West and Central Africa Regional Workshop on Orphans and other Vulnerable Children

Yamoussoukro, Côte d'Ivoire, 8-12 April 2002

Workshop Report

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Executive Summary

About 140 delegates, including people from 21 countries in West and Central Africa along with facilitators and observers from at least another 10 countries, met in Yamoussoukro from 8–12 April 2002 to review the situation of orphans and other children made vulnerable by HIV/AIDS (OVC) in this region.

This was the third regional workshop on OVC in sub-Saharan Africa – the others were held in the East and Southern Africa region – the first in Pietermaritzburg, South Africa, in June 1998, and the second in Lusaka, Zambia, in November 2000.

The 5-day Yamoussoukro Workshop was a joint initiative of UNICEF, USAID, Family Health International, the International Save the Children Alliance and UNAIDS, in line with the commitments made at the UN General Assembly Special Session on HIV/AIDS, 10 months earlier.

Invited countries were required to set up a multi-sectoral Task Team several months before the Workshop and to complete an assignment which involved collating information on OVC in their respective countries, and sending a delegation to Yamoussoukro.

The outputs of the Workshop included the development of an action plan by each country delegation, for implementation by their Task Team, and an inventory of action and resources needed at regional and global level to support their action plans.

Opening

During the opening sessions, a number of speakers said there is no room for complacency in the West and Central Africa region, despite HIV/AIDS sero-prevalence levels which are somewhat lower than those in East and Southern Africa. "Just ten years ago South Africa, Namibia and Swaziland had a (HIV-prevalence) rate of under 5%, akin to a number of countries in this region," said Peter McDermott of USAID. Today those countries are amongst the worst-affected in the world.

Already Cote d'Ivoire is the 15th most affected country in the world with HIV-prevalence hovering between 8% and 12%, depending on the region, according to Dr Assana Sangare Ouattara, Minister in charge of AIDS control in the host country. HIV/AIDS is already the first cause of mortality among young adults and about 600,000 children have been orphaned by HIV/AIDS.

Delegates have to plan for a situation which is unprecedented in history, said Stephen Lewis, Special Envoy to the UN Secretary General for HIV/AIDS in Africa. "In a number of countries, in the next very few years, between 20% and 40% of the child population will be living as orphans – and we're not yet at the top of the curve of parental death. No government has ever taken such a possibility into account."

HIV/AIDS is having a profound effect on nations and on individuals, but none are worse affected than children who have to watch their parents dying a slow and agonizing death and then face disinheritance, separation from siblings, removal from school, stigmatisation within their community and exploitation by those closest to them, starvation, denial of health care, and many forms of abuse.

There is, however, consensus on a few principles on how best to help them:

- Families and communities are the first line of defence – the biggest effort must be to help them care and protect vulnerable children among them. The most important form of intervention is to strengthen the economic coping capacity of households – particularly those which take in orphans.
- The problem is too big for any one role-player – including governments – to deal with. The only solution is to work through partnerships of community- and faith-based organisations, NGOs, UN agencies, donors and governments. Interventions have to be brought rapidly to scale to address the sheer magnitude and urgency of the problem.

- It is essential that children, women and people living with AIDS are also part of the solution – their voices need to be heard, their rights to be protected, and their capacity to meet their own needs strengthened.
- Lack of access to schooling for many children is setting up a vicious circle of ignorance, poverty and vulnerability to even higher levels of HIV. Universal free education is a fundamental human right which was endorsed by every country in the region when they ratified the Convention on the Rights of the Child. The time has come to hold them to their promises.

It was also pointed out that there is a huge body of knowledge and experience in West and Central Africa, and well-established programmes dealing with children caught up in armed conflict, subjected to trafficking and slavery, or separated from their families as refugees. Vaccination and emergency relief operations also provide skills and networks which can be built upon in responding to the new challenge of OVC.

Country Presentations

Participating countries were invited to make presentations on their pre-workshop assignments during a series of mini-plenaries, which allowed time for questions and discussion around the situation in each country.

These presentations highlighted that talking about AIDS is still taboo in many countries, and people living with HIV/AIDS – and their families – are often stigmatised by their communities and even within their families.

A considerable amount of time was taken up in most groups discussing definitions of an “orphan”, “vulnerable child” and the age-groups used for collecting data and programming for these children.

There was uncertainty about the use of “AIDS orphans”, which is considered by many to be stigmatising and not very useful, and about the value of enumerating or registering orphans, which often uses up the limited energy and resources which should have been used to actually help them.

Institutional care – orphanages – were discussed in most groups. The consensus was that these institutions are too expensive to play a significant role in caring for OVC, and that growing up within the extended family was in the best interests of the child.

Copies of those country presentations which were submitted to the secretariat on diskettes are included in the CD-ROM which is being circulated with the Workshop Report.

‘Theme’ and ‘Core Element’ Groups

The main part of the Workshop was taken up with a series of working groups, each focussing on a specific theme or topic. On the second day of the Workshop, each delegate was able to attend two out of a series of eight theme groups, each with simultaneous translation. The topics were:

- Psycho-social care of OVC;
- Institutionalisation of OVC;
- Children infected with HIV/AIDS;
- Participation of children and young people;
- Care and support of OVC;
- Access by OVC to quality basic services;
- OVC in situations of armed conflict;
- Community capacity development for OVC.

The purpose of these theme groups was to give delegates an opportunity to share their own views and experiences on these topics.

On the third day, country delegations were divided into four groups – three for Francophone and one for Anglophone countries – and each group was invited to participate in a series of four seminars covering the following "core elements":

- Community mobilization for OVC;
- Conducting an OVC Situation Analysis;
- Reviewing policy and legislation affecting OVC;
- Human-rights-based programming for OVC.

Summaries of the presentations and discussions in these groups are included in the full report.

Plenaries

The Workshop featured a series of plenaries to cover topics of common interest, and to provide feedback on discussions within the working groups. The themes for the various plenaries were:

- Setting the scene;
- Issues, challenges and standards;
- Good practice;
- Regional action and support.

Extracts from all presentations and key points from discussions are included in the full report.

Country Action Plans

A major objective of the Workshop was to help country delegations prepare an Action Plan, to be implemented by their Task Team on their return to their respective country.

On the fourth day of the Workshop, a format or 'matrix' for these plans was distributed to country delegations and they were given several hours to prepare a draft Action Plan. Each delegation was then invited to present their ideas for review by their peers in a mini-plenary, and thereafter to finalise their plans and present them on a poster.

Virtually all of the delegations proposed taking the following steps:

- Conducting a participatory situation analysis of OVC;
- Holding a national consultation and establishing coordination mechanisms;
- Reviewing policy and legislation to protect the rights of children;
- Implementing an action plan for a large-scale response.

Most country teams said their first step would be to hold a series of debriefings with key government and representatives of civil society to widen the ownership of the issue and process, and to define their goals and norms for the care and support of OVC.

Copies of all Action Plan matrixes are included on the CD-ROM.

Regional Support

Delegates were given an opportunity in plenary to suggest what kinds of regional action and support they needed to implement their action plans.

Common themes were the need for technical support, funding and advocacy. The creation of a database and sharing of information on good practice and successful programming were mentioned by a number of countries, as was the need for more documentation in French.

Speaking at the end of the country presentations, Jean Claude Legrand of UNICEF committed the co-sponsoring organisations to a range of follow-up actions including:

- A review of country action plans, followed by discussions with each country on the technical and material assistance they needed for implementation;
- The mobilization of partners, governments and other stakeholders to provide technical and material support for OVC programming;
- An information system to keep country teams up-to-date – beginning with the conference report, supporting documentation and lists of resource materials and available technical support;
- Facilitation of situation analyses, national consultations and plans of action, where necessary. Consideration was being given to holding mini-workshops to provide country teams with more in-depth knowledge on these activities.

Close

Speaking during the closing plenary UNICEF Regional Director Mrs Rima Salah stressed the importance of involving all role-players in defining and addressing the OVC challenge. She also called for the increased involvement of children in planning for, and responding to, the difficulties faced by OVC. She asked country delegations to advocate for OVC at four levels: heads of state, ministries, parliamentarians and with national foundations..

The First Lady of Cote d'Ivoire, Mme Simone Ehivet Gbagbo, read a motion sponsored by the first ladies of six countries – four of whom attended the closing session – expressing solidarity in the fight against HIV/AIDS and for OVC.

Mme Gbagbo echoed the needs for stronger partnerships, more sharing of information, a greater emphasis on satisfying children's basic needs, and bringing national legislation into line with the Convention on the Rights of the Child.

Background

The United Nations General Assembly Special Session from 27-27 June 2001 approved a Declaration of Commitment which solemnly declared their “commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world.”

This commitment includes the following paragraphs under the heading “Children orphaned and made vulnerable by HIV/AIDS”:

> *Children orphaned and affected by HIV/AIDS need special assistance.*
>
> 65. *By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;*
> 66. *Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;*
> 67. *Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa.’*

Goal and Objectives

The overall goal of the Workshop was to build the capacity and commitment of governments, civil society and other partners in 24 countries in West and Central Africa to fulfil the commitments made at the UN General Assembly Special Session on HIV/AIDS in June 2001 in relation to orphans and children made vulnerable by HIV/AIDS (for convenience shortened to ‘OVC’).

Specifically the Workshop was intended to:

- act as a catalyst for setting up multi-sectoral OVC Task-Teams in each country prior to the Workshop;
- provide a mechanism for collating and sharing information on the challenges faced by OVC, and the current level of response, in West and Central Africa;
- promote understanding among Task-Teams of the dynamics of the OVC challenge, and of the most effective responses in this region and elsewhere;
- enable Task-Teams to formulate appropriate and effective action which will lead to a rapid scaling up of the response to OVC in their countries and region;
- enable regional and global actors to consider mechanisms and resources for supporting country-level action to help OVC in this region;
- strengthen advocacy and mobilise responses and resources for OVC among governments, donors and civil society, including the media.

Structure and Process

The Workshop was jointly convened by UNICEF, USAID, Family Health International, the International Save the Children Alliance and UNAIDS. It was held in Yamoussoukro, Côte d'Ivoire from Monday 8 to Friday 12 April 2002.

The Workshop, and the process which preceded it, were designed to build capacity and commitment throughout West and Central Africa to rise to the enormous challenges posed by the HIV/AIDS pandemic, particularly to the children of our region.

The process began by establishing multi-sectoral OVC Task-Teams in each participating country. These Teams were set an assignment to enhance their understanding of the OVC situation in their own country and to facilitate collaboration between the stakeholders who must ultimately respond to this challenge.

Each Task-Team was then asked to select four of its members to travel to Côte d'Ivoire in April to share their findings with colleagues from other countries in the region. At the Workshop they were exposed to current thinking on policies and programming for OVC, and discussed the application of those ideas to their own situation.

The last day of the Workshop was devoted to helping delegates formulate action plans to guide their Teams on their return. This process also gave regional and global planners some idea of the resources needed to support country-level action.

A feature of the Workshop was that the Workshop conveners did not pay the travelling or subsistence costs of any delegates – all were asked, and 21 out of 24 invited countries were able, to raise their own funds for this purpose. Apart from helping to spread the cost of staging this major event, this was seen as a practical way in which Task-Teams could demonstrate their collective commitment to the OVC challenge.

The Workshop was attended by 90 delegates from 21 countries in West and Central Africa, namely: Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Congo Brazzaville, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.

Approximately 50 other delegates attended the Workshop, including representatives of the convening organisations, the host country, the steering committee, facilitators and invited guests.

Simultaneous translation was provided for the plenaries and the theme groups, while the remaining sessions were divided into four mini-plenaries – three in French and one in English – to allow for own-language interaction among delegates.

Day 1 : Opening Plenary

Dr Assana Sangare Ouattara

The official opening of the Workshop was performed by the Ministry Delegate under the office of the Prime Minister in charge of HIV/AIDS control in Côte d'Ivoire, Dr. Assana Sangare Ouattara.

In her presentation, Dr Sangare said HIV/AIDS was taking a heavy toll on Africa. "UNAIDS and WHO estimate that by the end of 2001, 30 million of the 40 million HIV-positive adults and children in the world lived in Africa, and HIV-prevalence among adults in Africa was 8.5% on average, while the world average was 1.2%."

She said that Côte d'Ivoire was the country most affected by the HIV/AIDS infection in the West African region. It was the 15th most affected country in the world with HIV-prevalence hovering between 8% and 12%, depending on the region. HIV/AIDS was already the first cause of mortality among young adults and about 600,000 children had been orphaned by HIV/AIDS.

> *We are well aware that the number of these orphans will increase because of this human catastrophe, which has been sapping our lifeblood. The number of children orphaned by AIDS keeps rising from year to year, and this may increase the number of "street children" and others with no fixed abode, who will be exposed to delinquency, rape and theft. The number of child prisoners and child prostitutes will also increase. All these calamities will spoil these children's chances of attending school and benefiting from the education to which they are legally entitled. Access to care and family welfare is also a problem.*

Mr Stephen Lewis

The UN Secretary General's Special Envoy on HIV/AIDS in Africa, Mr Stephen Lewis, made five major points in his presentation:

> *First, the pandemic is dramatically worse in East and Southern Africa. But it's creeping up on West and Central Africa… Côte d'Ivoire, Burkina Faso, Nigeria, Central African Republic, Cameroon, Togo.. they're all walking along the edge of catastrophe. That catastrophe has already struck elsewhere – it is impossible to describe the devastation. You have the chance to stop the horror in its tracks – you'll never forgive yourselves if you lose the opportunity. You give this pandemic even a modest grip, and it will strangle a country…*
>
> *Second, Africa has made real progress in addressing prevention, treatment and care on many fronts. But our greatest weakness lies in dealing with orphans and vulnerable children. We aren't doing enough; some interventions aren't working; the numbers are rising; children are falling through the safety nets of compassion. Of course it varies from country to country but, for whatever complex of reasons, around orphans and vulnerable children, we've just begun to work.*
>
> *Third, there is one thing we feel confident about – the extended family remains the best source of care for orphaned children. But so often children are left in the care of impoverished grandmothers, barely able to look after themselves, or enter an extended family only to suffer the barbs of resentment, exploitation or even sexual assault; or to suffer the appalling isolation of intolerance, stigma and rejection. How do we reinforce the extended family, stabilize it, feed it, secure it for the children it embraces? And what happens when there are no more grandmothers or extended family left – what happens when the pandemic has swept the society clean of relatives, which is now occurring in a number of countries? How then do you handle the phenomenon of child-headed households?*
>
> *Fourth, one terrible obstacle is driven home to me time and again: the question of school fees. What is going on here? Every single country in Africa, save one, has ratified the Convention on the Rights of the Child, which is absolutely clear: primary education is to be free and universal. There is nothing more important for a vulnerable child than the anchor of a school,*

just as there is nothing more important for a society struggling with survival than to have a school as the heart of a community. What is needed on this continent is a vast campaign to abolish school fees, once and for all.

Fifth, there has never in living history been a period where country after country was faced with hundreds of thousands, even millions of orphans. In a number of countries, in the next very few years, between 20% and 40% of the child population will be living as orphans – and we're not yet at the top of the curve of parental death. No government has ever taken such a possibility into account. How do you plan for it? How do you budget for it? How do you fashion social and economic policy? If ever civil society, including all of the community-based organisations, had to become part of the fabric of state, in order to rescue the state, this is it.

Mr Lewis said vulnerable children orphaned by the AIDS epidemic give trauma a new meaning.

Nothing quite approximates the Pandora's box of AIDS. These are children who watch their parents die long and agonizing deaths; who watch the mortifying process of physical decline; who observe the family struggling and disintegrating before their eyes; who watch the household food security wither away; who watch the tiny income disappear; who plead for medicines for their mothers and can't get them; who are forced to leave school; who feel forlorn, terrified and abandoned when death claims its victims, victims whom the children loved as only children can love.

What happens to these kids inside their psyches and their souls? What happens to them ten years from now? What new forms of delinquency and anti-social behaviour will they be driven to? Given the potential numbers, could it one day threaten to destabilize society? I've met African presidents who think that's a possibility.

And what happens when these orphan children have children? How do you parent when you've lost so much tenderness and nurturing and confidence and love along the way? And suppose the orphan parent becomes infected and dies? What happens then? It's like some demented molecular chain reaction of self-destruction.

Finally, he added two footnotes..

We know that if we could get money right down to the community level, even in very small amounts, there would be great progress made. It seems so hard to do. And even those governments who want to make it happen are desperate for dollars.

And then there's the question of the mothers. Somehow we must keep HIV positive mothers alive long enough to bring up their children. Orphanhood need not begin at an early age. We have the anti-retroviral medicine… what twisted conspiracy keeps the drugs from the mothers? Who is holding the world's moral compass? You not only bring premature death to the mother, you doom the children. What in God's name is going on?

Mrs Carleene Dei

Mrs Carleene Dei, Director of West Africa Regional Programme of the United States Agency for International Development (USAID), called on all the key players to collaborate in finding solutions for orphans and other vulnerable children.

Without collaboration our individual efforts simply are insufficient to address key issues. More importantly, by dealing with our partners on an individual basis, we frequently create more problems than we actually solve.

At a time when the continent needs to harness all of its meagre resources to address the challenges presented by the emergence of globalism, it finds itself faced with a pandemic that is eroding the small gains that it has managed to make over the last two decades – falling life expectancy, rising infant mortality rates, decreasing literacy rates, rising dependency ratios, the decimation of its educated cadres, all culminating in stagnant economic growth are but a few of the facts that quickly come to mind.

Mrs Dei said that since 1986 the US Government, primarily through USAID, has dedicated over US $1.6 billion to prevent and lessen the impact of HIV/AIDS. This amount had been significantly increased over the last five years, and most recently by President Bush's commitment this year.

Funding has also expanded for other US Government agencies involved with the epidemic. USAID:

- Currently worked in 50 of the hardest-hit countries and undertakes a wide range of interventions;
- Had been at the forefront of delivering testing and test kits, managing sexually transmitted diseases, voluntary counselling, condom promotion and distribution, and research;
- Played a key role in the creation of UNAIDS, the joint UN program, and remained one of its largest donors;
- Significantly expanded its response to the pandemic in 2001. The expanded response was designed to enhance the capacities of developing countries to prevent an increase in HIV/AIDS and to provide services to those who were infected and affected;
- Had a special focus on children infected and affected by HIV/AIDS, including funding and publishing 'Children on the Brink' in 1997, and again in 2000 with new estimates for 34 countries.

Dr Rima Salah

UNICEF Regional Director for West and Central Africa Dr Rima Salah said that for UNICEF, the situation of orphans and other children made vulnerable by HIV/AIDS was above all an issue of child protection.

> *Over 50 million children in our region are in need of special protection measures. This means addressing and preventing violence, abuse and neglect, exploitation and discrimination against them. Anecdotal evidence, studies and research tend to demonstrate that the AIDS pandemic has intensified the impact of all these child protection issues.*
>
> *For this reason, UNICEF's response to this growing phenomenon is designed within the framework of child protection measures and enriched by our experiences in child protection activities in the region. In the area of orphans and vulnerable children, priority actions include:*
>
> - *Protecting orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;*
> - *Providing appropriate counselling and psychosocial support to orphans and other children;*
> - *Ensuring their enrolment in school and access to shelter, good nutrition, health and other social services on an equal basis with other children;*
> - *Strengthening community capacities to identify and monitor vulnerable households.*
>
> *The complexity of the challenges facing children affected by HIV/AIDS cannot be emphasized enough. Winning the battle against HIV/AIDS is a top priority for UNICEF because millions of children are being deprived of their rights to develop, to be protected and to survive.*

However, Dr Salah said UNICEF could not win the battle alone.

> *Our response pivots on partnerships at all levels: partnerships with governments, NGOs, faith groups and traditional and religious leaders; partnerships with groups of People Living with HIV/AIDS; and, of course, partnerships with bilateral and multilateral donors.*
>
> *We do not have one minute to spare. It is URGENT. We must mobilize NOW all actors, governments, international organizations, NGOs and donors. And, together we will succeed.*
>
> *In four weeks' time, more than seventy Heads of State will meet at the United Nations General Assembly Special Session on Children. This will be an excellent opportunity for them and for all of us to pledge commitment to ensuring that children grow in 'a world fit for children', where every child's rights to dignity, security and self-fulfilment are respected and realized.*

Day 1 : Plenary – 'Setting the Scene'

Dr Kalanidhi Subbarao

Dr Kalanidhi Subbarao, Lead Economist at the World Bank, described the sheer magnitude of the orphan problem. He said the cumulative number of orphans in many countries was already into the millions – such as Ethiopia, Nigeria, Uganda and Tanzania – and by 2010 a number of other countries would reach this level, including Kenya, Zambia and Zimbabwe.

He spoke of the social costs attached to OVC, where orphans are less likely to attend school, which in turn leads to them becoming less literate, and less productive as adults, thus setting up a self-sustaining cycle of poverty and vulnerability to the further spread of HIV/AIDS. Girl children were the most likely to be withdrawn from school to care for ill parents, which had long-term implications for their own families when they grow up.

According to the data assembled by UNICEF, in 15 countries, children whose parents were alive and who lived with at least one parent had a significantly better chance of being in school – compared with those whose parents were deceased. In Benin, for example, 50% of children aged 10-14 and living with one or both parents were attending school, compared to less than 20% of those in the same age-group who had lost both parents.

In African countries, most orphaned children were being cared for within the extended family, but there were signs that these traditional coping mechanisms were coming under severe stress. A case-study in Uganda showed that fostering households were consuming less, saving less and investing less. There was also anecdotal evidence of stigmatisation and denial of health care by families and health care workers.

Dr Subbarao drew attention to many programmes to help OVC, such as improving child maintenance payments and protecting children's inheritance (Mozambique); using immunization programmes to register vulnerable children; providing early-childhood support (Uganda and Kenya); and providing social pensions for the elderly (South Africa and Namibia); providing fostering grants to communities (Eritrea); waiving school-fees for double-orphans (Burundi); and providing innovation grants to communities that cared for orphans (Uganda).

An important question was: who should be the primary focus of attention – the orphan directly, the household caring for the orphan, or the community – perhaps through a school or NGO?

Also, what should be the nature of the intervention? Direct cash assistance? Programme assistance such as early childhood development programmes or school subsidies? Or supporting income-generating activities for families?

Finally, how should one go about targeting the most needy children – if targeting was considered desirable? On the basis of some objective criteria (such as being a double orphan), at community meetings, or how?

Mr Peter McDermott

Mr Peter McDermott, Principal Advisor at USAID's Bureau for Africa, said the spread of the HIV/AIDS pandemic in West and Central Africa was clearly worrying.

> *No longer can the region say it is unaffected, and uninfected by the pandemic. Furthermore just ten years ago South Africa, Namibia and Swaziland had a low rate, of under 5% akin to a number of countries in this region. Today we are aware of the very high, and still increasing prevalence rates in those countries.*

Make no mistake, because of HIV/AIDS, and the silence and stigma that surrounds it, children are suffering and dying in numbers no earlier generation could have imagined, and for which no future generation will forgive us.

- *By 2000, 4.3 million children had already died*
- *Over 600,000 infants are infected annually, primarily through mother-to-child transmission.*
- *More than 13 million children are already orphaned and that number could easily reach 30-40 million in the coming years.*
- *In addition millions are traumatized by sick parents, have limited access to services, are at greater risk of neglect and abuse etc. The vast number of these children are in Sub-Saharan Africa, and an increasing number in West and Central Africa.*

Mr McDermott said West Africa had a huge opportunity to build on 20 years of African experience of the pandemic, and its impact on children. There was also a huge experience in West Africa on issues such as child protection, tools, practice, knowledge, expertise, networks, civil society etc.

We know more than ever what works and what needs to be done. Senegal remains one of the only success stories in the world. The pandemic in many places is still at low prevalence rates, but the main determinants are in place for a rapid explosion. We don't need to reinvent the world, what we need to do is to scale up responses that we know work.

He said that experience showed the most practical steps to be taken were:

- Conducting a participatory situation analysis of OVC;
- Holding a national consultation and establishing coordination mechanisms;
- Reviewing policy and legislation to protect the rights of children;
- Implementing an action plan for a large-scale response.

Dr Pierre M'Pele

Dr Pierre M'Pélé, Team Leader of UNAIDS Inter-Country Team for West and Central Africa, said the number of orphans in more than 10 West African countries had doubled over the last three years. In Côte d'Ivoire, for example, the orphan populations had increased from 240,000 in 1997 to more than 620,000 today.

These children, as you know, often lose their rights to cleanliness, inheritance, access to information, to education and to primary healthcare. Their living conditions often lead them to adopt survival strategies which increase their vulnerability and infection with HIV. The vulnerability of girls has drastically increased.

If we are not careful, this is a lost generation in the making, as our traditional systems of social support, of economic solidarity and social solidarity, area already under strain.

Dr M'Pele called on roleplayers to ensure that children were not just the "target" of interventions which were designed by adults in governments and big organisations, far from the everyday reality which confronted those children.

It's all about transforming the children into key players by listening to them attentively and without preconceived ideas, and by supporting them in their participation. We must be the facilitators of actions which are thought out and carried out by the children.

Our role, the role of the adults and institutions, is to create a new dynamic which favours solidarity between the children – between those who have lost everything or who stand to lose everything, and those who have enough.

He called on participants to take the momentum of the Workshop back to their countries, to empower each community to come up with a strategy and concrete action, based on dialogue, consultation and the taking of responsibility. Their collective actions should permit children "to find smiles, joy and confidence in life now and in the future."

> *A more urgent and more rigorous response is called for because time is not in our favour. We must act today – the time for planning is over. We must act quickly and effectively to alleviate suffering wherever it occurs, if we are to fulfil commitment 65 of the declaration at the United Nations Special Session on HIV/AIDS in June 2001.*

Dr M'Pele said that within three years all of the countries in the region should have national policies and strategies which enabled governments, families and communities to provide an environment favourable to orphans and to boys and girls infected and affected by HIV/AIDS.

> *This is a colossal challenge. Will our workshop give us the means to make these things widely known? We must innovate!*

Day 1 : Country Presentations

The afternoon session was devoted to presentations by participating countries. These presentations were made in four concurrent mini-plenaries, three of which were in French and one in English. Prepared presentations which were submitted in electronic form are included on the post-Workshop CD-ROM.

The facilitators of the four sessions were:

- *Group 1: Mr Ibrahima Diallo (UNICEF); Ms Tamar Renaud (UNICEF); Dr Willibrord Shasha (USAID)*
- *Group 2: Dr Pierre M'Pele (UNAIDS); Mr Augustin Sankara (FHI)*
- *Group 3: Ms Mananza Koné (FHI); Dr Eric Mercier (UNICEF)*
- *Group 4: Mr Peter McDermott (USAID); Mrs Rosemary Nnamdi Okagbue (FHI)*

The following is a compilation of points made by the facilitators during their feedback to the plenary:

Commonalities

- Talking about AIDS is still taboo in many countries;
- Identifying children orphaned by HIV/AIDS is extremely difficult, the value of doing so is not clear, and identifying them could increase stigma;
- Not all orphans are vulnerable, and some non-orphans are very vulnerable;
- The extended family is the first and most effective safety net for OVC – but it is increasingly over-burdened;
- It's too late to intervene when a child is orphaned – children are made vulnerable when their parents are ill;
- Orphans and vulnerable children must be part of the fight against HIV/AIDS;
- There is a need to involve people living with AIDS much more substantively;
- There is a need to differentiate between the role of the government and the role of the community – both have significant roles in scaling up the response to OVC;
- The UN can play role of negotiator between government and civil society;
- Church/Faith Based Organisations can play an important role in responding to the needs and rights of OVCs;
- Many countries lack a legislative framework to protect OVCs or an institutional grounding for interventions for OVCs;
- Each country needs to develop a strategic plan;
- Free access to education and health-care services must be assured for OVCs;
- We need to train teachers so they know how to deal with AIDS affected children;
- We need to work collaboratively in networks – exchanging information makes all the difference.

Challenges and unresolved issues

- Are children (and therefore orphans) aged up to 15 or 18?
- Traditional and customary law issues complicate the definition issue in some countries, for example through early girl child marriage.
- A point of discussion arose during the presentation of CAR which introduced the notion of orphans with parents alive (parents resigning from their parental responsibility).

- Do we name AIDS orphans as such? What are the implications? Does that lead to the marginalisation and stigmatisation of the children? How do we protect them?
- Should we have specific programmes for orphans? AIDS orphans? Or should we have complementary programmes for all vulnerable children?
- How do we manage confidentiality when we need to have open discussions on HIV/AIDS so as to reduce discrimination?
- How do we avoid confusing 'institutional response' (action by organizations) and 'institutional care' (placing children in orphanages)?
- What are the appropriate roles for institutional care (orphanages)?
- What is the best way to identify and support foster-families?
- What is the best way to strengthen community based responses?
- How do we most effectively involve children and young people affected by HIV/AIDS?
- How should we involve adults living with HIV/AIDS?
- Children have a right to know if their parents have HIV – how do parents tell their children?
- How do we make existing legal systems and public policy to respond to the needs of OVC?
- How do we solve the problem of nutritional assistance to OVC?
- How do we plan activities that are complementary to each other for care and support to OVC?
- What is the best way to secure free basic primary education and reduce indirect costs?
- How do we share information on what works in certain countries and what doesn't?

Quotes

> *Children prefer to stay together (with their siblings) and live without an adult rather than be separated and live with adults.* (Côte d'Ivoire)
>
> *Kids want to know their parents' status so they can care for their parents, so they can prepare for later…*(Côte d'Ivoire)
>
> *Donors make us use terms that we would rather not use, but we have to use these terms to get the funds. When we go to the communities we do not use the term "AIDS orphans"*

Day 2 : Plenary – 'Issues, Challenges and Standards'

The presentation was made jointly by:

- *Ms Elaine Ireland of Save the Children UK; and*
- *Mr Stanley Phiri of UNICEF Eastern and Southern Africa Regional Office.*
- *Mr John Williamson of the Displaced Children's and Orphans Fund;*

The major points of the presentation were as follows:

Main considerations:

- How many countries, even those with a low HIV prevalence, can ignore HIV/AIDS as an issue? None. HIV/AIDS amplifies the vulnerability of children who were already poor, affected by conflict, or exploited.
- How many experts can provide your country with an effective plan of action to address the situation and impact of OVCs. None. Experts have experience that may be useful to you, but you are the ones who have the experience to design solutions that will make sense in your country.
- This Workshop is to allow you to benefit from the experience of others. Try to make new mistakes – not the same ones that were made before. What should you do to the threats that face children in your country? You need to define those answers.

Children's rights:

We need to consciously remember that children have rights. That is why we do this work, not because we are being charitable. Our responses to children's vulnerability should take into account these four principles of the International Convention on the Rights of the Child:

- The right to survival and protection from abuse and neglect;
- The right to a voice, to be listened to and to participate;
- The best interests of the child should be the major consideration of all policies and decisions;
- All children should be treated equally without discrimination, and vulnerable children and orphans should have the same opportunities as others.

All these principles are being seriously compromised.

The rights of children are so varied that there is a clear need for diversity of response, with a multitude of actors.

Strategic considerations:

- The scale of orphaning is enormous, and orphans are only a portion of the children seriously affected by AIDS;
- The problem is long-term;
- Responses must be developed and sustained at scale;
- We have to hit a moving target;
- Collaboration is essential;
- Both the big picture and the impacts at the level of the household and child must be considered in planning.

Strategies for intervention:

- Strengthen the capacity of families to cope with their problems;
- Mobilize and strengthen community-based responses;

- Strengthen the capacity of children and young people to meet their own needs;
- Ensure that governments protect the most vulnerable children and provide essential services;
- Create an enabling environment for affected children and families.

Specific steps to build a strategic response:

- Organise a collaborative national situation analysis;
- Develop a national policy and strategic plan of action;
- Develop, strengthen, expand and replicate interventions that can be sustained at scale;
- Systematically mobilize communities and build their capacities;
- Target priority areas with effective economic interventions, like microfinance services;
- Increase access to education for the poorest children, especially girls;
- Increase everyone's access to health services;
- Incorporate psychosocial interventions into all activities;
- Monitor, evaluate and do research on key issues.

Challenges/issues:

- Responses are not commensurate with the scale of the challenge;
- Little is known about how communities are coping;
- Little is known about what works, and how do we scale up what seems to work;
- Agreeing on policy and programme-related definitions;
- Agreeing on definitions of 'good practice';
- The realization of a human-rights approach to programming for OVC;
- Effectively and efficiently channelling resources to households;
- The development of strategic partnerships;

What have we learned?

- Study how communities are responding, and build on that;
- Form community coalitions – use existing structures such as faith groups, women's groups, credit committees, funeral committees, youth associations etc;
- Do not impose definitions – communities should define the children about whom they are most worried, using their own index of vulnerability.

What is 'best practice'?

- There is no 'one-size-fits-all';
- There are certain principles which can be applied elsewhere;
- Scale is the issue.

AIDS in the context of poverty:

- Resource mobilization and channelling remain the major challenges;
- What about Poverty Reduction Strategy Papers? Strategy should include factoring in responding to the impacts of HIV/AIDS in these processes.

Getting resources to the frontline / community level:

- Do no harm – do not undermine the motivation base of communities;

- There are limitations of absorption capacities where there are low levels of resources;
- Do not compromise on transparency and accountability;
- Develop capacity in tandem with the infusion of resources;
- Explore mechanisms to get resources to the frontline.

Mobilizing and sustaining political will:

- Governments have signed the UN's declaration of commitment on HIV/AIDS;
- Advocacy is critical;
- In terms of human-rights, duty bearers at all levels have a duty to respond to children's needs;
- Governments have a leadership duty – to provide resources and to sustain a conducive political and policy environment.

Developing strategic partnerships;

- There is no way anyone can do this alone!
- Partnership and coordination are critical – but they must be strategic;
- For example, faith-based organisations are enduring, far-reaching, have legitimacy, and are already engaged – we must engage more seriously with them.

Discussion during the plenary brought out the following points:

Strategic considerations:

- Orphans are only a portion of the children seriously affected by AIDS:
- Children with sick parents or children in poor households that are taking in orphans and are becoming even poorer;
- Children who themselves are infected.
- No silver bullet – each country is affected differently (e.g depending on labour input requirements)

Programming:

- We have to hit a moving target. What we are seeing today is the result of something that happened 10 years ago. We need to prepare for and anticipate what is going to come at us 10 years from now.
- Children do not live as individuals, they live within communities. That is why we have to respond at the community level. Policies should be informed by community practice.
- Affected families and communities are the first line of response. We have to strengthen their capacity to care.
- Children must be part of the solution to the problem. Our responses should not only be child-centred but child-focused.

Cycle of poverty:

It is important to look at what is happening at the level of a child within a household:

- breadwinner becomes ill – family savings are used for medical costs;
- breadwinner can no longer work so income stops – no money for school-fees, so children are removed from school (especially girls) – quantity and quality of food decreases, shelter deteriorates, loss of access to health care;
- children's own vulnerability to HIV infection increases as they care for sick parents and try to cope with economic problems;

- children often become caregivers to the parents – psychosocial distress on children may begin at a fairly early stage – parent does not tell the child about the HIV, thus intensifying the stress of the child – child faces intense grief at the loss of parent, insecurity about the future – children are often separated from siblings to live within extended family, causing huge distress;
- financial insecurity is compounded by property grabbing, loss of inheritance – many children face exploitative child labour, sexual exploitation and even life on the street;
- children have their own children, are highly vulnerable to HIV infection;
- cycle begins again.

Even where the HIV prevalence is low, households are still confronting these issues.

Institutional care:

Costs of institutional care are prohibitive – with the same money you can support many more children through community initiatives, foster care, small group homes.

Wherever you create special institutions for children, parents send their children to the institutions. It is an expensive way to expand the problem. We have to use our limited resources in effective ways.

Targeting:

- Geographic targeting – some areas are more affected. Where are there more orphans? Where are households having a more difficult time caring for their children? Where are the street children coming from and why?
- Decisions of which children and households to help should be made by the communities themselves. They know who is most vulnerable. Have them define what their criteria are.

Intervention strategies:

1. Strengthen the capacities of families to cope with their problems – material assistance is not sustainable, but can be used as a short-term response in immediate crisis;
2. It is often too late to start interventions like income generation once a family is in crisis – by then they will often have sold their productive assets like land, animals and tools – credit saving, income generation should start before the death of a parent;
3. Help parents get treatment for opportunistic infections – it is inexpensive and will help them live longer and most comfortable.
4. Provide psychosocial and spiritual support and help families plan for the future.
5. Community responses should not just be community based but should be community managed. Initiatives should be developed by communities with facilitation and technical assistance of external facilitators.
6. Don't always start with a needs assessment – try starting with the strengths of a community. Before NGOs and donors came, people were taking care of themselves.
7. Our small input is to help capacity development, with provision of resources, to make responses more effective.
8. Children and youth must participate – not only in prevention but also in care activities. Provide children and young people with the knowledge, skills and capacities they need. Involve them in the decision making process.
9. Most governments have ratified the CRC. UN declaration of commitment has made governments accountable and responsible. Government should coordinate the response at country level.
10. Create an enabling environment. Implement laws to protect the property rights of widows and children. Implement poverty reduction strategies to get resources to the children who have been negatively hit by the epidemic. Provide quality, free and obligatory education for all children. Support economic empowerment of women. Provide safe drinking water for all.

Questions and pointers:

- Where do you draw the line between needs and rights?
- So many action plans are never implemented. But there is synergy between child-trafficking, HIV prevention and OVC care. Let's link OVC to our other activities where the agendas are already completed. (Nigeria)
- You cannot determine what your country is going to do, but you can determine what you are going to do in your own country… how you are going to get the ball rolling.
- Put children at the centre of defining their needs, not adults. (SCF)
- We need a coherent child protection framework with guiding principles that apply across the board and different actions for different categories of children. (UNICEF)
- How do we bring people from different sectors together to share their experience?
- How do we ensure the sustainability of interventions and their effectiveness given repeated displacement of people? (DRC)
- How do we support people living with HIV/AIDS ?
- Some families will take in children that are HIV positive and should be given guidance on how to care for them. (Benin)
- We don't need to ask communities to take responsibility for vulnerable children because our traditional values are of solidarity. Communities are already doing the work that needs to be done.

Day 2 : Theme Groups

Delegates were offered a choice of four themes during the morning session, and another four themes during the afternoon. Simultaneous translation was provided in all groups. The emphasis in these sessions was on country participation. A summary of points raised by facilitators and delegates in each session follows:

Psycho-Social Care of OVC

Facilitators: Sara Bowsky (Family Health International); Linda Sussman (USAID)

Addressing the psychosocial needs of children requires the involvement of parents, extended family, community – and the children themselves. In general, the earlier a child is included in the process, the more positive the outcome will be.

Children's needs and responses to their psychosocial needs cannot be separated from the context in which they are living. Some of the common issues discussed during this theme group included the following:

Emotional support to parent living with HIV/AIDS:

When a parent (particularly the mother) learns she is terminally ill, the way in which she accepts and deals with her illness will affect her interaction with her children.

Many people living with HIV/AIDS have accepted their HIV status. It is sometimes easier in urban areas where the disease may be better understood than in rural areas, where people may be more fearful of people who are living with HIV/AIDS.

When people are able to accept their HIV status, they are better able to deal with family and neighbours without feeling shameful. This helps to decrease stigma.

Therefore, consider interventions that provide emotional support and counselling to people living with HIV/AIDS, helping them to accept their HIV status and to deal with the implications of the disease on themselves and on their children.

Disclosure:

How a person living with HIV/AIDS discloses his/her status to others (friends and family) and ultimately to her child will affect the child's understanding and emotional response to the parent's illness.

Children are often aware of a parent's illness before they are included in discussions that explain to them what is happening. Sometimes they hear about their parent's HIV/AIDS infection from others in the community.

Informing children in an age-appropriate manner and addressing their fears and concerns will better enable them to cope with changes in the household that result from AIDS.

Therefore, consider interventions that help parents to decide:

- whether and when to disclose their HIV serostatus;
- to whom and how to disclose; and
- how to disclose to children, depending on the situation and the age of the child.

Included in these interventions, consider how best to work with men *and* women to disclose their HIV status to their spouse and other partners.

Gender-related issues will affect communication about the disease between partners and should be identified and addressed within these interventions.

Impact of parental illness on children:

Children whose parent(s) are known to have HIV/AIDS are often stigmatised and discriminated against by others. This stigma may come from both adults and peers.

Therefore, consider interventions that:

- support children in responding to the stigma they may experience;
- educate adults and children in the community about HIV/AIDS so that fear and discrimination is replaced by understanding and mutual support.

The household may experience economic stress as a result of being unable to work and facing increased expenses. This often leads to there being less money for school, food, and other essentials. Therefore, consider linking psychosocial interventions with activities that provide direct material support.

Loss of adult love, affection, protection and guidance often result from adult illness and death. Children may take on adult roles in the household, such as caring for ill parents. They may not know how to best care for a parent who is ill or how to protect themselves from infection.

Therefore, consider interventions that:

- provide emotional and spiritual support and protection to children;
- provide skills that children need to care for themselves, when they take on adult roles in the household; and
- provide information and resources to enable them to protect themselves from AIDS-related illness and HIV/AIDS infection.

Consider the context in which children live, which may include support from (and to) grandparents, aunts and uncles, and others in the extended family and community.

Planning for the future of the child:

A primary concern of parents who find out they are HIV-positive (and of children when a parent becomes ill) is how the child will be cared for upon the illness/death of the parent?

In many places there are cultural taboos against talking about death. This is sometimes made even more complicated by the association of AIDS with sexual relations and the resulting taboos around discussing AIDS.

An intervention that was developed by women living with HIV/AIDS in Uganda is a memory book, box or basket. The parent shares information, pictures, anecdotes, stories about the child when he/she was young, future aspirations for the child, information about family values, and discusses future plans for the child, etc by talking and writing about these topics and placing the information and mementoes in a book, box, or basket for the child.

Therefore, consider interventions that help parents plan for the future of their children, involving children themselves when it is appropriate.

In addition legal issues, such as establishing marital status and writing wills, can be addressed in order to better establish property rights upon the death of a parent.

Children infected with HIV/AIDS:

Children who are infected with HIV/AIDS experience illness that they might not understand unless their infection is explained to them. Some do not adhere to medical interventions, such as drug regimens, because they don't understand why they should be taking medication if they don't feel sick.

Some children who are HIV infected experience stigma and discrimination from adults, including health care workers, and from their peers.

Therefore, consider interventions that support parents and other caregivers to determine how and when to discuss their HIV status with children who are infected.

Institutionalisation of OVC

Facilitators: Cornelius Williams (Save the Children UK); John Williamson (Displaced Children's and Orphans Fund)

Discussion focussed on all orphans – including but not limited to those orphaned by AIDS. Institutional care was generally seen as a last resort.

Definition of institution:

- Formal institution, run by government or civil society organisations, including religious organisations;
- Caring for children in group setting away from family;
- Regulated by laws or regulations.

Problems with institutions:

- Young people who have difficulty reintegrating in society once they are too old to remain in the institution – development needs are not met, family ties are ;broken.
- Lack of / outdated standards, legislation;
- Poor gate-keeping – children admitted for whom there are better care alternatives;
- Existing institutions suffer from:
    - Poor quality care
    - Inadequate resources
    - Inadequate training of staff

Alternatives to institutionalisation include:

- Care within extended family;
- Fostering (informal or legal);
- Informal care arrangements within the community;
- Adoption (formal);
- Children or adolescents living on their own with supervision and /or support.

Unresolved Issues

How to deal with children living with HIV /AIDS – stigma, taboo, potential rejection of children by caregivers if they are informed of HIV status.

Challenges

- Applying best practices/lessons learned elsewhere, e.g. Uganda, Rwanda, Ethiopia;
- Ensuring children's participation;
- De-institutionalisation of children and their reintegration into family and community;
- Inadequate database on children who are in institutional care and on the institutions, themselves.

Children Infected by HIV/AIDS

Facilitators: Hélène Badini (UNAIDS); Rose Dossou (Projet Enfant)

- Experience of children's project in Côte d'Ivoire developed by Mme Rose Dossou;

- Care and treatment of 150 children infected by HIV/AIDS with a long waiting list of children whose parents desire a therapeutic component;
- Main activities: child care, home visits, information and communication through counselling groups specifically for parents and children.

Lessons learned:

- Feasibility of interventions for children infected by HIV/AIDS;
- Possibility and need for total care (medical , psychosocial, nutritional, legal and spiritual);
- Changing nature of interventions which take into account the age of the child, his environment and living conditions.

Recommendations :

- Care provision to be developed at the start of pregnancy (before the birth of the child);
- Feeding issues for the new born baby to be addressed using the family approach (with the two parents, if possible);
- Negotiation and production of pediatric forms of anti-retroviral therapy;
- Greater mobilization of socio-health staff to assist parents in their choice of feeding for their children of HIV-positive mothers.

Challenges :

- Undertake initiatives, national programmes of care for children infected by HIV/AIDS;
- Publication of best practices in the management of infected children.

Participation of Youth and Children

Facilitators: Ibrahima Diallo (UNICEF); Tamar Renaud (UNICEF)

Points in common

- Weak participation of girls compared to boys.
- There are few organizations for children orphaned or made vulnerable by HIV/AIDS. There are, however, informal initiatives bringing OVCs together for discussion and support (Informal gatherings of OVCs in Mali, CAR. Formal gatherings in Burkina Faso and in Côte d'Ivoire).
- Children forced to work when their parents cannot because they are too sick.
- Need for communication: members to monitor the vulnerable children in the communities. Can help by training mothers/foster parents on CRC.

Differences

Among the OVCs present at the session, one noticed a difference in the discovery of the sero-status of the parents.

- First case: youth from Bouake – serological status of parents revealed by social aid after their decease and after the child had asked, i.e. at his request.
- Second case: child from Mali – serological status of mother confirmed by the father after the mother's death, the child having approached her father after having seen photographic information on AIDS showing a person presenting the same symptoms as her mother.

Differences in approach to invite children to get involved actively.

- Initiative based on Bouake – a child took the initiative in contacting other children affected in order to develop a spirit of solidarity and mutual assistance amongst themselves.

- With the other experiences presented, the initiative to involve children/young people was taken by adults.

Challenges

- Effectively involve OVCs in the decision-making process and in programmes that concern them.
- Identify adequate strategies for effective participation by children and especially by girls. For cultural/gender reasons, girls are not allowed out of the household, or to participate in organizations or events – especially after puberty. There is a need to find ways to give girls an opportunity to participate. For example, negotiating with employers of child domestic workers to allow them to attend school and to share experiences.
- Promote respect among adults for the rights of children. How do we encourage adults to ensure children's participation? A particular challenge will be to get fathers to accept the necessity of children's participation.
- Ensure the participation of children/young people in rural areas.
- Ensure the participation of affected young people/children does not contribute to stigmatising them.
- Make young people/children real participants, not just background figures in the process.
- Help parents to reveal their serological status to their children.
- Help parents talk to their children about their children's desires, wishes, rights, so as to reduce their vulnerability to sexual exploitation. Right now there is a problem of lack of respect by parents for children.

Quotes

> *"Des que mon pere m`a dit qu`il etait seropositif, j`ai eu peur" ("Ever since my dad told me that he was HIV positive I've been scared.") - orphan from Mali*

Some practical examples of intervention

- Children affected by HIV/AIDS supporting their peers in the case of hospitalisation.
- Affected children in rural areas helping families with a member that is ill due to AIDS.
- Training of the youngest OVCs by older children with the same experience.
- Groups of mothers making families aware of the rights of children.

Care and Support of OVC

Facilitators: Rosemary Nnamdi Okagbue (FHI); John Williamson (DCOF)

Psychosocial care and support:

Infected child:

- Needs to be cared for by adults who care about the child
- Must help child to understand that he has a chronic disease without revealing what the disease is
- Should assess what he needs

Infected adolescent without external signs or symptoms

- Should be helped to understand serostatus
- Should be instructed adequately on taking medications

- Should be taught how not to infect others through appropriate behaviour

Infected adolescent with external signs of symptoms

- Will experience discrimination and stigmatisation
- Help child develop skills to respond to this difficult situation and sometimes negative response of others
- Help child to accept his situation

Affected child

- Has sick parents but child may not know what the disease is
- Should encourage parents to engage in dialogue with the child/children
- Ensure decisions are taken to avoid problems after death (legal – property inheritance, reduce trauma)
- Strive to make available psychological support and counselling

Comments

- Should differentiate levels of responsibility of different actors
- When providing psychological support, take into consideration a family's individual situation
- Adoptive families should be included as part of the picture in organizing a child's psychological support
- Memory book approach (Uganda): Sara Bowsky here at conference has info. Structures opportunity for HIV+ parents to talk with child – child then has reminders of good things of parent/family; also helps the family plan and prepare for future death (will, etc.)
- Importance of spiritual support: right to know Word of God – comfort the child in the midst of hardship.

Medical care and support:

Problems	Solutions
Access to treatment	Increase access to free care – medications, follow-up monitor medical care at home
Distance from health care	Develop care network between specialities (ex: dermatology and ophthalmology; should understand problem based on diagnosis)
Economic barriers	Increase solidarity and responsibility of community members for these children (ex: during vaccination campaigns, ensure someone can take these children)
Lack of experts	Paediatric tri-therapy should be available
Lack of equipment to follow-up care and treatment	

Comments:

- Strengthen network around the child
- Subsidize free care – free provision of ARVs
- Should help the child while preserving confidentiality
- Ivory Coast – have association in charge of medical care & support. Have initiated home-visits in all associations. Re: opportunistic infections – can provide home care on weekends until clinics & hospitals open
- Congo – in addition to home visits, provide quality training of volunteer counsellors for VCT

- Encourage traditional medicines. Need to test remedies effectiveness for those without access to ARVs.
- Relieve the child of the burden of care, by caring for parents' medical needs.

Social welfare / well-being of the child:

Definition: all material and moral elements that improve the child's well-being.

Elements: adequate food, education, clothing and shelter; vocational training; health care access; affectionate parenting; right to information on serostatus of parents; income-generating activities to heads of households.

Actions to carry out:

- Advocacy with governments to take necessary steps to ensure access to social services, health care, lodging;
- Community awareness raising to encourage – create committees of care and support
- Leisure hobbies play areas need to be provided for children

Comments

- Capacity building to provide care and support to these children's families
- Set up groups of affected/infected children with peer educator programs
- To sensitize other children from 10-15 years;
- To prepare for problems that will arise in their lifetimes.

Child's rights:

Sources: civil status, national, name, survival, right to protection, right to participation in society, right not to be discriminated against or stigmatised, right to education, training, shelter, food.

Needs:

- Free legal assistance where children are in conflict with the law and with inheritance problems
- Children's courts should be established
- Separate areas for children who are imprisoned – apart from adults
- Mainstreaming employment.

Comments:

- Need formal laws for when children's rights are violated (including for victims of abuse, sexual exploitation and rape, child trafficking).
- Legal texts and judgements aren't always effective – don't replace community advocacy and sensitisation to bring people along with the processes; mediation should be available as an alternative.

HIV/AIDS prevention, training, monitoring and evaluation:

HIV/AIDS prevention needs:

- Sex education, reproductive health, HIV/AIDS prevention (knowledge, attitudes, skills, practices) appropriate to age and development stage;
- Prevention during care of sick parents to avoid their own infection;
- High risk behaviour prevention education.

Training needs

- Home based care skills for children who are caring for family members

- Provide access to education and training in family life-skills (values, goal-setting, education and family goals, gender relations in future relationships and gender balance in division of labour for domestic responsibilities)
- Vocational training access for those not in formal schools.

Monitoring and evaluation

- Home visits / assessments
- School visits / performance assessments
- KAP studies / focus groups on HIV/AIDS prevention.

Access by OVC to Quality Basic Services

Facilitators: Elaine Ireland (SCF-UK); Willibrord Shasha (USAID)

This session opened with a difference of opinion between those who felt the definition of 'basic services' should be limited to education, health, nutrition, water, food and sanitation, and those who said they should include leisure and recreational activities, protection, micro-credit schemes, reception structures etc.

To facilitate work delegates agreed that the development of OVC should be the focal point for discussion and to share experiences on what role-players are doing for these children in their respective countries.

Education:

In some countries there are formal and informal education systems. State-run schools are often in a state of dilapidation and delegates felt their governments should repair them before any intervention in favour of OVC.

Other initiatives do exist, following the example of the *Medean d'Afrique* project, and the Martin Luther King Centre in Congo Brazzaville that organizes the care and support of orphans with the help of sponsorship.

Delegates expressed concern over discrimination against girls in the education system. Access to schooling was the responsibility of governments.

In general, delegates said their countries were in an embryonic state, and faltering in their response to OVCs and HIV/AIDS. A strategy was needed in most countries to ensure unrestricted access to schooling.

Health:

Some countries stipulate that all people have the right to healthcare, although the reality is often quite different. Other countries have decentralised primary healthcare facilities, although they are not specifically geared for OVCs. Governments are not budgeting for the cost of providing care to these children.

Successful initiatives in providing free care and support to children in Dakar are being extended to the interior of Senegal. Also, a system of replicating successful projects is being developed by *MINAS* (Ministère des Affaires Sociales).

Negotiations for the placement of children in reception centres do exist (Cameroon). Others are attempting initiatives that are worth following, like the case of CARITAS in Niger.

In other countries, care and support systems exist – but are not free – as a system of cost-recovery applies (as in the instance of CHAKA of Mali).

It was recommended that these programmes should be evaluated and adapted to the needs of different countries.

Water and sanitation:

Initiatives in the direction of OVCs are still insufficient. However, the experiences of Burkina Faso, which consist of providing services to children at bathing places and the project for improvement of water-sources and the construction of tanks, which also benefit OVCs, are worth following.

Leisure and recreational activities:

Certain delegates spoke of experiences of NGOs – for example in Togo with *Centre de Loisirs et d'Orientation des Enfants Défavorisés (CLORED)*, that has put into place strategies for the identification of orphans and other vulnerable children. These pilot experiences are worth a follow-up and evaluation.

Nutrition:

Experiences meriting special attention included those of

- Congo Brazzaville, with the reception centre and of the help of the PAM [what is this?];
- Chad with the project of orphans placed with foster families;
- Ghana with the project with regards to techniques for the mobilisation of nutritional resources (rice, cassava/manioc);
- Togo with the nutritional care and support of OVC merit special attention.

Protection:

The system put in place by Ghana to assure the protection of children in all categories merits special attention.

The same applies to Cameroon, which has put into place a protection system to protect children through a national adoption strategy.

Micro-finance:

The experiences of Ghana with the project *CEPPA* and those of Congo Brazzaville with the *Medean d'Afrique* projects and the Martin Luther King Fund should be investigated in full and monitored.

Reception structures (*structures d'accueil*):

Certain delegates were of the opinion that reception structures are a means of access to education services and healthcare, and that their existence should be promoted.

From the point of view of the exchange of local experience and the contributions of the delegates, several recommendations were made:

Commitments:

In order for OVCs to have access to quality basic services, delegates proposed advocating that all countries:

- Provide free education to primary school level, especially for OVCs; provide school hostel facilities for primary and secondary schools, to accommodate OVCs;
- Provide free primary healthcare for OVCs; expand and support these facilities;
- Provide technical and financial support to families, communities and institutions responsible for the care and support of OVCs; support associations and NGOs which facilitate revenue-generating activities for the benefit of OVCs;
- Support a national situation analysis, strategic plan of action, and review of legislation, for OVCs; identify the most cost-effective strategies for care and support of OVCs;
- Advocate for the protection of children's rights; undertake legislative, political and institutional reforms, allowing the taking into consideration of matters pertaining to OVCs;
- Increase efforts to identify OVCs in rural as well as urban areas;

- Develop new types of partnership between the state, NGOs, families, communities, and development agencies; keep all role-players informed;
- Put into place an effective system for monitoring and regulating the application of all the texts/commitments for the benefit of the child.

OVC in Situations of Armed Conflict

Facilitators: Tamar Renaud (UNICEF); Cornelius Williams (SCF-UK)

Commonalities:

Children affected by armed conflict are made vulnerable to HIV/AIDS by

- forced displacement;
- the breakdown in family units that usually provide the first line of protection;
- extreme economic need that may push them to exchange sex for survival; and
- lack of access to health services, adequate nutrition, shelter and education.

Adults sometimes use the extreme vulnerability of children affected by armed conflict to abuse and exploit children (e.g. sexual exploitation in West Africa by humanitarian workers).

Stigma and discrimination because of HIV in a conflict setting may further compromise a child or adolescent already made vulnerable by the conflict.

When people stop moving, that is when humanitarian organizations can most effectively intervene, within the structures that the displaced communities have (families, community leaders, spiritual leaders).

Before intervening we must do a vulnerability analysis and then build on programmes that have already been developed through family structures, simple social work, counselling, etc…

The Convention on the Rights of the Child provides the framework of action: health, education, nutrition, shelter, identity, reproductive health.

Access to reproductive health services must be a key element to conflict work (non-judgmental, confidential, free).

Challenges

Need a vulnerability framework to analyse the manifestations of a child's vulnerability.

Livelihood analysis – need to find alternatives to sex-for-survival for women and girls affected by armed conflict.

Unresolved issues:

In caring for separated children, should we distinguish between those that are affected by HIV and those that are separated because of other causes? Programmatically, these children are difficult to differentiate, and doing so may increase the stigma they face. However, families with HIV positive children should be assisted to care for them.

How to make income generating activities effective and sustainable in societies where the entire economy has been destroyed by the conflict.

Quotes

> *"Let not your moral judgement cloud you" on judging children surviving through sex work.*
>
> *"Children are exchanging sex for a bowl of rice … a school book"*

Community Capacity Development for OVC

Facilitators: Stanley Phiri (UNICEF); Linda Sussman (USAID)

Consensus Issues

- There was agreement on the fact that development should as a rule use existing community resources, foundations;
- There was also agreement that development should utilize participatory approaches;
- There was agreement on the fact that it was a big challenge because of resources.

Unresolved Issues

- Participants spent time discussing what community development was – and was not. This was an unresolved issue as no agreement was reached.

Key Questions

- A key question was: who initiates and owns the process?
- What about sustainability of resources?

Day 3 : 'Core Element' Working Groups

Country delegations were divided into four groups – three from Francophone countries and one for Anglophone nations. Each group was taken through four successive topics over the course of Day 3 and the morning of Day 4.

These 'core element' sessions were intended to impart new concepts and skills to the audiences. The conveners felt these topics were so important that every delegate was exposed to all four topics.

Community Mobilization for OVC

Facilitators: Marc Aguirre (Hope Worldwide); Stanley Phiri (UNICEF)

Methodology/Process :

This was made up of the following:

- Introduction
- Expectations
- Presentation of two scenarios – to facilitate discussion on ways of working with communities
- Dividing into working groups: 'elements of a mobilized community'
- Feedback in plenary
- Identification and discussion of common points
- Divide into working groups : 'steps towards mobilizing communities'
- Feedback in plenary
- Identification and discussion of common points
- Plenary discussion on qualities and skills necessary for effective facilitators/mobilizers
- Summary of key points/issues and focus on applying approach to country work plan

A. Introduction

Participants in this session were exposed to two small-group exercises to draw out their individual experience and expertise. It was stressed that the point of facilitation is to build capacity rather than directing or instructing communities. In the plenary, participants identified and reached consensus on the common points from all the presentations:

- Communities are aware of the problem, they define it and they internalize it
- They show commitment to working towards resolving the problem
- Communities make decisions and prioritize concerns
- Invariably, communities find ways to respond

For example by mobilizing internal resources including time; moral; material; financial and technical. They are also informed of external resources and may be able to access them

- Communities mobilize internal resources – some are also able to identify and mobilize external resources
- They check their own progress against goals set periodically through meetings and discussions (Communities are capable of evaluating their actions)

Other elements that were identified and discussed included:

- Communities are utilizing leadership and other existing structures to build on
- All groups (as relates to gender, status, age etc) in the community are represented on groups responding.

In summarizing the discussion the facilitators also emphasized that it was important to ensure that communities have ownership of the activities and plans. It was not a question of participation by communities in programs that were designed and dictated by outsiders but participation in programs they felt they themselves owned.

B: Steps towards mobilizing a community

The same process was followed in this section of this session: working groups and then a plenary to identify common points. The common points that came out of the facilitated discussion were:

- Contact with the community including use of appropriate entry points. The contact was a critical step towards relationship building (trust)
- Facilitated community exploration and identification of problems or concerns (local situation analysis)
- Community prioritization of problems
- Community identification and acknowledgement of internal resources
- Community led development of an action plan (response)
- Community Action
- Communities facilitated and assisted in self monitoring and reviewing progress against set objectives (monitoring and evaluation)

C: Qualities/Skills necessary for effective mobilization

In this section of the session the following qualities and skills were identified as being necessary for effective mobilization.

- Listening
- Empathy
- Flexibility
- Patience
- Being discreet
- Honesty
- Humility
- Openness
- Communication
- Open-mindedness
- Gender sensitivity
- Observational skills
- Being able to see the big picture

D. Summary of key points/issues and focus applying approach to country work plans

The facilitated discussion of a summary of key points led to the conclusion that:

- Community mobilization is a continuous process, it is a living process, dynamic and it should be so to be effective.

- Communities have capacity – they are already doing something long before we even write our proposals and go to them
- We outsiders have a tendency to act as experts with communities rather than working with them as facilitators and capacitators within a mutual learning process where we outsiders also learn

It was also agreed that the action plans then should identify opportunities that will enable country teams to acquire skills and attitudes that will enable them effectively utilize community mobilization in the response to OVC.

Community capacity development was also discussed as a way to enable communities that have been mobilized to more effectively respond to the OVC. Capacity development goes in tandem and is part of community mobilization.

E. Divergence

One divergence that came out was that although the facilitated approach was recognized and identified as a more effective, inclusive and capacitating approach to working with and engaging communities, there was still a lack of its internalization by external agents thus the contention by some that the "expert approach" in scenario one was also useful in certain contexts and that the facilitated approach was not useful in all situations.

Conducting an OVC Situation Analysis

Facilitators: Mananza Koné (FHI); Rosemary Nnamdi Okagbue (FHI); John Williamson (DCOF)

The sessions were structures as discussions sessions, but following the framework of 6 questions as guidance.

1. What is a situation analysis?

Situation is one step in a process of mobilizing action to improve the safety and well-being of especially vulnerable children.

2. Who should be involved?

During the discussions, the following groups were identified:

- Ministries with responsibilities in such areas as health, social welfare, education, nutrition, community development, youth, gender, agriculture, planning, and registration of NGOs
- Child- and family-oriented NGOs
- Organizations engaged in grassroots development
- Religious bodies
- International organizations, such as UNICEF, the World Bank, UNDP, and UNAIDS
- University departments with expertise in such areas as social welfare, social research, public health, education, nutrition, demography, anthropology, and public policy
- Associations and support organizations for people living with HIV/AIDS
- Bilateral donors
- Foundations
- Youth associations

Involving strategically important groups in the situation analysis not only increases the kinds of technical expertise available, it can generate commitment to the eventual recommendations. Involving representatives of HIV/AIDS-affected communities can help ensure the findings and recommendations will be on target. Being more inclusive requires more time, but it can help accelerate subsequent

action. Involving groups in developing a shared understanding of key issues and consensus about priorities, can lay the groundwork for collaborative action.

3. What types of information should be gathered?

- Demographic patterns.
- Health conditions, including HIV/AIDS
- Economic situation
- Social, cultural and religious beliefs, activities, and networks
- Existing services and programs
- Laws and policies
- Key problems and their causes

4. What methods can be used for gathering information?

Every approach to gathering information has strengths and limitations. Using multiple sources and methods helps confirm major findings. Some of the methods that have been used include:

- review of existing statistical data,
- review of existing reports and other descriptive information,
- interviews with key informants,
- case histories of affected children and families (presented so as to guard the confidentiality of those concerned),
- research among affected children and families
- in-depth interviews among those affected and
- focus group discussions and other group interview methods among affected families, community members and/or key informants.

5. What are the challenges encountered during the data collection?

- data on the subject are quasi inexistent
- Problems of planning
- Financial resources not always available
- Socio-cultural burden (women's participation)
- Real engagement of the institutions
- Finding a consensus among the different actors
- Apathies noted within the local population interviewed du to their past experiences, where not results are communicated to them
- Child participation (shyness)
- Problems of accessibility in some areas fro security reasons
- Difficulty of conducting an assessment with the stigmatisation and confidentiality issues pertaining to HIV/AIDS
- how to manage the allocated time in order to collected the maximum of information within a limited period of time?

Technical skills needed:
The team that carries out a situation analysis will deal with information from such fields as public health, social welfare, child welfare, economics, community development, anthropology, psychology,

and law. They will identify and collect information in administrative documents, studies, reports and program descriptions. Direct research in affected communities requires skills in interviewing as well as group and community work. It may also involve special skills in conducting surveys, focus groups or other information gathering methods selected. Training the team is then an important factor in the preparation in order to insure a good coordination and comprehension.

6. What is the follow up with the information gathered?

- Analysis and Recommendations
- Set Geographic and Social Priorities
- Identify Key Problems
- Develop an Overview of Current Action
- Prepare Recommendations
- Mobilize Action
- Convene a National Planning Conference.
- Establish a Monitoring System

Reviewing Policy and Legislation Affecting OVC

Facilitators: Jean Claude Legrand (UNICEF); Peter McDermott (USAID)

There was a general agreement among all four groups on the International Legal instruments that outlined the responsibilities of the state with regard to the protection and assistance for children affected by HIV/AIDS. In addition to the general principles enshrined in the Human Rights legislation, three other conventions were cited as being of importance:

- The Convention on the Rights Of the Child
- The African Charter on the rights and welfare of the child
- The ILO convention on Child labor.

Nearly all countries stated that they had national policies and legislation that provided some limited protection to children affected by HIV/AIDS. Most countries also identified two major constraints:

1. There was a plethora of policies, laws and legislation related to children. However much of it was contradictory, outdated and inconsistent. In addition it did not necessarily cover some of the newly identified threats to children affected by HIV/AIDS.
2. That despite a number of policies and laws being in place, there was little effective implementation of existing policies and laws. In addition there were limited sanctions for contravening the policies and laws and almost no monitoring systems were in place.

During the various discussions it was agreed that there needed to be immediate action in the following three areas:

- Harmonization between International treaties and conventions and national Policy and legislation.
- Harmonization and consolidation of existing policies and legislation within country
- Putting in place a monitoring system to oversee implementation and compliance. This would entail some form of enforcement and sanction mechanism.

Each group spent considerable time outlining some of the protection issues related to children affected by HIV/AIDS, and other vulnerable children.

1. **Discrimination:**

This took on many forms, both direct and indirect. Access to and use of health and education services were identified as the main threat to children affected by HIV/AIDS. A great deal of time was spent discussing the barriers to services and how they could be overcome. The role of public policy actions such as universal free primary education as in the case of Uganda was discussed at length. There was a strong consensus that similar public policy measures needed to be put in place in the health sector to reduce costs, both direct and indirect.

2. Placement and guardianship.

Placement and guardianship were issues that participants felt were not currently well-developed in existing policies and legislation at country level. To date very few formal adoptions took place and the mechanisms were lengthy, expensive and cumbersome. Traditional customary measures were the norm. However it was recognized that as numbers increased, and as the potential for abuse also increased, children needed greater protection in this area. Issues such as tracing, placement, adoption, foster care, institutional care, group homes, community etc.

3. Legal Protection.

It was clear from all country presentations that children affected by HIV/AIDS and other vulnerable children required special protection measures in a number of areas. Most obviously in the area of property and land rights, as well as inheritance rights. Secondly they needed to be protected from exploitation and abuse especially when in informal extended family fostering situations. In addition there were several categories of children who also need specific protection given their vulnerable status such as street children, trafficked children, children in conflict and abused and neglected children. Legal protection was also required to protect a child's name, birth registration and to protect children from mandatory HIV/AIDS testing, and to ensure informed consent and the confidentiality of HIV/AIDS results.

4. Information and participation.

It was agreed that children affected by HIV/AIDS and other vulnerable children need to be given information that could protect them from harm, information on their rights and sources of protection, as well as a voice and participation in decisions that affect them.

The conclusion of the discussions was that although all countries had in place some policies and laws that could be applicable to children affected by HIV/AIDS, their special circumstances meant that much stronger, comprehensive and more consistently applied mechanisms needed to be put in place. As such a review of existing policies, legislation and the implementing mechanisms were required.

Other issues discussed:

1. Registration

There was a lengthy debate on the need to and programmatic utility of registering orphans. The discussion centered on the possible stigmatization of children as a consequence. The programmatic utility of registration was not clear. The debate did not lead to a consensus on the issue within or between the various groups.

2. Targeting.

There was a lengthy discussion following on the debate on registration that related to the concept of targeting. It was accepted that to date the response to the situation of OVCs was not commensurate to the need. It was also accepted that despite new global mechanisms and funds, there would not be sufficient funds to fulfill all needs. As a consequence some form of criteria needed to be established to target resources. Issues such as poverty levels, child headed households, double orphans, community identification etc were all touched on.

3. Roles of Government and Civil Society.

There was a general point that came out from each of the groups, the different roles and responsibilities of Government and civil society in ensuring that a comprehensive protection environment existed for children affected by HIV/AIDS and other vulnerable children.

Human-rights-based Programming for OVC

Facilitators: Hélène Badini (UNAIDS); Ibrahima Diallo (UNICEF); Elaine Ireland (SCF-UK)

Rights-based programming takes as its basis the UN Charter, the Convention on the Rights of the Child (CRC) and the Universal Declaration of Human Rights.

The four underlying principles of rights-based programming are the principles of:

- Universality (that rights should be accessible to *all* people, including children)
- Indivisibility (rights cannot be separated from each other - they are all interdependent and inter-linked)
- Responsibility (there is a universal responsibility to ensure that rights are fulfilled and upheld and that all actors, especially governments, are held accountable for this)
- Participation (rights-holders must be actively involved in programmes aiming to fulfil their rights)

When developing programmes to respond to the situation of orphans and other vulnerable children, it is also important to consider the four guiding principles of the CRC which are that all children have a right to:

- Survival, development, and protection from abuse, neglect and economic exploitation
- Participate freely in decision-making in matters that concern them
- Have their best interests as the primary consideration
- Be free from discrimination

Differences between rights-based and needs-based programming:

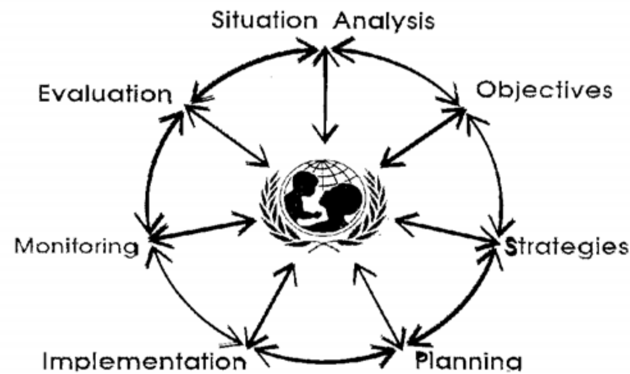
Rights-based programming builds on the more traditional needs-based approach to programming for HIV/AIDS. It aims to provide a more holistic view of issues and is a useful tool for identifying root causes of problems. Needs-based approaches, however, form an integral part of rights-based programming.

Some of the key differences between rights-based and needs-based programmes include:

Needs-based programming	Rights-based programming
Sector-specific, vertical, often fragmented	Holistic, inter-sectoral
Needs are often met and satisfied	Rights are respected, promoted, fulfilled and protected
Needs are not necessarily universal	Rights are universal
Needs do not imply duties or obligations	Rights bring with them duties and obligations
Goals and objectives are short-term and focused on results	Goals and objectives are long-term and focused on both results and the process
Needs can be met according to priorities	All rights are equal and therefore should not be prioritised
Participation is an option	Participation is obligatory

What are the implications of a rights-based approach to programming?

As can be seen below, the key stages of the rights-based programming cycle are very similar to the programming cycle for needs-based approaches. The most significant difference, however, is that rights-based programming requires participation of the rights-holders at every stage of this process.



Moving from needs-based programmes to rights-based programmes implies a number of changes to the way that we conduct our programmes. These include:

- Programmes need to be developed, implemented and assessed using a conceptual framework based on the fulfilment of rights.
- Goals and objectives of the programme are fixed in terms of the fulfilment, protection, and respect of human rights, especially the rights of children and women.
- Programmes should be based on the guiding principles of human and, in particular children's, rights (e.g. non-discrimination, best interests of the child).
- Programmes need to include activities that are integrated, intersectoral, decentralised and use participatory approaches.
- Programmes need to consider how they can support the adoption and implementation of conventions, laws and policies relating to the protection of children.
- Programmes need to analyse the actual/potential role of partnerships.

Some of the most significant differences between needs-based and rights-based programming can be seen in the way that rights-based programmes are monitored and evaluated:

- Rights-based approaches take a long time to produce clearly identifiable results. As a result we need to review the indicators we use to monitor and evaluate programmes.
- Because rights are universal, we need to measure not only the extent to which rights are being fulfilled, but also the extent to which they are being neglected.
- The interdependent and indivisible nature of rights requires an analytical apporach that can monitor and interpret changes.
- The guiding principle of participation means that the process of monitoring and evaluation must involve children, especially orphans and other vulnerable children, their families, communities and civil society.

The key elements of rights-based programming therefore are:

- Working through **partnerships**, strategic alliances, networks
- Adopting a **holistic/integrated** approach
- Placing **participation** of rights-holders at the centre of the response.
- Ensuring that programmes are **sustainable**

Discussion on rights-based programming:

Some of the key questions that came out during the discussions with participants on rights-based programming included:

1. ***How can we do rights-based programming in countries where rights are not respected and where governments are not open to advocacy around the fulfilment of rights?***

There was wide agreement from the participants that a direct advocacy approach in terms of lobbying government to fulfil the rights of children would be highly unlikely to achieve results. On the whole, participants agreed that a more effective approach would be to aim towards gaining a gradual shift in attitudes, among both government and community actors. Ways in which this could be achieved are through experiential influencing, involving relevant government departments in the programme cycle and working with both local communities and government partners.

In order to reduce rights-based programming being perceived as a threat to government and community actors, it was suggested that there is a need to begin by addressing some of the less controversial rights to which children are entitled. Participants also felt quite strongly that rights-based programming should not necessarily always be introduced as such. A more effective approach would be to begin by encouraging communities to look at the problems they are facing and to identify how these impact on the vulnerability of children. Once this has been highlighted, it then becomes easier to identify how addressing these problems serves to not only reduce children's vulnerability within communities, but moves communties and governments closer towards fulfilling human and children's rights.

2. ***How do we ensure that by promoting awareness of children's rights, we do not encourage disrespect for adults and increase delinquency?***

The response to this question was that as we develop rights-based programmes we need to be clear about the fact that rights also come with responsibilities. In working with children to raise awareness of their rights, it is therefore essential that they are also informed of the responsibilities that accompany these rights. If these responsibilities are not respected, then children and young people could have their rights taken away from them.

Participants also recognised that as well as raising awareness of children's rights among children, parents and other adults need to be made aware of these rights. This involves providing parents and other adults with training on what children's rights are and how they can help to fulfil these. Training for parents and adults should also provide them with skills that will help them to ensure that children act responsibly in relation to the fulfilment of their rights and that they do not use these rights to justify irresponsible and inappropriate behaviour.

Conducting participatory situation analyses, involving both children and young people and all those who are responsible for protecting and upholding children's rights, can help duty-bearers to understand more clearly what children's rights are and makes it possible to gain a better respect of rights amongst all those involved.

3. ***If rights are indivisible, how are we able to respond to them all when we only have limited resources?***

One of the ways in which it was suggested that people could respond to rights with minimal resources is through taking a much longer-term view of a rights-based programme than they might have of a needs-based programme. This will then enable them to move towards a gradual fulfilment of all of the rights of children.

Whilst the principle of indivisibility of rights means that we should be aiming to fulfil all children's rights, it is also necessary to recognise that one organisation cannot fulfil all rights all at once. As such, it is necessary to consider which rights that are not being fulfilled are having the greatest impact on the vulnerability of children to abuse, neglect, exploitation and discrimination.

It is also clearly evident that one organisation cannot expect to fulfil every single right of the child. As such it is essential that agencies, communities and governments work together and develop strategic partnerships and alliances that will enable us all collectively to move towards fuflfilling all of the rights of children.

Key points raised by participants in regard to rights-based programming:

- Rights-based programming makes it easier to identify the source of a problem and to develop more integrated and holistic responses, which in turn makes the response broader and more sustainable.
- Rights-based programming needs to take place on two levels - it needs to involve awareness-raising of the issues relating to the fulfilment of children's rights among government representatives and direct lobbying of the government to hold them accountable for applying the CRC. At the same time rights-based programming needs to work at the community/grassroots level so that communities and children and young people themselves recognise and understand what the implementation of the CRC means for the respect of children's rights.
- All actors at all levels have a key role to play in rights-based responses to the situation of orphans and other vulnerable children - we need to clarify what these different roles are and put pressure on the relevant actors to make sure that they take note of and begin to play their roles.
- It is essential that needs-based programming and rights-based programming are not considered to be separate from each other as this only serves to mystify the concept of rights-based programming. The two approaches are complementary, with rights-based programming being based on an analysis of needs but broadening out the scope of a needs-based approach so that it becomes easier to conduct a holisitc and inter-sectoral response that addresses the root cause of children's vulnerability. It is also important to note that the fulfilment of rights has to go through a process of ensuring that needs are met - if needs are not met then rights cannot be fulfilled.
- There is a need to simplify the language of the CRC and make it more accessible to communities (whilst at the same time not diluting the legality of the convention). If people understand what the CRC is about and what it contains it will make it much easier for them to conduct rights-based programming and, more importantly, to identify the links between the CRC and programming for orphans and other vulnerable children.
- A rights-based approach is likely to require a reallocation of resources - in particular it is likely that a rights-based approach will serve to highlight the need to commit more resources to health and education services.
- The more participatory a process is, the greater respect there is likely to be for the fulfilment of rights.
- Rights-based programming should consider the core values of communities and build on these as a means of contributing to the fulfilment of children's rights.

Links between rights-based programming and programming for orphans and other vulnerable children:

Whilst many participants seemed to be very clear on what we mean by rights-based programming, there were greater difficulties in identifying what this meant in practical terms for reponding to the needs of orphans and vulnerable children.

However, those participants who were able to identify some links mentioned the following as areas of possible interventions:

- Ensuring that education and health services are available to all children without discrimination
- Efforts to prolong the lives of mothers/parents so that children have better opportunities for survival and development
- Talking to orphans and other vulnerable children themselves about how to resolve their problems and fuflfil their rights
- Holding ministries/governments accountable for ensuring the fulfilment of children's rights
- Ensuring that children's rights are protected after their parents have died (e.g. protecting inheritance rights).

Young People's Plenary Presentation

The three young people attending the conference addressed the plenary. They were Kassim Dramé, president of N'zrama in Côte d'Ivoire, Jocelyn Olona, head of OVC solidarity group in the Central African Republic and Seydou-Modibo Kané of Mali.

They spoke of the difficulties of communication between parents and children, which makes it difficult for children to participate in decisions which affect them. They said that orphans and vulnerable children ask that their basic needs be fulfilled: access to food, education, vocational training, health services, affection/love and care, information on serostatus of parents. "We want integration into new families, and recreation and leisure."

They urged financial and material support for NGOs that care for OVCs so they can better defend the rights of children. They called for the complete involvement/ participation of OVCs in sensitisation on HIV, and in decision-making on projects that affect them – they need information and education on this.

They also urged that effective application of the CRC be ensured and monitored – at all levels, down to the community. There must be an emphasis on OVCs in implementation of rights.

The young people hoped that:

- These plans of action do not fall through the cracks and remain dead letter like so many action plans before.
- The development of associations of orphans and vulnerable children would be supported in each countries and that yearly meetings to exchange experience will be organised

Discussion:

During the discussion, questions were asked about the difficulty of telling a child, particularly a young child that their parent is living with HIV/AIDS or died from AIDS. "If we do not have the courage to tell our children it's because we are afraid of making them suffer," said a mother living with HIV/AIDS from Côte d'Ivoire.

Participants wanted to know from the young people how and when to talk to them about this. The children responded that the older people are too secretive, that children also can think and that it is necessary to tell them the truth. ("*Vous les vieux , vous etes trop confident. Nous les enfants nous avons aussi des idees. Il faux nous dire la verite.*" Jocelyn).

They advised getting the children who are interested involved in organizations with other orphans and vulnerable children… they will begin to see things around them and understand. When asked whether children blame their parents for transmitting the virus to them, the answer was no, that it was not their fault. (*"C'est n'est pas la fautes des parents s'il sont infectes"* Seydou).

The young people said that if they don't have information, if adults don't talk to them, they are at risk of becoming infected.

Day 3 : Plenary – 'Good Practice'

The Role of Faith-Based Organisations

Presenter: Mr James Cairns, World Conference on Religion and Peace

The World Conference on Religion and Peace (WCRP) is an international inter-religious organization that fosters communication and collaboration between religions.

Faith-based organizations play a critical, and can potentially play an even greater role, in work related to orphans and other vulnerable children. They represent two especially important assets: 1) social and 2) moral:

Social assets represented by faith-based organizations:

- They represent an extensive infrastructure that exists in local small villages, as well as global networks;
- Communications networks attached to faith-based organizations have a durable local presence;
- They have been in existence longer than any other structure;
- Their work includes deeply entrenched habits of care for members of community;
- Well-organized women and youth groups are common;
- They can mobilize local resources – both financial and human resources.

Moral assets represented by faith-based organizations:

- The values and teachings around welfare, the place of children, and the importance of caring for them;
- Value and respect for life;
- Behavioural ethic - set of moral tools that can be brought to this issue (i.e. how do you treat yourself and each other?);
- Accountability- within the community and the infrastructures of the organization;
- Legitimate authority, moral voice and respect.
- Faith-based activities focusing on orphans and vulnerable children exist widely.

Multi-religious collaboration is extremely important: Facilitating collaboration across religious lines on this issue is easier than for other issues because there is a strong base of concern for children across religions.

Collaboration can:

1. Increase effectiveness of public advocacy by religious leader for needs of children;
2. Create efficiencies of scale – Increased efficiency in delivery of services results from information exchange and increased coordination in multi-religious settings. For example, more efficient utilization of a clinic supported by one particular religion results when activities are coordinated with local partners of other religions.
3. With regard to service delivery, it does not make sense to develop multi-religious mechanisms. Use existing structures for efficiency of delivery.

WCRP has become a partner in the Hope for African Children Initiative (HACI). This represents an important example of partnership with faith-based organizations.

Local communities' religious organizations represent a large percentage of local capacity to support children affected by HIV/AIDS. Thus, the partnership with WCRP builds on the strengths of existing structures.

Challenges to working with faith-based organizations:

1. Working with whole communities. Development efforts often work with the local religious group as a contractor or implementing organization, separate from the rest of the religious community. In order to unlock the potential of working with a greater part of the community, we need to begin to engage the entire community in constructive ways and to increase our understanding of the way communities work.
2. It is important to understand and to document the work being done by faith-based organizations. The more that this work can be put into language understood by donors, governments, etc, the better potential there will be to work with them in supporting orphans and other vulnerable children.

Situation Analysis and Mobilization for OVC in Nigeria

Presenter: Rosemary Nnamdi-Okagbue, Family Health International, Nigeria

This situation analysis stemmed from an analysis conducted in Zambia, adapting the tools for use in Nigeria. The tools will be made generic and will be available in the form of a guide this summer for use by other countries.

The situation analysis discussed in this presentation was conducted basically for program design in Nigeria. Six states were involved; in four of them FHI is implementing comprehensive programs.

Objectives included:

- To provide baseline information for program design and for evaluation
- To gather information about the impact of HIV/AIDS on children and families.
- To identify structures within communities and what they have been doing
- To begin the mobilization process of key stakeholders
- To understand how communities are coping

The Methodology included:

- initial consultation meetings, documentation review;
- development , testing, and translation of tools;
- training of core researchers at national and state level;
- contact of State field level partners (government, NGOs/CBOs, and RAs); and
- a briefing at the end of the data collection.

Both qualitative and quantitative data collection were collected. Data is being analysed and a final report produced.

Who was involved?

- National Action Committee on AIDS (NACA)
- Federal Ministry of Women Affairs and Youth Development/State rep.
- Federal Ministry of Health – NASCP/SAPC
- Federal Office of Statistics – State office
- National Population Commission – State office

- Consultants, including paediatrician, sociologist, micro-finance expert, psychologist, physician, statistician, research assistants from the State
- Person Living with HIV/AIDS
- FHI/IMPACT implementing organization engaged in care and support efforts

Tools: Qualitative and quantitative.

- Quantitative tool was developed to survey heads of households to find out how people were coping
- Qualitative methods included focus groups, key informant interviews, organizational assessments, and included representatives from Line Ministries, health care workers, community members, people living with HIV/AIDS, people affected by HIV/AIDS, and organizations.

Definition of orphans and vulnerable children led to many discussions – whether to use the definition in the Convention on the Rights of the Child (CRC)? Voting age? Etc? The decision was to include children 18 years old and younger.

Limitations of the situation analysis include:

- Perspective of children was not obtained;
- Ensuring that research assistants used consistent definitions of vulnerability;
- No data collected on children living outside of household – e.g. those living on the street, hawkers, etc.
- Reality in field necessitated adaptations

Challenges:

- Limited info on ground
- Stigma and concealment attached to HIV/AIDS
- Timing of data collection
- Commercial nature of some sites affected timing for heads of household and necessitated extended working hours to collect data.

Lessons learned:

- Assumptions made prior to field assessment may not be practical in the field (timing and household sampling methodology)
- Involvement of the staff of data collection agencies is crucial
- Flexibility is necessary during field work and data collection
- Selection and recruitment of research assistants from the site of assessment is critical
- Obtaining permission of and working with gatekeepers in the community cannot be overemphasized
- Poverty and malnutrition and disease have implications for OVC programming.

2,100 households were interviewed. Only six households were headed by children aged 10-19.

Of the orphans identified, 22.6% were double orphans; 59.5% were paternal orphans, and 17.7% were maternal orphans.

According to the heads of the households, the highest needs of the orphans and vulnerable children were for education, followed by health and nutrition.

A significant number of households did not receive external assistance. Among those who did, the most common form of assistance was money, followed by educational and food assistance. Most of the assistance was from relatives

General findings included:

- There was no clear or consistent definition of an ”orphan”. Double orphans were the most common criteria. Age of orphans varied from 0-15 to 0-18. In some places, emphasis was on the maternal or double orphans. In others it was paternal orphans. This varied by location, religion, culture, etc.
- There was relative consistency on the definition of “vulnerable children”, i.e. children who are hawkers, beggars, living on the street, sex workers, child labour, etc.
- There were strong feelings that government and faith-based organizations have a responsibility to care for OVC
- There has been a shift from extended family to nuclear family, but they felt strongly that it was important to return to the extended family structure.

Findings from interviews/focus groups with particular groups:

- Line Ministries: No specific policy for the protection and well-being of OVC. There is verbal indication of free education and health care policies for children but little evidence of implementation in the field
- Health care workers: Noted increased cases of malnutrition, anemia, ARI, etc. Collaboration and referral systems are weak; there are inadequate social welfare services in place.
- Community members: Noted high level of unrecognized community support. They had the impression that most of the OVC are living on the street or institutionalized, but this is not the case. There was concern that children living with foster parents might be abused.
- People Living with HIV/AIDS: They experience high level of stigma and misunderstanding. They fear their children may experience the same stigma. There were extremely concerned about the future of their children, especially with regard to education and medical care. They felt that health care workers contribute to stigma toward people living with HIV/AIDS.
- Organizations: Program coverage is limited and not matching the magnitude of the problem. Capacity building is considered important, as is linkage to legal services

Recommendations included:

- National OVC consultation is needed;
- Update policies and implement them, streamlining them so that people who qualify can access services, such as education and health care for children;
- Develop and implement institutional and foster care guidelines;
- Strengthen coping and care by families to provide support to children;
- Caution to be exercised when introducing external funding to long standing community based initiatives;
- Use orphanages as a last response for care of children.

Conclusions:

- Children need care and nurturing for a better future for them and for ourselves – for the health of society

Discussion Following "Good Practice" Plenary

1. At what age are you no longer counted as an orphan?

UNAIDS collect statistics on children under the age of 15, because this is how health statistics are collected. It is hoped that in the future, this data will include children up to 18 years of age.

In addition, UNAIDS report on maternal and double orphans, but not on paternal orphans, because of the difficulties inherent in calculating the latter statistic. However, new data that will be released by UNAIDS, USAID, and UNICEF at the International HIV/AIDS meeting in July in Barcelona will include maternal, paternal, and double orphans.

In summary, the definition of orphans used in collecting data is different to the definition used by governments, donors, implementing organizations, and other partners in developing and implementing activities to support children affected by HIV/AIDS.

2. ***When and how to tell children infected by HIV/AIDS of their serostatus and of their parents' serostatus?***

A participant shared the following observation: If you do not tell a child he/she is HIV+, then the child may not maintain ongoing treatment when they feel better.

In one instance, they found that children actually know their serostatus, though their parents had not actually told them. They talked with the children and found that they wished that their parents would talk to them about their infection, and the HIV infection of their parents, so that they would know what to do if their parents become sick or die.

3. ***Why do church leaders sometimes contribute to stigma associated with HIV/AIDS?***

For example, social marketing of condoms is working well as a method of HIV/AIDS prevention, but churches sometimes oppose it. Working with faith-based organizations has not always been constructive when working around some issues related to HIV.

Part of the challenge is to find the space for dialogue that is public language, and also incorporates faith-related values in the discussion. Faith-based organizations have particular language. It is best to work together to identify language that acknowledges the legitimacy of faith-based values, but at the same time addresses public realities.

The more that religious leadership is involved in working with vulnerable people, the more the instinct for care and provision of support and well-being becomes primary. The desire to protect the well-being of the community is intrinsic. Doctrine and theology sometimes takes longer to catch up with situations on the ground. It is helpful when leadership see the issue in terms of persons' suffering.

A balance is needed and must be sought. Regarding the condom issue and the position of faith-based organizations: there has to be a way to break through the impasse. We have to find new language and new ways. The more that good information is given to religious leadership, the more responsive they will become. We need to find common ground to build partnerships that will make it easier to move ahead in a constructive manner.

Day 4 : Country Action Plans

Each country delegation was asked to prepare an action plan for implementation by their Country Task Team on their return to their respective countries. A standardised format ("matrix") was provided for these action plans. The development of these action plans took place in three stages:

- Country delegations were given time to work together on the first draft of their action plans;
- Each delegation was then asked to present their action plans for review at a mini-plenary, where they could comment on each other's plans and modify their own;
- Finally, each delegation was asked to finalise their action plans and to present them on posters.

The action plan matrixes are included in the attached CD-ROM. The key themes which emerged from were as follows:

Country	Situation Analysis	National Cnslt'n ➨ Plan of Action	Policy & Legisla-tive Review	Co-ord Structure ➨ Part-nerships	Other
Benin	Yes		Yes		• Sensitise families and communities; • Provide socio-professional training for OVCs; • Ensure medical and nutritional care for OVCs.
Burkina Faso	Yes	Yes			
Cameroon	Yes	Yes		Yes	• Undertake studies and additional research.
Cape Verde	Yes		Yes	Yes	• Mainstreaming of OVC issues; • Improve access to basic services, income-generating activities.
CAR	Yes	Yes			
Chad	Yes	Yes	Yes		• Community mobilization.
Congo B'ville	Yes	Yes	Yes		• Development of care activities for OVC.
Côte d'Ivoire			Yes	Yes	• Community mobilization; • Stakeholder capacity development; • Involving OVC.
DRC	Yes		Yes		• Advocacy for care of OVCs; • Campaign against stigmatisation of OVCs.
Gabon	Yes	Yes	Yes		• Advocacy and resource mobilization.
Gambia	Yes	Yes			
Ghana	Yes	Yes			• Advocate for resource mobilization.
Guinea	Yes		Yes		• Communication advocacy for behavioural change • Establishing monitoring and evaluation mechanism.
Liberia	Yes	Yes	Yes		• Sensitisation on CRC.
Mali	Yes				• Enhancing local response (community mobilization); • Resource mobilization; • Advocacy.
Mauritania	Yes	Yes			
Niger					
Nigeria	Done	Yes	Yes	Yes	
Senegal	Yes		Yes		• Advocate for interventions that care for OVC • Assist organisations which work with OVC
Sierra Leone	Yes	Yes			• Advocacy for OVC and CRC • Community-based care & support for PLWHA • Foster parenting and educational support for OVC.
Togo			Yes	Yes	• Identification survey of OVC • Capacity building for stakeholders (including families) to care for OVC.

Note: many plans included briefing stakeholders on the workshop, implementation of action plans, and monitoring and evaluating results.

At the following plenary, the facilitators of the mini-plenaries described the similarities, challenges and unresolved issues which emerged from group discussion around the various action plans:

All groups felt the exercise was very productive, resulting in both substantive and substantial work by the various country teams. The presentations and resulting discussions were very lively and informative and a number of important cross-cutting issues were raised.

1. Leadership and partnerships:

Facilitators observed a significant difference in outlook between those delegations which had strong government representation and those with strong community representation. This strongly influenced their recommendations – such as assigning roles and responsibilities, and deciding who should lead the follow-up process. Most countries saw a need to set up multi-sectoral teams, including all stakeholders, to supervise their response.

Government had a major role to play in leading the response, coordinating action, creating an enabling environment and reflecting public policy. Civil society had a comparative advantage in community mobilization, advocacy, expanding responses, delivering services, care and support activities, training etc. Both groups had a major role to play but it was essential their actions were coordinated for maximum benefit.

2. The next steps:

Most country delegations proposed key actions that included a participatory situation analysis, national consultation, coordination mechanism, national action plan, and policy and legislative review. Most felt that it would take approximately a year to implement these plans.

However, some facilitators said the sequence of the proposed actions needs to be more explicit – some can (and should) be done simultaneously, in view of the urgency of the situation. They also pointed to the need for more attention to be given to scaling up existing responses immediately, without waiting for research to be completed.

It was pointed out that the response to OVCs could originate within the different ministries of government (health, education, social welfare etc) and be coordinated centrally, or the response could start with a central strategy, decided by all role-players, with the individual ministries formulating their responses afterwards.

3. Legitimacy:

It was clear that many teams needed to seek greater "legitimacy" on their return to their respective countries. While senior government officials from a number of countries attended the Workshop, this was not true of all delegations, and some felt they did not have a sufficient mandate to prepare an action plan. Most teams planned to hold a series of debriefings with key government and civil society officials on their return in order to widen the ownership of the issue and process, and to define their goals and norms for the care and support of OVC.

4. Targeting children:

Only a few of the action plans made reference to involving children in the planning or the execution of those plans. It was also important to be clear as to which children would be targeted by OVC research and interventions - they should include all children affected by HIV/AIDS, not just orphans, as well as other vulnerable children.

It was not enough to include orphans and other vulnerable children in the strategic framework established in most countries to respond to HIV/AIDS – they needed a strategic framework designed to protect children's rights. If a child protection framework existed, OVCs should be included.

5. Resources:

Most country teams proposed using internal financial resources for their activities – fundamentally those of the state – directing requests for supplementary to financial partners where government funding was insufficient. However, some countries proposed the idea of collecting funds at community level.

In terms of non-financial resources, external technical support would be sought if the need arose. However, there was a need for more skilled personnel, training and materials in French and Portuguese.

Briefing of First Ladies

The First Ladies from Côte d'Ivoire, Senegal, Nigeria and Benin joined the Workshop on the last day. In addition to a briefing by members of the Workshop Steering Committee, the country delegations from those countries briefed their respective First Ladies on their draft action plans, and the roles which their First Ladies could play in supporting these initiatives. In several cases, concrete steps were identified for the First Ladies' participation in the implementation of those plans.

Day 5 : Plenary – Regional Action and Support

Country delegations were encouraged to give an indication of the kinds of support they would need from a regional and global level in order to successfully implement their action plans. The following is a summary of the countries' suggestions:

Burkina Faso:

- Technical assistance;
- Human resources;
- Financial assistance, including to CSOs;
- Medical care for HIV+ people (triple therapy);
- Data collection: translation of Nigeria tool into French so that can adapt.

Cameroon:

- Technical assistance for situation analysis;
- Support for advocacy at highest level to bring in political leaders (heads of state meeting) – UNICEF specifically mentioned.

Central African Republic:

- Palliative/medical care;
- Human resources development/training;
- Capacity on social mobilisation (don't have the right people).

Chad:

- International consultant for situation analysis;
- Financial support for situation analysis;
- Advocacy on the CRC;
- Exchange visits to share best practices.

Congo (Brazzaville):

- Advocacy materials and assistance to get government to do more;
- Involvement of international development agencies (nothing now);
- Framework for exchange of views and experience.

Democratic Republic of Congo:

- Methodological tool;
- Implementational databank.

Gabon:

- Technical assistance, financial assistance.

Gambia:

- Technical assistance for situation analysis and policy and legislative review.

Ghana:

- Technical assistance;

- Best practices;
- Funding from development partners.

Guinea:

- Facilitators
- Sharing of TORs prepared by countries;
- Training in social service and assistance;

Liberia:

- Technical assistance – consultant; capacity development; policy development and implementation.

Mali:

- Financial support;
- Technical support;
- Material support.

Mauritania:

- Exchange visits;
- Technical assistance- international consultant;
- Financial support.

Niger:

- Assistance for implementation of best practices.

Sierra Leone:

- Technical assistance in palliative care.

Togo:

- Missions to exchange experiences;
- Best practices;
- Capacity building on advocacy aimed at getting political leaders committed;
- Financial resources.

The common themes in these submissions were captured on an overhead transparency:

Technical assistance	**Assistance technique**
Situation analysis	Analyse de la situation
Mobilising leadership around CRC	Mobilisation des leaders CDE
Moving from words to action	Plus que les paroles → actions !
Logistics	Logistique
Providing care to OVCs	Provisions de soins pour les OEV
Giving palliative care	Soins palliatifs
Legislative reviews	Révisions législatifs
Planning	Planification
Methodological tools	Outils méthodologiques
Study tours	Tours d'échange
Advocacy – social work	Plaidoyer – assistance sociale
Best practices	Meilleures pratiques
Funding	Fonds

Data bank	Banque de données
Training	Formation
Networks/coordination	Réseau/coordination
Exchange of experience/Terms of reference	Echange d'expérience /Termes de référence
Human resources	Ressources humaines
Translation into French	Traduction en français
International agencies in each country	Organisations internationales dans chaque pays

Regional Commitment

Responding on behalf of the convening organisations, Jean Claude Legrand (UNICEF) said the Workshop was part of an on going process.

Country teams were given a number of assignments prior to the Workshop, and during the meeting were taken through a number of theme and technical assignments.

This process continues on your return – we now need to discuss how each of the country delegation and the regional offices will take this process forward at country level. This will require each one of us to make a personal and professional commitment.

We too, at the regional and HQ level, here in Abidjan and colleagues from London, Washington and elsewhere also commit to follow up this conference in the following ways, based on the points raised earlier this morning.

1. The co-sponsors will meet tomorrow morning to review the Workshop and to discuss next steps and follow up action points;
2. We commit to put in place a follow-up mechanism in the region;
3. We also commit to mobilise resources for country follow-up actions and to scale up assistance to families and communities;
4. We will review the various action plans, and discuss with each individual country team on their return the technical and material resources required to implement the action plans;
5. We will put in place an information system to keep country teams up to date on developments in other countries, and on OVC issues in general;

6 We commit to continue to mobilize partners, government and others in the region to support your country efforts in assisting children affected by HIV/AIDS;

6. We will provide you all with a conference report, copies of a CD-ROM with all the documents;
7. We commit to assist and facilitate the national situation analyses, the national consultations and the development of national action plans. We are considering hold a series of mini workshops on both situation analysis and national consultation to assist countries in their efforts in these areas;
8. We will provide a list of resource materials, and technical support that is available;
9. We will also discuss the possibility of holding a follow up consultation to this meeting to take stock of what actions have taken place.

Day 5 : Closing Plenary

Dr Rimah Salah

UNICEF's Regional Director for West and Central Africa, Dr Rima Salah, paid tribute to the country delegates and organisers: "we're on the right track, and it is difficult for me to hide my satisfaction with the outstanding and concrete results which you have achieved."

Referring to the plans of action which each country delegation had produced, Dr Salah said the next step would be for returning delegates to enlist the support of their partners to ensure those plans were implemented.

She emphasized the importance of ensuring that communities and key role-players were involved in defining and addressing the OVC challenge, and that they supported the action plans which had been drafted within the "serene confines of Hôtel Président". "I strongly urge you to try as much as possible to secure this endorsement which is a prerequisite for the sustainability of the results of our activities."

Secondly, she called for a holistic approach to protecting children: "Your work has clearly shown the interrelationship between the children orphaned by AIDS and vulnerable children. Only a holistic approach for the protection of children against all forms of violence, abuses, exploitation and discrimination can help to break the vicious circle of children orphaned by AIDS and other vulnerable children."

Third, she called for the increased involvement of children in all deliberations, and pledged that at all future UNICEF regional meetings, where such a move was called for, children's participation would be used as a quality indicator. "I strongly exhort you to ensure that this happens in your respective countries."

Fourth, Dr Salah noted "with much satisfaction" that the Workshop had underscored the need for stakeholders to be more humble in their approach to community members. "I feel that is essential. It is a truism to say that sustainable solutions to the problems faced by children orphaned by AIDS, and by other vulnerable children, are those that are founded on community participation. We cannot understand them, we cannot communicate with them, nor can we help them effectively if we do not learn to listen to them."

Finally, she called for country delegations to advocate for OVC at four levels, on their return to their respective countries:

> ***Heads of State:*** *You can help break the silence by including in the agenda of public discussions the debate on children orphaned by AIDS and other vulnerable children. If we wait to first resolve the problem of AIDS among the youth or that of mother-to-child transmission before addressing the situation of children orphaned by AIDS and other vulnerable children, it will be too late.*
>
> ***Ministries:*** *For our action to be effective, we have to know the real situation in the countries. That is why any actions you carry out with the ministries responsible for health, the family, social affairs, HIV/AIDS, etc. should lead to a situation analysis on children orphaned by AIDS and other vulnerable children, whose outcomes may be debated nationally with all stakeholders.*
>
> ***Parliamentarians:*** *You can influence legislation on the status of orphans and women. By scrutinizing the legislation on inheritance you may, for instance, discover many unpleasant surprises concerning orphans. Your personal involvement will unquestionably be instrumental in the amendment of the legislation, where necessary. This will be in line with the actions you are currently undertaking to combat the violations to the rights of vulnerable children (sexual and economic abuse, conflict situations, child trafficking, etc.) that we all know too well.*

*Lastly, **through targeted ad hoc activities of your Foundations** with associations of vulnerable children or groups or organisations that support them, you will be contributing to keeping children orphaned by AIDS and other vulnerable children on the national agenda.*

First Ladies' Motion

The closing day was marked by the presence of a group of First Ladies from four countries – Côte d'Ivoire, Nigeria, Senegal and Benin – together with envoys from the First Ladies of Niger, Rwanda and Gabon.

These ladies tabled a motion during the closing session, which was read by the First Lady of Nigeria, Mrs Stella Obassanjo. The motion read as follows:

Considering the fact that HIV/AIDS continues to pose a serious threat to the populations of African countries, and especially the fact that children and women are the most vulnerable;

After listening to the proceedings of this outstanding seminar;

We, the First Ladies of Benin, Nigeria, Senegal, Rwanda, Gabon, Niger and Côte d'Ivoire, having assembled in Yamoussoukro on April 12, 2002;

Commend UNICEF, UNAIDS, USAID and NGOs such as the International Save the Children Alliance, and Family Health International for holding this seminar;

Express our sincere gratitude to the United Nations Office, the World Bank and the Red Cross for their support and presence at this Workshop;

Encourage and support them in all their endeavours with regard to children and pledge to continue to fight against this pandemic with a view to ensuring an HIV/AIDS-free future for the African Child.

Mrs Simone Ehivet Gbagbo

In closing the Workshop, Mrs Gbagbo said the growing number of orphans and other vulnerable children, and the fate to which they were condemned, constituted an insult to Africa's conscience and posed a challenge to our countries.

By translating words into action, and making orphans and other vulnerable children our top priority, we will not only be assuming our role as parents but, above all, ensuring that our continent has a future for its children.

Natural catastrophes, diseases, hunger, armed conflicts and poverty have now been compounded by HIV/AIDS, whose devastating effects cancel out in one fell swoop the outcomes of the best-designed development programmes and projects. AIDS is therefore the key obstacle to be addressed in any development planning process.

Therefore, it is in our countries' best interest that we ponder the impact of this pandemic which, coupled with poverty, is undermining the fundamental values of African society – namely solidarity and social integration. Once a child is infected or affected by HIV/AIDS, he is stigmatised and marginalized.

Such marginalization generally results in the loss of a child's rights, an absence of family life, early responsibility, infant morbidity and mortality, dropping out of school, lack of access to health care and proper nutrition, and a host of opportunistic infections.

In this regard, the girl-child deserves special attention, since she is often pulled out of school to do household work or care for the sick, and quite possibly exploited and subjected to various forms of abuse.

How can the human values which characterize our African communities be preserved and their expression encouraged for the benefit of AIDS patients and affected persons in general and in particular children – these sacred beings whose psychosocial equilibrium depends on our love and our understanding?

That is why we need greater community mobilization and a better partnership between communities and the main stakeholders, particularly government agencies, religious organizations, community leaders, children, NGOs and other community groups, since it is necessary to involve all levels of society.

Successful experiences in other countries in the area of care and support of orphans and other vulnerable children should encourage exchanges between countries, bearing in mind the basic needs of children, which are education, health care, socio-economic assistance and psychological support.

As far as legislation and human rights are concerned, governments should bring their laws in line with the provisions of the Convention on the Rights of the Child, enact special laws applicable to the situation of orphans and other vulnerable children, and ratify, defend and ensure the implementation of the conventions which have not yet received such attention.

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Steering Committee

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Workshop Report

This report was compiled by Mark Loudon from copies of presentations and notes written by facilitators and rapporteurs. To correct errors please contact: mark.loudon@pixie.co.za.

Annex

A CD-ROM has been prepared to accompany this report.

This CD contains the following:

Directory	Subdirectory	File name	Description
Pre-workshop		Invitation cover letter, Workshop Overview, Task-Team Assignment	Package of documents sent to 24 countries in early December 2001 – all documents in both French and English
		Participants	List of participants with contact information
	Action Plans	Matrix	Blank Country Action Plan matrix form, in French and English
		Country names	Action Plans (in matrix form) from 21 countries
	Country Assignments	Country names	Country assignments (as requested prior to workshop) where submitted
	Country Presentations	Country names	Presentations made, or submitted, at the Workshop
	Plenary Presentations	Session and speaker names	Presentations made during the Workshop
Post-workshop		WCAR OVC workshop report	This report