response Council on HIV/AIDS (NERCHA) in Swaziland builds on the traditional concept of *Indlunkhulu*, in which food from the Chief's fields is allocated to members of the community who are unable to support themselves, with a particular emphasis on orphans and vulnerable children. The fields are communally attended, and the project provides support for farm inputs to all Chiefdoms through the Ministry of Agriculture and Co-operatives (MOAC). OVC participate in the work to enable them to obtain practical experience in subsistence farming, ensuring them access to important life-skills that are central to the rural local economies of the Chiefdoms. Recognizing that people are hungry before the fields are ready for harvesting, WFP has provided food for immediate distribution during the lean period. Other activities in the NERCHA model demonstrate a comprehensive approach to community-led OVC care, and are described more fully in the Action Aid (2005) document Food Security and HIV/AIDS in Southern Africa: Case Studies and Implications for Future Policy.

Building these practices into existing cultural or government frameworks contributes greatly to their potential for sustainability. The NERCHA[56] approach in Swaziland, for example, links the MOAC with existing social structures such as *Imphakatsi*, or Chiefdoms, to deliver services. **Institutionalization and government involvement of food security and nutrition interventions is crucial to their sustainability.** Real fears exist about the cost of long-term, large-scale OVC and HIV interventions shared by food programmers, educators, health care providers and others. There is a call for UN agencies to lead the way by 'doing the math' with macro-level information about what the actual funding challenges looks like.

Finally, **graduation and exit strategies must be considered early in the conceptual process and refined continuously throughout implementation.** Certain programmes are potentially open-ended (e.g. food for HBC, school feeding) while others are generally offered on a fixed time frame (e.g. FFW, FFA). Where chronic food insecurity and high prevalence of HIV co-exist, graduation criteria for nutrition interventions should be based on anthropometric and clinical criteria (as well as food access and socio-economic criteria), rather than a fixed time frame. Much of our hope for sustainability rests with intentionally building the capacity of local partners, not only to 'manage a food assistance pipeline' but to do so in ways that contribute to their own organizational development, including strategic planning, fund-raising and financial management, human resources management and M&E.

10. The ultimate sustainability strategy – keeping parents alive

A common and very pragmatic response to the trepidation about sustainability is: "If we want children to be fed and healthy, we need to start by keeping their parents alive." While not diminishing the importance of the wage-earning role that fathers generally play and acknowledging that in certain cultural contexts paternal orphanhood can influence malnutrition more than maternal (e.g. the Kenya example given earlier), **it is generally held that mothers hold the greatest influence over what a child eats and how often.** Women's positive influence over household food and nutrition decisions is well-documented, as is their propensity for good caring practices and health-promoting behaviours.

> "We have been so fearful about sustainability and dependency syndrome that we failed to provide food to parents who would have stayed alive longer if they'd had food, especially if something really nutritious like CSB could be included in a household ration. Our HBC staff have begged for food again and again, just to help patients get back on their feet. Their main concern is the children. Feeding the parents is a lot more sustainable than trying to care for all these children who have been orphaned prematurely."
>
> *-- Interviewee from Zimbabwe*

Except in the worst of circumstances, children are most often found in the care of an adult caregiver, and that caregiver is almost always a woman.[57] We know that even when there is food in the home, the caring practices and nutrition knowledge of the caregiver have a huge impact on children, influencing nutritional status, dietary diversification and healthy food choices, immunization status and household hygiene. In fact, their survival is at stake: children age 0-3 are 3.9 times more likely to die during the two years surrounding a mother's death.[58] And for those who do survive, the mother's experience with malnutrition has far-reaching implications. As stated in a recent World Bank publication: "There is also clear evidence that the major damage caused by malnutrition takes place in the womb and during the first two years of life; that this damage is irreversible; that it causes lower intelligence and reduced physical capacity, which in turn reduce productivity, slow economic growth, and perpetuate poverty; and that malnutrition passes from generation to generation because stunted mothers are more likely to have underweight children."[59]

> "A review of a number of studies has shown that substantial reductions in rates of malnutrition, especially among infants and young children who are most vulnerable, can be accomplished through interventions designed to increase women's access to resources that support their income-earning and care-giving roles".
>
> *ICRW (2000)*
> *Enhancing Nutrition Results*

Therefore, investment in the health of HIV-positive mothers (through enhanced access to appropriate health and food security options) has far-reaching benefits. In addition, knowing that children become vulnerable when their parents are ill and that decisions taken during that period (such as the withdrawal of a child from school) can have long-term consequences provides even further incentive to protect the health of the parents with every means possible, including ensuring access to sufficient food. Thus simply supporting efforts to keep children in households is not enough. **A more deliberate strategy that protects and promotes the health of parents, and in particular mothers, is required.**

11. The challenge of scaling up

There is real concern from interviewees and the literature about the challenge of scaling up. Many excellent small-scale model programmes exist, yet little has been done to determine whether it is feasible to scale them up. While the need to scale up is acutely felt, many interviewees (especially field-based staff) worry that scaling up invariably fails because the very essence that made it successful – the in-depth local

knowledge, relationships and, often, the charisma of a single leader who made the difference – is lost. Interviewees suggested that more candid analyses of scaling up that did *not* work would be useful in order to generate more meaningful lessons about how to scale up with success.

It is increasingly likely that we will not be able to scale up through a standard 'multiplier effect' simply because there is no one right way to ensure food and nutrition security to vulnerable children and their families. **Communities engage in hundreds of different strategies to protect and feed children – we need to support them all.** There is no one right answer, no tidy package, but instead a plethora of solutions and coping strategies, each responding to the needs of the community that devised them. As one expert put it, "Order, classification and structure must yield to what might seem like anarchy but in reality is 'planned chaos.'"[60] This does not mean there is no system – in fact, there is a need to create and strengthen systems that coordinate, lead and measure responses at local, national and international levels.

> "Many people talk about scaling up as if it's just a simple matter of multiplication – to reach a certain target number of people. But it's not that easy. The very ingredients that often make up successful community programs, such as investment in local resources and partnerships, may be lost if you just try to increase the scale. That's why some frontline providers advocate for more of a patchwork quilt, in which you create a quilt of myriad successful community- based initiatives, versus a huge blanket."
>
> *-- Anne-Christine d'Adesky, Women's Equity in Access to Care & Treatment Initiative*

What More Can We Do to Improve Programming?

1. Revitalize nutrition education as a core strategy

While this may seem passé or self-evident, there is overwhelming evidence that we need to re-dedicate ourselves to this forgotten intervention. Nutritionists and child survival programmers welcome the current momentum behind nutrition education, applauding both the World Bank's and WHO's recent announcements that they are throwing their weight behind this simple but much-needed strategy. Small-scale better-practice examples abound, demonstrating that in the context of comprehensive child survival and HIV programming, relatively inexpensive nutritional education programmes are successful in preventing morbidity and mortality among infants and children, regardless of HIV status. Agencies that implement food programmes could investigate the potential of food-assisted nutrition training for teachers and community health volunteers. Schools and community early childhood care settings, MCH and PMTCT programmes, HBC programmes and food distribution points could greatly benefit by going beyond simply providing 'nutrition messages' and expanding to nutrition education and related skill-building.

2. Adapt growth monitoring and care programmes to respond to HIV

It is clear, at least in high-prevalence countries, that HIV infection rates among children at NRUs are sufficient to warrant a significant effort to expand GMP and NRU services and adapt protocols to ensure that these children are identified as early as possible. Building on early identification, programmes need guidance on the management and care of identified children (and their families) as close to home as possible, and on making appropriate referrals when necessary. Guidance on how to adapt existing mechanisms to be more responsive should include incorporating VCT and establishing appropriate referral networks, especially in high HIV-prevalence settings.

3. Improve access to RUF and RUTF

There are a number of ready-to-use food (RUF) and ready-to-use therapeutic food (RUTF) products under development and a few in production. Intermittent donations of RUTF components (by WFP and other

donors) in Malawi have been helpful in the short term but had serious long-term consequences on pricing. Experts believe that it will be much more effective and sustainable to stimulate local market production of RUF and RUTF products, with subsidized pricing derived through a carefully designed process of competitive local purchase. In essence, it is possible (and worthwhile) to subsidize the purchase price by supplying a component (dried milk powder, for instance), but maintaining a level playing field for all competitors is essential. Healthy competition would help keep cost to the consumer down, and building local production capacity would help to ensure availability of products for rapid deployment during emergencies.

5. MONITORING AND EVALUATION: OVERCOMING THE BARRIERS

What We Know about M&E for OVC Programmes

1. Emphasis on care and protection

Several interviewees contended that it would be extremely useful to have more information on the effect of food support on the food security and livelihood status of OVC. However, this view was carefully balanced with an appreciation and an admonishment that food should not be seen as an isolated benefit. Instead, both current literature and OVC programmers interviewed noted that food, like any material benefit, is one of many inputs which should aim to contribute to the care and protection of OVC.

This holistic viewpoint on programming also translates to monitoring and evaluation – e.g. how food contributes to creating a protective and caring environment. Even for older OVC, it was noted that "it is wrong to assume that care is unimportant." Increasingly, the real purpose of providing food is to create a protective environment for the child or young people, hence the need to emphasize indicators that reflect this goal.

Along these lines, a range of other indicators *not* related to food security or nutrition are commonly used for monitoring of school feeding, ECCD programmes, PMTCT, and training of OVC in life, agricultural and vocational skills. Some of these indicators are measured at the programme level (e.g. participation/ attendance in skills training, ECCD, primary school and food-for-listening), and uptake of the programme (e.g. PMTCT). Others are measured at the beneficiary level (e.g. improvement in school performance, reintegration with family, improved knowledge/understanding of prevention and behaviour change).

Keeping a child within a family unit, in school, and improving participation in healthy, appropriate and supervised after-school activities (limiting their exposure to risk, exploitation and abuse) were repeatedly emphasized as an indicator for successful programming.

A review of WFP THR programmes in 12 countries revealed the following list of indicators, in order of frequency used:

- ✓ attendance and enrollment in school
- ✓ attendance and enrollment of orphans (as distinguished from the general student population)
- ✓ exam results for food and non-food recipients (one case)
- ✓ incidence of reintegration of orphans with foster families (one case)

The stated goal of most of these programmes was to improve school attendance among vulnerable children. While food insecurity was commonly used as part of geographic targeting, only one programme used household food security indicators as part of project monitoring, and another mentioned its struggle to capture household food security with monitoring at schools.

Staff from one large OVC programme noted that they also do not examine the outcome or impact indicators of food and nutrition support, but instead, and understandably, focused on monitoring the effect of the overall care and protection package – primarily on the psychosocial and capacity-building aspects of the interventions. For OVC programmers in general, food was seen as an add-on to OVC programmes – something that complemented, provided an incentive for, and added value to the core programme, but did not necessarily drive or influence its primary goal. Most expected the food provider, in these cases WFP, to handle the M&E of the food component, while they (the NGO implementing the

OVC programme) focused on the indicators required by their primary donor – President's Emergency Plan for AIDS Relief (PEPFAR), UNICEF, USAID or other.

2. Including standardized food security indicators

While the role of food in OVC programming was generally seen to be in support of care and protection outcomes, there was considerable uncertainty and debate around whether food security should be monitored as well. After all, food insecurity is the entry point for food programming and there is a perceived need to understand and monitor the extent to which OVC remain food-insecure (or become more food-secure) over time. In a comprehensive OVC programme, however, assigning attribution (for success or failure) is very difficult since inputs and activities are deliberately designed to be interdependent. This makes separating out the specific outcomes and impact of the food security or nutrition intervention challenging.

Furthermore, there was sense among some interviewees that when food is used as an input (for *any* type of programme), some standardized food security (e.g. food access) indicators should be monitored. For example, food is used to support ART primarily to promote drug adherence and efficacy. However, in the more comprehensive ART programmes, e.g. the Academic Model for the Prevention and Treatment for HIV/AIDS (AMPATH) in Kenya and The AIDS Support Organisation (TASO) in Uganda, food access indicators are also used to determine eligibility and the need for extended receipt of rations beyond the initial period.

The inclusion of standardized food access indicators (e.g. dietary diversity) across all HIV-related food programs – including OVC – is currently being discussed and proposed for inclusion in the draft HIV M&E Framework and Indicator Matrices for WFP. Incorporating food security indicators in post distribution monitoring systems (PDM) and end-use monitoring (EUM) was suggested as a relatively inexpensive means of gathering information (see example, on the following page, of the adoption of EUM for monitoring C-SAFE school feeding). One interviewee noted that while these tools can be effective for larger food programmes, OVC programming usually consists of many small (e.g. 50 OVC per site) and geographically distant distribution points, undermining the financial viability of applying these tools.

3. Household-level food security monitoring

Where food security indicators are included in M&E systems for OVC programmes, there are significant challenges. Food security programmes have become fairly adept at measuring the food security status of vulnerable households using relatively efficient indicators and indices such as: the Coping Strategy Index[61] (to gauge changes in frequency/severity of negative coping strategies); the Food Consumption Score (to gauge dietary diversity); and the Asset Ranking systems (to monitor accumulation or depletion of assets).

We know that these are relatively accurate indicators of food security. However, the challenge with most of these indicators is that they measure at the *household* level, and not at the level of the individual child being targeted. Given the considerable mention of intra-household discrimination in the studies reviewed (see Chapter 1), we cannot be certain that the results generated by these tools necessarily apply to the status of the vulnerable child residing in that household (i.e. while the overall household may exhibit an acceptable level of food security, the child's situation could be worse due to discrimination).

4. Time and financial constraints

As in M&E for other sectors, two constraints repeatedly mentioned with regards to M&E for OVC were time and money. In one southern African country, WFP has more than 60 partners, many of which are relatively small FBOs with little or no training in M&E. Developing the capacity of these partners for collecting and analysing data is simply beyond the budget of WFP as well as that of several international NGOs interviewed. Moreover, M&E is not a priority or, in the opinion of interviewees, the best use of the comparative skills of local partners who specialize in caring for OVC. Obtaining output reporting (number of OVC receiving rations) is the most that can expected, and even that is not extremely accurate since partners often report the same numbers from month to month, instead of investing the time and money to create systems that will collect accurate numbers. The bottom line is that financing for strong M&E is frequently inadequate.

What More Can We Do to Improve M&E

1. Develop child vulnerability indices/scales to compare and track progress holistically

Interviewees noted that while various indicators are promoted and required by donors to measure certain aspects of child vulnerability (e.g. psychosocial support), there has been less focus on developing tools to measure vulnerability in a holistic manner. Constella Futures (previously Futures Group) has developed one such tool called the Child Vulnerability Index (CVI) which is used to gauge child vulnerability in several 'domains': 1) food security; 2) shelter and care; 3) protection; 4) health and wellness; 5) psychosocial; and, 6) education and skills. The rating system is fairly simplistic but represents a good effort to gauge the 'overall' vulnerability of the child.

The tool was designed to help summarize complex information in a comparable manner (using the domain scores) and can be used for mapping and setting geographic priorities; or for tracking the development of children on the multiple domains over time.[62]

2. Engage children in measuring food security

As noted earlier, interviews with field staff revealed that not being able to get an accurate read on the food security situation of OVC (due to biases in intra-household distribution) is a significant limitation that has yet to be overcome. Both the literature and several interviewees suggested going 'straight to the source' (the child) for information on children's status and experience. While some interviewees expressed skepticism about the approach due to the child's age/maturity and limited understanding of the issues, there were compelling examples of where this was being done effectively by adjusting the language of the interview to the level of the child.

C-SAFE - Listening to Children

By describing food-insecure friends as 'having small, long, and weak bodies,' or as being 'timid and standing alone in the playground,' children proved perceptive of the realities in many food-insecure communities in Zimbabwe.

By virtue of who they are – being sensitive and vulnerable to shocks including food shortages and disease outbreaks – children's perceptions are powerful indicators of the health, quality of life and well-being of their companions and the community at large. According to one NGO M&E officer in Zimbabwe, "Unlike adults who may have a hidden agenda when responding to questionnaires regarding their level of wealth, food security status and general well being, children tend to be more honest and respond to questions based on their level of understanding of the question and their knowledge of the situation."

C-SAFE's 'Listening to Children' used focus groups with school-age children as part of its larger End-Use Monitoring process to understand perspectives of children about school feeding programmes, and gain greater insight into the food security situation within beneficiary households.

WV's Hope Initiative (2005 in Uganda and Zambia) and CRS STRIVE (2002 in Zimbabwe) engaged children on questions of food insecurity for their baseline surveys. And C-SAFE (2004 in Zimbabwe) also held focus group discussions with children as part of their monthly EUM in an exercise called 'Listening to Children' (see box on previous page). Furthermore, in a recent document on promising practices in M&E, CRS describes the use of **'Station Days'** (see box at right) to elicit information from children on various issues, including measuring weight and height. And finally, Cape Town University's study on Health and Social Services engaged children in a comprehensive situation analysis on the needs of orphans and other children affected by HIV and AIDS. The literature emphasized that these exercises can help to obtain a sense of trends in intra-household food distribution within a particular context, as well as how the child's perception of being 'food secure' might differ from that of an adult head of household.

CRS – M&E Station Days

Working with children adds an additional complication to the M&E process: getting children to sit still long enough for monitors to collect accurate information. 'Station days' make data collection enjoyable for the children.

During the station day, school-aged children are brought to a specified location where they participate in different stations that either collect or distribute information. For example, children might rotate from height/weight measurements, to playing an HIV prevention game, to answering survey questions on psychosocial support, and then finish by attending a presentation on personal hygiene where they are given a bar of soap.

By combining M&E with participatory activities for the children, station days have proven to be an effective means of collecting data in a non-'extractive' and participatory manner, both in urban and rural settings.

3. Develop qualitative approaches where quantitative ones are not feasible

Interviewees suggested that given the significant limitations of quantitative approaches to measuring food security and nutritional status of OVC, more should be done to develop acceptable qualitative methods that can be used as reliable proxies. Developing standardized questions around 'perceptions' of hunger/food insecurity/ill-health and experimenting with the 'most significant change' methodology were mentioned. Finally, it was noted that use of anecdotal testimonies was often avoided due to the difficulty in validating their representativeness. However, in absence of empirical data on the local health, nutrition and/or food security situation of OVC, one interviewee encouraged practitioners to embrace anecdotal evidence, suggesting that "often all you can get is anecdotal, but this is the basis to start programming." Furthermore, a documented and somewhat orderly collection of anecdotal evidence also provides a basis on which to design a quantitative tool.

4. Improve monitoring of HIV-exposed infants

With the rollout of PMTCT programming now taking hold, there is a tremendous need to strengthen postpartum monitoring of mother-infant pairs to provide early HIV infant diagnosis and ensure that other clinical protocols are followed. In many countries, the availability of pediatric ART has increased dramatically; thus ART programmers welcome any assistance in identifying HIV-positive children for care and eventual treatment. An examination of the local context (HIV prevalence, clinical capacity for infant testing and care, degree of stigma, level of food insecurity) will inform food assistance programmers about how to apply their resources to improve monitoring and care of HIV-exposed infants and children. In addition, strengthened PMTCT monitoring systems could fill a critical information gap about the medium- and longer-term well-being of these children and their mothers.

5. Seek opportunities for prolonged follow-up

Investments in the care and protection of OVC (including the provision of food and nutrition support) are long term in nature. As pointed out by OVC programmers, the impacts may not be visible for long after

the child/young person 'graduates' from participation in an intervention, and/or the programme exits a given area.

This points to the need for prolonged follow-up and 'longitudinal' analysis of children to better understand how various types of *events* and *interventions* affect the decisions that children make over time and how those decisions play out in terms of helping them to become healthy and productive adults and parents. For example, prolonged follow-up can show us the nutrition-related, long-term effects of orphaning (e.g. stunting) and allow us to see the effect on height long after the parental death has occurred, controlling for factors that might influence stunting *prior* to orphanhood.

> The 2005 World Bank study (by Beegle, De Weerdt and Dercon) entitled 'Orphanhood and the Long-run Impact on Children' makes an important observation:
>
> "Studies of long-run impacts and outcomes are rare. Certainly, understanding short-run outcomes is important, but short-run effects may not ultimately translate into worse welfare outcomes in the long run (that is, in adulthood). If the shock of an adult death (either a parent or other household member) is transitory, outcomes may be affected around the time of illness or during a period of funeral/ mourning, but may recover over time. On the other hand, the lack of any short-run effects is not evidence that long-run impacts do not exist. Understanding these long-run impacts is critical for intergenerational models of the macroeconomic impact of AIDS which take into account the impact on human capital formation and its transmission between generations."

This commentary is not only relevant to negative events (e.g. death of a parent) that occur in the life of a child but also to *positive* events (e.g. participation in programmes that aim to improve infant feeding practices or provide training in life skills, and leadership and vocational skills).

While the need for prolonged follow-up was unanimously encouraged, there were many questions from practitioners on how this could be achieved from a practical standpoint. Unfortunately, funding for post-exit evaluations as well as longer-term follow-up is not abundant, with donors for most programmes imposing a strict spending timeline on implementing agencies. Following programme participants into adulthood to understand how interventions have helped them requires the support of special interest groups, and even then, at what point do we measure 'impact' and what indicators do we use?

6. SUMMARY OF PROMISING PRACTICES AND RECOMMENDATIONS

In Search of Promising Practices

Research for this paper included a review of over 100 documents, and interviews with many of the key actors – both field- and headquarters-based – in the area of OVC programming. The intent was to document what we already know; what more we can do; and what 'promising practices' exist in support of orphans and other children affected by HIV and AIDS' with respect to food security and nutrition.

For the most part, the review identified an array of innovative ideas and good intentions. However, these were rarely supported with documented evidence of success. Opinions regarding 'what works' were frequently contradictory, with documentation from the field often carefully constructed to attract donor and media interest and containing limited objective analysis. Finally, where reviews or evaluations were done, their conclusions rarely captured the success (or failure) of graduation and exit strategies – which would begin to provide insight to the longer-term outcomes and impacts of these interventions.

Thus, despite the volume of written material, there remains a dearth of honest analysis and exposure of the lessons learned (both triumphs and mistakes). This is, of course, understandable in a competitive environment where resources are typically scarce, funding cycles are short, and those closest to the programming are working flat out to deliver against targets.

The following categories of interventions emerged from this review as warranting further investigation/ review in order to determine whether they are indeed sufficiently 'promising' to be advanced as models for replication, scaling up and/or further promotion.

- ✓ **Models of livelihoods and life-skills training for OVC in- and out-of-school youth (to fill intergenerational knowledge gaps)**, such as Junior Farmer Field and Life Schools and Mobile Farm Schools: in particular, to understand targeting, implementation processes and challenges; and assess graduation and exit strategies, and post-project impact;
- ✓ **Models of PMTCT Plus programmes**: in particular, to understand the impact of food assistance on programme uptake, adherence by and outcomes for mothers and infants from prenatal to 24 months postpartum;
- ✓ **Models of integrated growth monitoring, promotion and care programming adapted to HIV prevalence** (both high and low): in particular, to illuminate the process of adaptation to different settings, to describe various models of integration, and to better understand how to improve the effectiveness of referral mechanisms in an HIV context;
- ✓ **Models of comprehensive, community-led OVC care,** such as Neighborhood Care Points, Community Care Coalitions and NERCHA: in particular, to understand the process of implementation and the elements required for scaling up;
- ✓ **Models of alternative primary education for out-of-school children**, such as Food for Listening: in particular, to understand targeting, implementation processes and challenges, graduation and exit strategies, and post-project impact;

Monitoring and evaluation. In addition to the topics listed above, emphasis should be placed on examining existing M&E tools and systems, since without valid indicators and viable systems for collecting, analysing and interpreting data, long-term learning aimed at improving outcomes and bringing these interventions to scale will be jeopardized. Specifically, the interventions should: (i) apply holistic M&E tools for measuring progress of children/youth over a range of domains in addition to food security or nutrition specific measurements (where relevant to the intervention objectives); (ii) engage children wherever possible in M&E; (iii) apply qualitative approaches where quantitative ones are not viable; and

(iv) encourage prolonged follow-up of children/youth who have graduated from the programme (see Chapter 5 for details on each approach). Finally, the review should not only assess the strength of the M&E systems for the models/interventions in question, but *the review itself* should utilize/role-model these M&E approaches.

Graduation and exit strategies. A review of the various models should pay special attention to whether outcomes are sustained beyond the period of participation (beneficiary graduation strategies) and beyond the life of the intervention (exit strategies). It will therefore be necessary to include interviews with graduates of programmes, and to look at areas where an intervention has since phased down, out or over.[63] For example, for graduates of the Junior Farmer Field Life Schools, questions to be answered would include whether or not graduates have gone on to: secure employment; access land; apply the agricultural (or other vocational) skills that they acquired; remain HIV-free; and generally pursue viable livelihood strategies.

Finally, it would be useful to create a 'catalogue' of similar interventions that fits within each model category listed above. The catalogue could provide sufficient analysis to allow the user to compare and contrast various methodologies, capturing key elements of implementation such as minimum staffing/financial resource requirements, timeframe/length of cycle, predictable pitfalls, relevance to high/low HIV prevalence, etc. This would require the selection of a limited number of options and an investment in field work to elicit the information required. While a desk review (such as the one conducted for this report) can offer an overview of issues and options, it cannot provide direction on programme strategy decisions without evidence supported by on-site observation and interviews with beneficiaries and local stakeholders, etc.

Summary of Recommendations

The Situation

- ✓ **Accept global ambiguity:** Evidence of a generalized relationship between orphanhood and nutritional status remains tenuous. Differing findings on nutrition and food security across various settings/cultures are perfectly reasonable to expect since some societies have greater ability to protect and care for OVC than others. Accepting global ambiguity and improving our ability to characterize the situation locally will contribute to better programming.
- ✓ **Understand terminology:** A first step toward ensuring that we are comparing apples with apples is to define our terms, and to understand where definitions of OVC must be common, and where they will justifiably vary.

Targeting

- ✓ **Exploit and expand GMP and NRU services:** These services are under-rated entry points for more comprehensive care of children and families and should be exploited and expanded for early identification of HIV-positive infants and children.
- ✓ **Support PMTCT and PMTCT Plus programming:** These programmes target not only mothers and babies but also, by extension, fathers and other children at home. Food support serves to increase programme uptake, bolsters ongoing activities, and helps to maintain contact with mother-baby pairs until they are safely through this vulnerable period of potential infant exposure to HIV.
- ✓ **Seek out pediatric hospices/day-care facilities, and transition and foster-care programmes:** These facilities and programmes serve some of the most vulnerable children. Ensuring that food and nutrition resources go to the right partners can free up resources for other high-priority needs such as medication, clothing and transportation.

Programming

- ✓ **Revitalize nutrition education:** This should be a core strategy: Relatively inexpensive nutritional education programmes are successful in preventing morbidity and mortality among infants and children, regardless of HIV status.
- ✓ **Adapt growth monitoring and care protocols to respond to HIV:** Normalized management of HIV-positive under-fives and their families is a natural extension of traditional GMP, NRU and CTC programming. Adapted protocols and functioning referral mechanisms are required to take successful pilots to scale.
- ✓ **Improve sustainable access to RUF and RUTF products:** Local market production of RUF and RUTF products could be stimulated with subsidized pricing derived through competitive local purchase of the more costly components.

Monitoring and Evaluation

- ✓ **Promote holistic M&E:** The contribution of food cannot be seen as an isolated input. There is a need to apply M&E tools that measure child vulnerability in a holistic manner – covering progress on a variety of domains (e.g. food security, health and wellness, psychosocial) over time.
- ✓ **Engage children:** Discrimination and biases in intra-household distribution make it difficult to get an accurate read on the food security situation of OVC using traditional monitoring. Engaging Children in M&E has the potential to overcome this challenge.
- ✓ **Develop qualitative approaches:** Given significant limitations of quantitative approaches, more should be done to develop acceptable qualitative methods such as exploring 'perceptions' of hunger/food insecurity/ill-health, 'most significant change' and anecdotal evidence.
- ✓ **Monitor HIV-exposed infants:** With the rollout of PMTCT programming now taking hold, there is a tremendous need to strengthen postpartum monitoring of mother-infant pairs to provide early HIV infant diagnosis and ensure that other clinical protocols are followed. In addition, strengthened PMTCT monitoring systems could fill a critical information gap about the medium- and longer-term well-being of these children and their mothers.
- ✓ **Prolonged follow-up:** Investments in care and protection (including food and nutrition support) are long term in nature and the impact may not be visible until many years later. Opportunities for prolonged follow-up to see how events/interventions play out in terms helping young people to become healthy and productive adults (and parents) are urgently needed.

Final Thoughts

There is mounting pressure to deliver strong programming to orphans and other children affected by HIV and AIDS. This review revealed an overwhelming sense of frustration about the lack of options with proven success in terms of achieving sustainable outcomes. At the same time, there was absolute clarity that multi-sectoral approaches must be put in place (not simply discussed or envisioned) where food is viewed as one of many inputs to a holistic care and protection package. Strong partnerships and investment in capacity stood out as absolutely key. Standard operating procedures, checklists and practical tools are needed to guide implementation, and opportunities for learning and sharing experiences are also required. In all of these efforts, there is an expectation that the leadership and technical supervision will be provided by UN agencies.

There was also a sense of relief and anticipation that food insecurity and poor nutrition are beginning to capture attention and that there is real momentum at policy level. The World Health Assembly recently adopted a resolution[64] requesting countries to include nutrition as an integral part of the overall response to HIV by identifying nutrition interventions for immediate integration into HIV

programmes. The United Nations General Assembly also passed a Political Declaration on HIV/AIDS.[65] The Inter-agency Working Group on Food and Nutrition, chaired by Office of the US Global AIDS Coordinator (OGAC), is investigating ways to expand the existing partner base and to 'wrap around' other agriculture, food security and nutrition activities, particularly those of the United States Department of Agriculture and USAID, as well as WFP and other UN agencies. The World Bank also recently released its new framework for action, "Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action," intended to reinvigorate dialogue regarding what to do about malnutrition and encourage the development community to reevaluate the low priority it places on nutrition. Decisions are being made now that will shape food security and nutrition programming for the next several generations: we need to be sure that the voices of today's OVC help drive relevant and effective strategies.

Annex A: Summary of Surveys on Orphans and Other Children Affected by HIV and AIDS[66]

1. Zimbabwe – 2002 (Baseline Survey for Catholic Relief Services STRIVE programme[67])

Survey results demonstrate that the presence of orphans in a household is an indicator of household food insecurity, and that the level of food insecurity correlates with the number of orphans residing in the household. Households with no orphans had a 35 percent likelihood of reporting never having enough food. Thirty seven percent of households with one orphan, 41 percent of households with two orphans, and 47 percent of households with three or more orphans report never having enough food. The study noted, however, that these and other differences in food security reported do not necessarily imply that 'orphanhood' *per se* is disadvantaging the children, or that the 'presence of orphans' is necessarily disadvantaging households that care for them. Other factors correlated with orphaning may partially or fully explain the differences in food security rates.

Several demographic factors, for example, were also important determinants of food insecurity. "Having a female-headed household and having a larger household led to higher probabilities of food inadequacy, while having an older head of household led to lower probabilities." The overall effect of economic variables is as expected – better-off households have lower probabilities of being food-inadequate. The proxies for income and wealth used were stronger predictors of food insufficiency. For example, an orphan living in a household with a brick and corrugated steel house with piped-in-water and a flush toilet, and whose head of household is a skilled worker, has only a 17 percent probability of never having enough food, whereas on average an orphan has a 44 percent probability of never having enough food.

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2. Malawi – 2003 (Catholic Relief Services Malawi – Project Baseline in Central Region of Malawi)[68]

The number of months that households could meet their food demand with their current harvest was correlated significantly with the presence of persons living with HIV and AIDS (PLHA) and AIDS orphans in the household. Households with PLHA and AIDS orphans were significantly more food-insecure than non-affected households. The analyses also demonstrated that quality of life (QOL), (using a QOL Index) was associated with whether or not the household had sold assets in the previous three months, and whether their current harvest food supply was above or below average supplies. Decreased quality of life scores were also significantly associated with the presence of PLHA[69] and the presence of orphans in the household.

3. Malawi (Catholic Relief Services analysis of various secondary data sets over the last five years)[70]

The reported data demonstrate that approximately 30 percent of households in Malawi care for orphans, with an increasing percentage of these orphans being double orphans. Though much has been written on the existence and vulnerability of child-headed households (CHH), data show fewer CHH than previously estimated. Demographic analyses of CHH demonstrate the majority is composed of single orphans (deceased mothers; fathers living outside the household). Orphans were also significantly less likely to be enrolled in school, and 'asset poor' households were significantly more likely to host OVC. Finally, households with OVC were shown to exhibit increased negative coping strategies.

4. Soweto, South Africa – 2006 (Survey by University of Witwatersrand and Johns Hopkins University)[71]

This is the first significant survey on the effects of adult morbidity and mortality on children residing in Soweto in the era of HIV and AIDS. In 'sick households', defined as households where at least one sick adult resides, child health was adversely affected (increased vulnerability to disease and incomplete immunizations); children were less likely to have their school fees paid; more likely to be absent from school and unsupervised while doing homework; more likely to go hungry; and less likely to eat meat daily than children from non-sick households. Abuse also occurred more frequently in sick households.

Comparing orphans and non-orphans, the survey found that although immunization rates in Soweto are high, the likelihood of 'no immunization' was higher for orphans than non-orphans. Orphans were also more likely to go hungry a few times a week, more likely not to eat before going to school, and more likely to face abuse.

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5. Southern Africa – 2003-2004 (C-SAFE/WFP Community and Household Surveillance (CHS))[72]

A regional analysis (Lesotho, Malawi, Mozambique, Swaziland, Zambia, and Zimbabwe) of three rounds of CHS data during 2003 and 2004 found that there was *no significant difference* between orphan and non-orphan households in terms of the Coping Strategy Index (CSI) [73]. In a similar vein, the data also showed that the Food Consumption Score (FCS) was higher (indicating better dietary diversity) for orphan households than for non-orphan households. The report notes that these findings may reflect the fact that orphan households were targeted for food assistance in the areas where the surveys were implemented. The study did not analyse whether the *number* of orphans in a household affects the level of food insecurity, only whether the household was 'hosting' orphans.

The study also found that for households with chronically ill members, the mean CSI was *significantly higher* than for households without chronically ill members (suggesting households with chronically ill members were less food-secure). There was, however, no significant difference in FCS between households with and without chronically ill members. Finally, the report found that *asset ownership provided the best overall indicator* of vulnerability to food insecurity – with asset ownership highly correlated to both the CSI and the FCS; and a stronger indicator of food insecurity than chronic illness, presence of orphans and gender of head of household.

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6. Zimbabwe – 2005 (*preliminary draft* Baseline Survey by the Government of Zimbabwe and UNICEF)[74]

This survey applies a narrow definition of OVC,[75] which includes only orphans and those directly affected by HIV and AIDS. It uses the ten categories of indicators recommended by the UNICEF/UNAIDS (and partners) "Guide to M&E of the National Response for Children Orphaned and Made Vulnerable by HIV and AIDS," and is believed to be the first to operationalize those guidelines in a national survey.

The survey found that across the 21 districts of Zimbabwe, over 40 percent of children under 18 were either orphaned *or* vulnerable (thus 'OVC'); and 30 percent were orphaned. Notably, the large majority of the orphans had become orphans in the last four years, with 19 percent experiencing the death of a parent in the last 12 months. Orphaning was also found to cut across rural and urban areas, with 31 percent in rural areas and 28 percent in urban areas. Another striking point that emerges from this survey is the extreme variability in living arrangements (e.g. residing with surviving parent or extended relatives) for orphans across districts, demonstrating how caring practices are not necessarily homogeneous, even within the same country.

In terms of nutritional status, orphans, particularly maternal orphans, were *more likely to be stunted* than non-orphans (OVC 33 percent, non-OVC 28 percent and maternal orphans 43 percent). While school attendance remained strong for both orphans and non-orphans in the 10-14 age group, double orphans were slightly more disadvantaged. Finally, OVC were 30 percent less likely to access appropriate health care services than non-OVC.

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7. Uganda and Zambia – 2005 (World Vision Hope Initiative Baseline Survey)[76]

In Zambia, 65 percent of OVC were likely to have skipped meals during the past 30 days vs. 48 percent of non-OVC. Similarly, in Uganda, the comparable statistics were 51 percent vs. 40 percent. Indicators such as 'cut the amount of food' and 'did not eat for the entire day' revealed similar disparities. Focus group discussions with OVC, non-OVC and adult caregivers revealed frequent mention of abuse and discrimination of OVC, especially those who were ill, or whose parents had died of AIDS-related complications. OVC was defined an orphan, disabled child, or a child whose parent has been chronically ill for the past 12 months and/or living in a household where an adult member died past 12 months.

Notably, households with orphans were significantly more likely than those without orphans to be headed by women and elderly (over 65 years) caregivers. In both the Uganda and Zambia surveys, households caring for orphans generally kept a significantly higher number of children than households without orphans. Discrimination of OVC in relation to non-OVC (within a household) was featured as prominent issue in the focus group discussions and was noted by OVC, non-OVC and adult caretakers alike. Examples varied from what was perceived as outright exploitation to a 'natural' tendency of parents to prioritize their biological children in the face of extremely constrained resources.

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8. Sierra Leone – 2005 (Situation Analysis by the National OVC Task Force (Government of Sierra Leone, UNICEF and partners)[77]

The current estimate of HIV prevalence is 2.9 percent. Despite this relatively low figure, 14 percent of children are orphans, mainly due to the consequences of war and extreme poverty. In focus group discussions, the majority of orphans, non-orphans and adults reported a range of differences between the way orphans and non-orphans are treated with respect to access to food, both in quality and quantity; access to schooling; amount of domestic work; trading and farming undertaken; love and emotional support; clothing conditions; access to healthcare; provision of shelter and bedding; and physical violence and emotional abuse.

Nearly every orphan interviewed reported discrimination between themselves and their caretaker's children. The taking in of orphans for use as cheap labour and acquisition of their property or entitlements was commonly cited as a concern by all three groups. Notably, the report concluded that the needs of children orphaned by AIDS are not so very different from those of other children living in difficult circumstances, and should not be prioritized on this basis.

Other Studies: Other studies included in the literature review, but not summarized above are:

9. Malawi – 2006 (PRRO Integrated Support to HIV/AIDS Infected and Affected People in Eight Districts in Malawi – Baseline Survey Report)[78]
10. Lesotho – 2004 (OVC Rapid Assessment Analysis and Action Planning (RAAAP)[79]
11. South Africa – 2003 (Health and Social Services to Address the Needs of Orphans and Other Vulnerable Children in the Context of HIV/AIDS, Children's Institute of the Univ. of Cape Town)
12. South Africa – 2006 (A Situation Analysis of Orphans and Vulnerable Children in Four Districts in South Africa, Human Sciences and Research Council)[80]

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Annex C: Literature Review Reference List

1) ACDI/VOCA. 2004. *Mid Term Evaluation of the Title II HIV/AIDS Initiative in 11 Sampled Districts.* Kampala, Uganda: Ssemwanga Group.

2) ActionAid International. 2005. *Food Security and HIV and AIDS in southern Africa: Case Studies and Implications for Future Policy*. Johannesburg: Southern Africa Partnership Programme.

3) Barnett, T. *HIV/AIDS and Vulnerability: Sundering the Bonds of Human Society*. UNAIDS/IDS Vulnerability Workshop Outline paper. London: Development Studies Institute, London School of Economics & Political Science.

4) Beegle, K., De Weerdt, J., Dercon, S. 2005. *Orphanhood and the long-run impact on children*. Retrieved from http://www.economics.ox.ac.uk/members/stefan.dercon/orphans%20Kagera%20Beegle%20DeWeerdt%20Dercon.pdf

5) Binami, S., et al., ORC Macro, Understanding the positive association between household wealth status and HIV prevalence in sub-saharan Africa, 2006.

6) *Bissrat, Z.* (undated) PEPFAR Ethiopia: *HIV/AIDS OVC Wrap-around programs*—a powerpoint presentation. USAID.

7) Canahuati, J. 2004. *Basic Principles for food-assisted programs in the context of HIV/AIDS*. Presented at Entebbe, Uganda, November 2-5, 2004. Retrieved from www.fantaproject.org/publications/hiv_foodaid2004.shtml

8) CARE. July 2004. *Strengthening and Scaling up the Hope for African Children Initiative: A brief overview*. Atlanta: CARE.

9) CARE. (undated) *Mainstreaming Economic Development and Food Security With HIV and AIDS: Experiences from Malawi.* Atlanta: CARE USA.

10) CARE. 2005. *Poverty, Vulnerability, and HIV/AIDS Mainstreaming in Lesotho*. Livelihoods Recovery Through Agriculture Program (LRAP) and Secure the Child (STC). Atlanta: CARE.

11) CARE (undated) *Household Livelihood Security through an HIV and AIDS Lens: Uncovering and Influencing the Two-Way Link: Experiences from Angola and Mozambique*.

12) C-SAFE/WFP. 2004. CHS Regional Analysis, prepared by Tango International.

13) Chilima, Dr. D.M. 2006. *Protracted Relief and Recovery Operation (PRRO): Integrated Support to HIV/AIDS Infected and Affected People in Eight Districts of Malawi-Baseline Survey Final Report*. Lilongwe: WFP.

14) Constella Futures Group. 2006. *Building the Response to Orphans, Vulnerable Children, and Other Children in Need*. Washington, DC: Constella Group-International Development.

15) Crampin, A.C., Floyd, S., Glynn, J.R., Madisec, N. Nyondoa, A., Khondowea, M.N., Njokaa, C.L., Kanyongolokaa, H., Ngwiraa, B., Zabab, B., Fine, P.E.M. 2003. The long-term impact of HIV and

orphanhood on the mortality and physical well-being of children in rural Malawi. *AIDS 2003*, 17:389–397.

16) CRS, 2002. Abstract. Analysis of 2002 STRIVE data, CRS.

17) CRS. 2004. *Economic Strengthening: Discovering and Utilizing Sound Practices*. Baltimore: CRS.

18) CRS. 2004. *Food Security: Discovering and Utilizing Sound Practices*. Baltimore: CRS.

19) CRS. 2004. *Monitoring and Evaluation: Discovering and Utilizing Sound Practices*. Baltimore: CRS.

20) C-SAFE and WFP. 2005. *C-SAFE Regional Analysis: Household Vulnerability and the Impact of Food Aid.* Prepared by Tango International.

21) Dananai Child Care Organisation (DACHICARE). 2006 *Baseline Survey for the Food and Nutrition Plan (FANUP.)*

22) Masvingo, Zimbabwe: DACHICARE.

23) Davids, A., Letlape, L., Magome, K., Makgoba, S., Mandivenyi, C., Mdwaba, T et. al. 2006. *A Situational Analysis of Orphans and Vulnerable Children in four districts of South Africa.* Skinner, D. & Davids, A. (eds.). Capetown, RSA: Human Science Research Council.

24) Devereux, S., Mvula, P., Solomon, C . 2006. *After the FACT: An Evaluation of Concern Worldwide's Food and Cash Transfers Project in Three Districts of Malawi.* Lilongwe: Concern Worldwide Malawi.

25) Dewey, KG, Cohen, R.J. and Rollins, N.C. Feeding of non-breastfed children from 6 to 24 months of age in developing countries. 2004. WHO Technical Background Paper. *Food and Nutrition Bulletin*, vol. 25, no. 4 © 2004, The United Nations University.

26) DFID/UNICEF. February, 2006. *Technical Consultation on the Global Partners' Forum on Children Affected by HIV and AIDS: Universal Access to Prevention, Treatment and Care*—consultation report. London: DFID/UNICEF.

27) Donahue, J. 2006. *Children, HIV/AIDS and Poverty In Southern Africa.* Baltimore, MD: CRS.

28) Donahue. J. and L. Mwewa. 2006. Learning from Community Experiences and Perceptions: Case studies of Mobilization and Capacity Building to Benefit Vulnerable Children in Malawi and Zambia (Final Draft). San Diego, CA: PCI.

29) Dlamini, P. 2004. A Description of Selected Interventions for the Care of Orphans and Vulnerable Children in Botswana, South Africa and Zimbabwe. Capetown, RSA: Human Science Research Council.

30) Drimie, S. 2005. *Food Security for Orphan and Vulnerable Children, Mvuma Chiefdom, Hhohho Province, Swaziland: A Case Study*. In ActionAid International, 2005. *Food Security and HIV and AIDS in southern Africa: Case Studies and Implications for Future Policy*. Johannesburg: Southern Africa Partnership Programme.

31) Eastern and Southern Africa Regional Workshop on Children Affected by HIV/AIDS. 2002. *Implementing the UNGASS goals for orphans and other children made vulnerable by HIV/AIDS*. Windhoek, Namibia.

32) FANTA. 2006. *The Review of Food Aid-Assisted Livelihood Program Interventions in High HIV/AIDS Prevalent Communities.* Washington, DC: FANTA/AED.

33) FANTA. 2006. *Compilation of Monitoring and Evaluation (M&E) Indicators Used for Food and Nutrition Interventions Addressing HIV/AIDS*. Washington, DC: FANTA/AED.

34) FHI. 2005. A Framework and Resource Guide. *Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Guidelines and Tools*. Arlington, VA: FHI.

35) FHI. 2006. *A Guide to Monitoring and Evaluating Program-Level Activities for Children Affected by HIV/AIDS*. Arlington, VA: Family Health International.

36) Fidalgo, L. 2006. Relatorio Impacto da Ajuda Alimentar as Criancas Orfas a Nivel das Provincias de Sofala e Manica Maputo: PMA.

37) Foord, F. and Paine, K. 2005. *Situational Analysis of Orphans and other Vulnerable Children in Sierra Leone.* A Report to the National OVC Task Force for The Government of Sierra Leone.

38) Giese, S., Meintjes, H., Croke, R., Chamberlain, R. 2003. Health and Social Services to Address the Needs of Orphans and Other Vulnerable Children in the Context of HIV/AIDS. Capetown: Children's Institute of the University of Capetown. Report submitted to the National HIV/AIDS Directorate, Department of Health.

39) Gillespie, S., Norman, A., Finley, B. 2005. *Child Vulnerability and HIV/AIDS in sub-Saharan Africa: What We Know and What Can Be Done*. Retrieved from www.ifpri.org/themes/hiv/hivpubs.asp

40) Gray, G.E., Van Niekirk, R., Struthers, H., Violari, A., Martinson, N., McIintyre, J & Naidu, V. 2006. *The effects of adult morbidity and mortality on household welfare and the well-being of children in Soweto*. Vulnerable Children and Youth Studies, April 2006; I (1): 15-28.

41) Greenaway, K. and Mullins, D. 2005. *The HIV/AIDS Timeline as a Program Tool: Experiences from CARE and C-SAFE*. Paper presented to the International Conference on HIV/AIDS and Food and Nutrition Security , Durban, South Africa 14-16 April 2005.

42) HACI. 2004. The hidden face of the HIV/AIDS global epidemic is a child's. Hope for African Children Initiative—an overview. Nairobi, Kenya: HACI.

43) HACI. 2003. Monitoring and Evaluation—Regional Workshop Proceedings. Nairobi, Kenya: April, 2003.

44) Harvey, P. 2004. HIV/AIDS and Humanitarian Action, ODI.

45) Henne, K. 2006. *Using school feeding as an entry point to build resilient communities*. Powerpoint presentation, Africa Forum 2006, Lusaka, May 8-12, 2006. contact khenne@ethionet.et

46) Hossain, Dr. S.M.M. 2005. *Ensuring Food and Nutrition Security for Orphan and Vulnerable Children*—a powerpoint presentation. Durban: UNICEF.

47) IATT. 2006. *Meeting of the Inter-Agency Task Team on children affected by AIDS*—a powerpoint presentation.

48) IFPRI. Gillespie, S. (ed.). 2006. *AIDS, Poverty, and Hunger: Challenges and Responses*. Highlights of the International Conference on HIV/AIDS and Food and Nutrition Security, Durban, South Africa, April 14–16, 2005.

49) Jain, A. (undated) SIMBA: An initiative supporting the basic income and needs of HIV/AIDS-affected households and individuals. Atlanta: CARE.

50) Kurz, K.M. and Johnson-Welch, C. March 2000. *Enhancing Nutrition Results: The Case for a Women's Resources Approach*. ICRW.

51) Landis, R. 2004. Widening the 'Window of Hope': Using Food Aid to Improve Access to Education for Orphans and Other Vulnerable Children in Sub-Saharan Africa. Rome: WFP Occasional Papers no. 15.

52) Lesotho Orphan Database: Draft report on a census data (Data collected with the joint participation of the Ministry of Health and Social Welfare, Disaster Management Authority, NGOs and WFP). 2003.

53) Lindblade, K.A., Odhiambo, F., Rosen, D.H. and DeCock, K.M. January 2003. Health and nutritional status of orphans <6 years old cared for by relatives in western Kenya, *Tropical Medicine and International Health*, Volume 8, No 1, pp 67-71.

54) Lockwood, K., S. Senefeld, R. Mmanga. April 2005 "Mapping Orphan and Vulnerable Children Trends in Malawi." Presented at National AIDS Conference in Lilongwe, Malawi.

55) McDermott, P., Brakarsh, J., Chigara, P., Cogswell, L., Coombe, C., Himelfarb, T., et al. 2003. *Report on the Mid-term Review of the STRIVE Project*. Catholic Relief Services/Zimbabwe and USAID/Zimbabwe.

56) Marais, H. 2005. *Buckling: The impact of AIDS in South Africa 2005*. Pretoria, RSA: Center for the Study of AIDS, University of Pretoria.

57) Michaels, D., Eley, B., Ndhlovu, L., Rutenberg, N., and Khan, H. 2006. *Expanding pediatric access to antiretroviral therapy in South Africa*. Horizons Research Summary. Washington, DC: Population Council.

58) Mishra, V., Arnold, F., Otieno, F., Cross, A., Hong, R. 2005. *Education and Nutritional Status of Orphans and Children of HIV-Infected Parents in Kenya*. Calverton, MD: USAID DHS Working Papers series no. 24.

59) Njoroge, M. April 2006. *Profiles of WFP-supported OVC Take Home Rations Programmes* HIV/AIDS Service. Rome: WFP.

60) O'Donnell, M. 2004. Food Security, Livelihoods & HIV/AIDS: A Guide to the Linkages, Measurement & Programming Implications. SCUK.

61) Office of the U.S. Global AIDS Coordinator, U.S. Department of State. 2006. Food and Nutrition for People Living with HIV/AIDS. Report (the President's Emergency Plan for AIDS Relief) to Congress mandated by House Report 109-265.

62) Powell, G., Chinake, T., Mudzinge, D., Maambira, W., Mukutiri, S. (undated) *Children in Residential Care: The Zimbabwean Experience*. Better Care Network (http://www.crin.org/bcn/index.asp)

63) Richter, L., Foster, G. and Sherr, L. 2006. *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. The Hague, The Netherlands: Bernard van Leer Foundation.

64) Richter, L., Manegold, L., Rashnee, P. 2004. *Family and Community Interventions for Children Affected by HIV/AIDS*. Capetown: HSRC publishers.

65) Rivers, J., Silvestre, E., Mason, J. 2004. *Nutritional and Food Security Status of Orphans and Vulnerable Children*. A report of a research project supported by UNICEF, IFPRI, and WFP. New Orleans, LA: Department of International Health and Development, Tulane University School of Public Health and Tropical Medicine.

66) Rivers, J., Mason, J., Silvestre, E., Mahy, M., Monasch, R. and Gillespie, S. (undated) *Nutritional and food security status of orphans and vulnerable children in Africa*—a powerpoint presentation.

67) Roka, M. 2004. *Country and Emergency School Feeding Project: A Report on the Assessment of the Targeting of Take Home Rations*. Lilongwe, Malawi*:* WFP and Government of Malawi.

68) SARA project. 2003. *Orphans and Vulnerable Children: Technical Consultation Meeting Report*. Washington, DC: USAID.

69) Sellers, A. 2002. *CRS Approach to Food Assisted Education: A Programmatic Approach in Support of Food Security*. CRS West Africa Regional Office (WARO).

70) Senefeld, S. and Lockwood, K. (2003). Food Security, HIV/AIDS Affected Households and Quality of Life in Rural Malawi. Baltimore: Catholic Relief Services. Summarized in Emergency Nutrition Network, *Field Exchange*, May 2005.

71) Subbarao, K. Mattimore, A., Plangemann, K. 2001. *Social Protection of Africa's Orphans and Other Vulnerable Children*: *Issues and Good Practice Program Options.* Washington, D.C.: The World Bank, Africa Region Human Development Working Paper Series.

72) TANGO International, Developmental Relief Competency Based Curriculum, prepared for ADRA Int., 2006. (original source of quote Ellis 2003)

73) Tabor, J., Gachuhi, D., Sadia, C. 2001. *Food Security, Food Aid, HIV And AIDS Study: An Agenda, Strategy and Pilot Projects for WFP, Kenya*. Rome: WFP.

74) *Social Protection, OVC and Livelihoods Interventions—a catalogue*. July 2006.

75) UNAIDS, UNFPA and UNIFEM. 2004. *Women and HIV/AIDS: Confronting the Crisis.*

76) UNAIDS. 2005. *Facing the Future Together: Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa.*

77) UNAIDS. 2006. *Helping Ourselves: Community Responses to AIDS in Swaziland.* UNAIDS Best Practice Collection. Geneva: UNAIDS.

78) UNFAO/Government Co-operative Programme. 2003. *Protecting and improving food and nutrition security of orphans and HIV/AIDS affected children (Phase 1: Lesotho and Malawi)*—a project document.

79) UNICEF. 2005. *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS*. New York: UNICEF.

80) UNICEF, USAID, UNAIDS and WFP. 2004. *OVC Rapid Assessment Analysis and Action Planning*--a report of a planning exercise in Lesotho, 2004.

81) UNICEF/ Ministry of Public Service, Labour, and Social Welfare. 2005. *PASS II Survey: Orphans and Vulnerable Children*. Harare, Zimbabwe: UNICEF/GoZ.

82) UNICEF. 2005. *Orphans and Other Vulnerable Children Survey—Baseline Survey for the Government of Zimbabwe and UNICEF Country Programme 2005-2006 in 21 Districts*. Harare: UNICEF.

83) UNICEF. 2005. *Rapid Re-assessment of health and nutrition situation of OVC attending NCPs Swaziland 2005 Health & Nutrition Reassessment of NCPs 2005*. UNICEF.

84) UNICEF. 2006. *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*.

85) UNICEF. 2006. *Programme of Support to the National Action Plan for Orphans and Other Vulnerable Children Zimbabwe 2006 – 2010*. Harare: UNICEF.

86) UNICEF/UNAIDS/PEPFAR. 2006. *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*. New York: UNICEF.

87) USAID Project Profiles. 2005. *Children Affected by HIV/AIDS* (fourth edition) Washington DC: Population, Health and Nutrition Information (PHNI) Project.

88) WFP. 2002. *HIV/AIDS and Orphans: Issues and Challenges for WFP. Rome: A Background Paper.*

89) WFP. September 2002. *Food and Education: WFP'S Role in Improving Access to Education for Orphans and Vulnerable Children (OVC) in Sub-Saharan Africa.* Rome: Strategy and Policy Division, World Food Program.

90) WFP. 2002. *Improving Orphans' and Other Vulnerable Children's Access to Education: An interim report.* Cote d'Ivoire: Strategy and Policy Division, WFP.

91) WFP. 2005. Experience of a Food Aid Intervention in Western Kenya: An impact study. *Nutrition & Care of People Affected by HIV/AIDS*. Nairobi: WFP Kenya.

92) WFP. Fact Sheet: *CHS Zimbabwe October 2005 Round.* Johannesburg: WFP.

93) WFP. March 2006. *Community and Household Surveillance (CHS)*—a powerpoint presentation

94) WFP. March, 2006. Fact sheet: *CHS Zimbabwe*. Johannesburg: WFP.

95) WFP. 2006. *Literature Review on the Impact of Education Levels on HIV/AIDS Prevalence Rates*. Rome: WFP.

96) WFP. 2006. Draft HIV/AIDS M&E Framework (flowcharts and Indicator Matrices for TB, ART, PMTCT, HBC and OVC). WFP.

97) United Nations and Partners' Alliance on Orphans and Vulnerable Children. 2006. *Sustainable Livelihoods and Social Protection: Building livelihoods opportunities for OVCs* – a workshop report. Johannesburg: UNPA.

98) WHO, 2002. *Community Home-Based Care in Resource-limited Settings: A Framework for Action*. Rome: WFP.

99) Williamson, J. 2005. Finding a Way Forward: Reducing the Impacts of HIV/AIDS on Vulnerable Children and Families. In Foster, J. Levine, C. & Williamson, J. Eds.), *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (pp. 254-277). New York: Cambridge University Press.

100) World Vision. 2003. *World Vision's HIV/AIDS Response for Orphans and Vulnerable Children -- a Framework Paper* (Draft copy).

100) World Vision. 2005. *Core HIV/AIDS Response Monitoring System (CHARMS): Important Information and Practical Tips*.

101) *Baseline Information for the Mafeteng Multi-sectoral Project: Report on the Child and Adult Focus Groups,* Power Point presentation. Untraced.

101) OVC section of a USAID funded CRS project evaluation identifying best practices in Malawi, Zambia, Ethiopia, India, Kenya, Angola; LSE section of a project evaluation in the education sector in India and Madagascar. Undated. Untraced.

Annex D: ENDNOTES

[1] Adapted from the International HIV/AIDS Alliance / Family Health International – OVC Support Toolkit, http://www.ngosupport.net/sw505.asp
[2] Nutrition status refers to the wasting, underweight and stunting.
[3] Rivers, et al., Nutritional and Food Security Status of Orphans and Vulnerable Children, 2004.
[4] These 12 surveys were provided to the Consultants by interviewees in response to the question – 'Has your organization, or an organization working in your area, conducted any surveys or other learning oriented studies on the situation of orphans and other children affected by HIV/AIDS?'
[5] Gray, G.E., Van Niekirk, R., Struthers, H., Violari, A., Martinson, N., McIintyre, J & Naidu, V. 2006. *The effects of adult morbidity and mortality on household welfare and the well-being of children in Soweto*. Vulnerable Children and Youth Studies, April 2006; I (1): l5-28.
[6] Senefeld, S. and Lockwood, K. (2003). Food Security, HIV/AIDS Affected Households and Quality of Life in Rural Malawi. Baltimore: Catholic Relief Services.
[7] Gunderson, C. and Kelly, T, The Impact of Orphaning on Education in Zimbabwe, 2006.
[8] The CSI is a relatively simple and efficient indicator of Food Security status and looks at the frequency and severity of negative coping strategies employed by a given household. An increase in CSI score indicates an increase in negative coping strategies.
[9] e.g. an orphan, disabled, parent has been chronically ill past 12 months and child who lives in a household where an adult member died past 12 months.
[10] Giese et al, Health and Social Services to Address the Needs of Orphans and Other Vulnerable Children in the context of HIV/AIDS, Children's Institute of the University of Capetown.
[11] Orphans and Other Vulnerable Children Survey -- Baseline Survey for the Government of Zimbabwe and UNICEF Country Programme 2005-2006 in 21 districts. Draft: October 4, 2005
[12] A June 2006 UNICEF report (cited under the M&E section) notes that standards *are* known for children up to 8 years of age, however, combining data from these two age groups (under fives and 5-8) has not proven to be useful. See section on M&E for details.
[13] Lindblade, Kim A. Health and nutritional status of orphans <6 years old cared for by relatives in western Kenya
[14] Wasting: Moderate and severe- below minus two standard deviations from median weight for height of reference population.
[15] Foord, F. and Paine, K. 2005. *Situational Analysis of Orphans and other Vulnerable Children in Sierra Leone.* A Report to the National OVC Task Force for the Government of Sierra Leone.
[16] Secondary school teachers interviewed for community views on HIV/AIDS – UNICEF May 25, 2000 and community response interviews - 2004
[17] UNICEF, USAID, UNAIDS and WFP. 2004. *OVC Rapid Assessment Analysis and Action Planning*--a report of a planning exercise in Lesotho, 2004.
[18] This statistic is cited in Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS; UNICEF, 2006. The original citation comes from Monasch, Roeland, and J. Ties Boerma. The CRS Malawi study, the Zimbabwe national OVC baseline and the CHS country studies all concur that the number of CHH was far less than expected.
[19] UNICEF, USAID, UNAIDS and WFP. 2004. *OVC Rapid Assessment Analysis and Action Planning*--a report of a planning exercise in Lesotho, 2004.
[20] *Baseline Information for the Mafeteng Multi-sectoral Project: Report on the Child and Adult Focus Groups*—a powerpoint presentation
[21] Africa's Orphaned and Vulnerable Generations, Children Affected by AIDS, UNICEF, 2006 (original citation: Case, Anne, Christina Paxton and Joseph Ableidinger, 'Orphans in Africa: Parental Death, Poverty and School Enrollment', *Demography*, August 2004

[22] UNICEF, USAID, UNAIDS and WFP. 2004. *OVC Rapid Assessment Analysis and Action Planning*--a report of a planning exercise in Lesotho, 2004.
[23] *Baseline Information for the Mafeteng Multi-sectoral Project: Report on the Child and Adult Focus Groups*—a powerpoint presentation
[24] Michra, V. 2005, DHS Working Paper: Education and Nutritional Status of Orphans and Children of HIV-Infected Parents in Kenya, USAID; Landis, R. 2002, HIV/AIDS and Orphans: Issues and Challenges for WFP
[25] HPG Report #16; CHS Regional Analysis, C-SAFE/WFP, 2004; Senefeld and Polsky, 2005;
[26] C-SAFE/WFP, CHS Regional Analysis, prepared by Tango International, 2004.
[27] C-SAFE/WFP, CHS Regional Analysis, 2004 and Reducing the Burden of HIV/AIDS: Experience of a Food Aid Intervention in Western Kenya, WFP 2005.
[28] Orphans and Vulnerable Children: A Situation Analysis, Zambia 1999.
[29] Email correspondence, Dr Geoff Foster, Consultant in Paediatrics & Child Health, Mutare, Zimbabwe.
[30] UNAIDS. 1999. From Principle to Practice http://data.unaids.org/Publications/IRC-pub01/JC252-GIPA-i_en.pdf?preview=true
[31] World Vision ADP structures, Emmanuel International (Malawi).
[32] Landis, R. 2002, Widening the 'Window of Hope': Using Food Aid to Improve Access to Education for Orphans and Other Vulnerable Children in Sub-Saharan Africa.
[33] Greenaway, K. Integrated Programming: Delivering the Continuum of Care. C-SAFE HIV and Nutrition Newsletter, May 2006.
[34] These may include government agencies, church groups, OVC committees, home-based care programs, parent-teacher associations, etc.
[35] Landis, R. 2002, Widening the 'Window of Hope': Using Food Aid to Improve Access to Education for Orphans and Other Vulnerable Children in Sub-Saharan Africa. Rome: WFP.
[36] Goal 2 of the Millennium Development Goals sets out by the year 2015 to 'Ensure that all boys and girls complete a full course of primary schooling.'
[37] Landis, R. 2002, op cit
[38] CHILD Program, PCI Ethiopia and WFP; World Vision Malawi; others cited in the Reference List.
[39] Kelly, MJ . The Potential Contribution of Schooling to Rolling Back HIV&AIDS. In print in Commonwealth Youth and Development (University of South Africa, UNISA). mjkelly@jesuits.org.zm
[40] UNESCO, 2006. Strong foundations: Early childhood care and education. Paris, France: UNESCO.
[41] Kelly, MJ, 2000. Planning for Education in the Context of HIV&AIDS. UNESCO.
[42] The reasons are well articulated in Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS (UNICEF, 2006).
[43] Raising the Standards: Quality childcare provision in east and central Africa. Save the Children UK.
[44] For more information contact Margaret.McEwan@fao.org or Josee.Koch@fao.org
[45] Email correspondence, Ellen Piwoz, Director, Center for Nutrition, AED.
[46] Dewey, KG, Cohen, RJ and Rollins, NC. Feeding of non-breastfed children from 6 to 24 months of age in developing countries. WHO Technical Background Paper. Food and Nutrition Bulletin, vol. 25, no. 4 © 2004, The United Nations University.
[47] Email correspondence, Dr. Steve Collins, Director, Valid International.
[48] Email correspondence with UNICEF Mozambique, data collected on HIV prevalence in malnutrition wards of selected Central hospitals in Beira.
[49] XVI International AIDS Conference; Toronto MOPEO235 – HIV infection among severely malnourished children in a conflict affected areas in Northern Uganda, 2005.
[50] Thurstans, S et al 2006. HIV point-prevalence amongst malnourished children admitted to nutritional rehabilitation units in Malawi: geographical & seasonal variations. Presentation at IAC 2006, Toronto.

[51] Thurstans, S et al. 2006. VCT acceptability in children and their caretakers in the nutrition rehabilitation units in Malawi: NRUs as point of entry for HIV care. Presented at IAC 2006, Toronto.
[52] Operational Challenges of Implementing Community Therapeutic Care. ENN Report on an Inter-Agency Workshop, Washington DC, February 28 – March 2, 2005; Valid International 2006. Community-basedTherapeutic Care (CTC) -- A Field Manual.
[53] ENN Report on the Proceedings of an Inter-Agency Workshop: Community Based Approaches to Managing Severe Malnutrition (2003)
[54] C-SAFE 2004. Food for Assets through an HIV/AIDS Lens: Manual and Checklist. Johannesburg.
[55] Landis, R. 2002, HIV/AIDS and Orphans: Issues and Challenges for WFP. Rome: WFP.
[56] NERCHA is an acronym for National Emergency Response Council on HIV/AIDS.
[57] Harvey, P. 2004; UNSG Task Force on Women, Girls and HIV/AIDS, 2004; UNAIDS, UNFPA and UNIFEM, 2004. Women and HIV/AIDS: Confronting the Crisis; UNICEF, 2006. Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS
[58] Zaba, Basia, et al., HIV and mortality of mothers and children: evidence from cohort studies in Uganda, Tanzania and Malawi, Epidemiology, vol. 16, no. 3, 2005, pp. 275–280, cited in UNICEF, 2006. Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS.
[59] World Bank, 2006. Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action.
[60] Kelly, MJ. 2000. Planning for Education in the Context of HIV/AIDS. UNESCO.
[61] The Coping Strategies Index is a relatively simple and efficient indicator of household food security that correlates well with other more complex measures of food insecurity. Developed by CARE, and field tested by WFP and CARE, it measures the *frequency of use* and the *severity* of a household's coping strategies for addressing shortfalls in food supply.
[62] Constella Futures. 2001. Child Vulnerability Index (CVI).
[63] Gardner, Greenblott, Joubert, C-SAFE Learning Spaces, *What we Know about Exit Strategies, Practical Guidance for Developing Exit Strategies in the Field*. 2005.
[64] The Resolution can be found at: http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_R11-en.pdf
[65] The 2001 Declaration of Commitment: http://www.un.org/ga/aids/docs/aress262.pdf; The May 2006 UNGASS Declaration:
http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf
[66] These 12 surveys were provided to the Consultants by interviewees in response to the question – 'Has your organization, or an organization working in your area, conducted any surveys or other learning oriented studies on the situation of orphans and other children affected by HIV&AIDS?'
[67] An abstract of the findings was reviewed. The full report was not available at the time of this research.
[68] Senefeld, S. and Lockwood, K. (2003). Food Security, HIV/AIDS Affected Households and Quality of Life in Rural Malawi. Baltimore: Catholic Relief Services. Summarized in Emergency Nutrition Network, *Field Exchange*, May 2005.
[69] Chronic illness was not used as a proxy, but instead, households were asked to report whether or not a person with HIV or AIDS resided in the household. Some 12.9% answered affirmatively. The National AIDS Commission estimates the HIV prevalence in rural Malawi at between 10-15% (2003).
[70] Lockwood, K., S. Senefeld, R. Mmanga. "Mapping Orphan and Vulnerable Children Trends in Malawi." Presented at National AIDS Conference in Lilongwe, Malawi. April 2005.
[71] Gray, G.E., Van Niekirk, R., Struthers, H., Violari, A., Martinson, N., McIntyre, J & Naidu, V. (Johns Hopkins University and University of Witwatersrand). 2006. *The effects of adult morbidity and mortality on household welfare and the well-being of children in Soweto*. Vulnerable Children and Youth Studies, April 2006; I (1): l5-28.
[72] C-SAFE/WFP, CHS Regional Analysis, prepared by Tango International, 2004. Some of the data from this surveillance system was also included in the Tulane meta analysis.

[73] The CSI is a relatively simple and efficient indicator of Food Security status and looks at the frequency and severity of negative coping strategies employed by a given household. An increase in CSI score indicates an increase in negative coping strategies.
[74]Orphans and Other Vulnerable Children Survey -- Baseline Survey for the Government of Zimbabwe and UNICEF Country Programme 2005-2006 in 21 districts. Draft: October 4, 2005.
[75] The survey defines orphan as a child who has lost one or both parents; and a 'vulnerable' child as 1) a child who lives in a household where at least 1 adult died in the last 12 months; 3) A child who lives in a household where at least 1 adult was seriously ill for at least 3 months in the last 12 months; 4) A child lives in a child-headed household (where the head of household is < 18 years old). Through this definition, the survey focuses particularly on children orphaned and made vulnerable by HIV. Other factors influencing vulnerability, such as disabilities, poverty, social environment were not covered.
[76] World Vision Hope Initiative, Baseline Findings from Uganda and Zambia, 2005. Summarized findings for Toronto, 2006.
[77] Foord, F. and Paine, K. 2005. *Situational Analysis of Orphans and other Vulnerable Children in Sierra Leone.* A Report to the National OVC Task Force for The Government of Sierra Leone.
[78] Chilima, Dr. D.M. 2006. *Protracted Relief and Recovery Operation (PRRO): Integrated Support to HIV/AIDS Infected and Affected People in Eight Districts of Malawi-Baseline Survey Final Report.* Lilongwe: WFP.
[79] UNICEF, USAID, UNAIDS and WFP. 2004. *OVC Rapid Assessment Analysis and Action Planning*--a report of a planning exercise in Lesotho, 2004.
[80] Davids, A., Letlape, L., Magome, K., Makgoba, S., Mandivenyi, C., Mdwaba, T et. al. 2006. *A Situational Analysis of Orphans and Vulnerable Children in four districts of South Africa.* Skinner, D. & Davids, A. (eds.). Capetown, RSA: Human Science Research Council.