The use of terminology and labels attached to those affected by the epidemic is illustrative of the rapid shift in programming responses. Early studies in Uganda and Tanzania pointed to the increasing orphan burden as a result of a rising AIDS mortality rate, which led analysts to focus on the ‘AIDS orphan’ as a symbol of the epidemic and its dire consequences. While the term captured the imagination of programmers, fund raisers and activists at the time, it quickly lost value with practitioners due to the misinterpretation in the public’s mind as meaning ‘orphans with AIDS’; an illusion also underpinned by the lack of understanding around the perinatal transmission of HIV. While programming specifically for orphans of AIDS was never a strictly viable or attempted option, the recognition of more general child vulnerabilities beyond orphaning, such as chronic parental or guardian illness, chronic poverty or absence of household livelihoods, caused the broadening of programme targeting.

Recognition of AIDS as a principle ‘driver’ of child vulnerability allowed later concepts of ‘children affected by AIDS’ to encompass the majority of children in communities...
with high rates of AIDS-related morbidity and mortality. The logical end-point of this programmatic shift is to target (and ensure that programmes do not exclude) poor or vulnerable children in contexts where AIDS is a factor determining the degree of child vulnerability, as one of a number of determinants. From a disease-specific, almost pathological labelling of children at the outset of the response, programmers now work with ‘children of the community’ (Swaziland) or ‘leaders of tomorrow’ (KwaZulu-Natal). The transition from a representation of disempowerment to that of resilience and agency is dramatic.

**AIDS sensitive but not AIDS specific**

A significant factor in this rapid shift in the way we respond to children in contexts of HIV and AIDS has been the explicit need in rights-based programming to avoid discrimination, which in the case of child-focused programming entails decisions about who is included or excluded for the receipt of services or engagement in programme activities. The recognition of the value of full involvement of communities themselves in deciding on programme priorities and selection criteria has generally put an end to approaches where such decisions are made externally, criteria that often reflected the impressions or simplistic notions of the funding organization. A second and linked factor has been the consistent difficulty in demonstrating significant differences in vulnerability status between orphans and non-orphans. Whatever indicator is used, be it nutrition, access to primary education, shelter, access to basic material needs or services, the differences found are generally small, context dependent and not in themselves significant enough to justify externally-defined inclusion criteria.

In contexts of AIDS, programmers are now concerned with systemic responses to child vulnerabilities, which are AIDS sensitive but not AIDS specific. A systemic response entails the full contribution of government to basic service delivery, (health, education and social welfare especially), partnering as appropriate with civil society. Systemic responses need not exclude community-based responses and in fact they are critical to scale up any response.

**Social protection and the impacts of AIDS**

Greater coherence between state and civil society is probably best exemplified by the emergence of programmes in eastern and southern Africa that attempt to provide a minimum package of social protection to poor and vulnerable children. Social protection refers to policies that ensure that all people have adequate economic protection during periods they are unable to fully provide for their basic needs themselves. State social assistance includes the following four categories of benefits: those associated with old age, disability, child and family care, and poverty relief. The case for social protection in general, and cash transfers (e.g., child grants) in particular, can be made on both economic and human rights grounds. On economic grounds, the evidence demonstrates that grants enable productive investments which increase current income, consumption and health, as well as investments in children’s education which leads to increases in future income and breaks the inter-generational cycle of poverty. On human rights grounds, the right to a minimum level of social services, and the right to social protection for vulnerable children are stated in Articles 22 and 25 of the Declaration of Human Rights, and in Articles 20 and 26 of the

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**Editorial** From the individual to the system: the coming of age of programmes for orphans and vulnerable children

**Pilot** Offering space to children infected and affected by HIV and AIDS
The Maddox Chivan Children’s Centre in Cambodia

**Lessons** Providing livelihood options for children and youth living with and affected by HIV and AIDS in Uganda
The Villa Maria Hospital Home Care Programme

**Country Focus** Children and young people affected by HIV/AIDS in India
Challenges and emerging issues

**Pilot** The role of the media in disseminating HIV and AIDS information in Somaliland

**Pilot** A peer education programme for San adolescents in Namibia
The Namibia Adolescent Sexual Reproductive Health Programme

**Online resources**
Convention on the Rights of the Child. Thirteen countries have gone a step further in the Livingstone Accord of March 2006, agreeing to develop costed national social protection strategies, integrating them into national development plans, and initiating social cash transfers schemes by the end of 2008.

Cash transfer schemes
In impacting on poverty and hunger, cash transfers have demonstrated effects on food expenditure, diet quality and the availability of high-caloric food of poor households. In Zambia and Ethiopia, studies show that 63 and 78% of the cash transfer, respectively, was spent on basic needs: food, health care and education. Importantly, none of these studies showed that the transfer led to an increase in spending on alcohol or tobacco. Cash transfer schemes have had their most important impact on schooling children in recipient households. Not only does the infusion of cash lead to higher overall enrolment rates as demonstrated by evaluation results from Mexico, Colombia and Nicaragua, but quality of school achievement and transition from primary to secondary school also improve. For example in Nicaragua, pass rates among programme children in Grades 1-4 increased by 6 percentage points, and transition to upper primary school (Grades 5 and 6) increased by 11 points.

An International Labour Organization costing exercise shows that a national poverty-targeted cash transfer programme would not exceed more than 0.5% of gross domestic product (GDP) in sample countries. A study by UNICEF finds a similar result for Mozambique. Social protection is undeniably affordable. In comparison, over 3% of GDP in South Africa is spent on social protection schemes and the average in Europe is around 10%.

The role of community-based organizations
The key question is: do social cash transfer schemes in countries with high HIV and AIDS prevalence that target a broad spectrum of (extremely) poor households, but do not explicitly target HIV and AIDS-affected persons or households, have a significant AIDS mitigation impact? The answer is ‘yes’. Through analysing literature on the biggest social cash transfer schemes in South Africa and data from pilot schemes in Zambia and Malawi, it is estimated that the share of HIV and AIDS-affected households as a percentage of all households reached by the respective scheme ranges from 50-70%. How programmes use poverty ranking, labour availability in the household and orphan presence as criteria for inclusion will determine what proportion of child or care-giver beneficiaries are affected by AIDS. Community-based organizations are vital in assisting in the selection and follow up of households to ensure equity and that grants are used effectively. Schemes in Zambia and Malawi which transfer around $15-20 per month to each household reach the poorest of the poor because targeting and approval is done in a multi-stage participatory process involving community level committees.

Reaching AIDS-affected children with social assistance through broader based poverty reduction programmes, only addresses the impacts of AIDS that are directly material or economic in their nature. Increasing evidence suggests that some of the most important impacts of adult illness and death are the sociological factors related to increasing social distance between children and their care-givers. Recent evidence from Nyanza province in Kenya suggests that orphaned girls have sex at a younger age compared to non-orphans, and interestingly are more likely to engage in first sex willingly rather than being coerced. Are orphaned girls more likely to seek sexual relationships for anticipated material gain and/or the psychological need for intimacy with an older male? In addition, boys whose mother had died are more likely than other boys to report having first sex with someone older and having paid for sex. Sex itself was riskier, with lower reported condom use by orphans. The report concluded that “lack of supervision and/or loving care by parents/guardians was perhaps the key factor that increases vulnerability to risky behaviour by children.”
and orphans were felt to be at increased risk because of this”.

So while material deprivation of orphans may be a widespread problem, this is only part of a generalised and normalised child deprivation. Programmers need to somehow account for the various ‘psychologies’ related to family functioning in the case of parental and caregiver illness and death. Surveys from Zimbabwe and South Africa are now reporting higher HIV and STI rates amongst adolescents and adults who have been orphaned. The roles of child protection and HIV prevention are thus intertwined and should increasingly recognise common objectives, against a background where social protection for all children must become a reality.

The author would like to thank Sudhanshu Handa (UNICEF ESARO).

### Resources

**Enhanced protection for children affected by AIDS**

UNICEF, 2007 (60 p.)

This companion paper to ‘The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS’ discusses the protection issues facing children affected by AIDS and outlines the actions needed to reduce their vulnerability. It calls for enhanced social protection, legal protection and justice, and alternative care, underpinned by efforts to address the silence and stigma that allow discrimination, abuse and exploitation of children to continue.


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**Keep the promise. To children living with HIV/AIDS**

Ecumenical Advocacy Alliance, 2007 (10 p.)

This paper looks at the issues that prevent children from being tested for HIV and from receiving antiretroviral treatment, including the lack of research and development of diagnostic tests and treatments adapted for use in children; inadequate capacity to procure and supply medicines; unaffordable prices of paediatric antiretroviral treatment; and insufficient numbers of and insufficiently knowledgeable/trained healthcare professionals skilled in ensuring appropriate use of medicines for children.

PDF: [http://www.e-alliance.ch/media/media-6996.pdf](http://www.e-alliance.ch/media/media-6996.pdf)
The development of such children is interrupted by these hardships and other traumatic experiences such as the loss of loved ones, discrimination and stigmatization, family dysfunction or their own sickness or that of a parent whom they have to look after. They, therefore suffer from a vague but deeply rooted ever-present sense of anguish stemming from the fear of being abandoned.

According to the Cambodian Ministry of Health, some 9,000 children were living with HIV in 2003. In 2001, an estimated 51,000 children were orphans due to AIDS. The Maddox Chivan Children’s Centre (MCCC) in Phnom Penh is a project of Cambodian Health Committee, a Cambodian NGO. It targets children infected and affected by HIV and AIDS in disadvantaged circumstances. Children cared for by the MCCC often suffer from a lack of self-confidence, have an extremely low level of self-esteem and their performance in school is bad. They lack references and display learning disorders (memory problems, low attention span, and problems in learning to read and write), behaviour problems (hyperactivity, aggressiveness, withdrawal, isolation, emotional demand and desire for physical contact) which in some cases may be symptomatic of more deeply-rooted psychological problems and developmental delay.

Sound coaching
Successful survival in such circumstances requires a high degree of resilience, but this is not enough to give the children an opportunity to break free from the vicious circle of poverty and move into the future with optimism. Children living with HIV require more than medication and medical care; they must have enough to eat, a roof over their heads, go to school, be a part of their community, receive support to cope with the traumatic events, not being discriminated and, most importantly, be encouraged to renew their belief in a possible future. Affected children also need to be able to turn to a source of support, go to school, receive care when they get sick, not be forced to work and receive assistance to rebuild their lives. Children infected and affected by HIV and AIDS need sound coaching in a way that promotes their development and helps them cope with the many obstacles confronting them.

These are the founding principles of the Maddox Chivan Children’s Centre. Its goal is to give these children an opportunity to get out of their marginalization and develop a plan for their lives that will eventually lead them to become socially and economically integrated.
citizens. The strategy consists of providing multi-disciplinary support to meet their urgent needs (medical, nutritional and social) that compensates for some of the deprivations they suffer from with regard to their educational and psychological needs. Since its initiation in February 2006, the centre has provided assistance to 350 children aged 0 to 16. Factors considered while selecting children to be assisted include their medical needs, family situation (priority is given to orphans and children living with a widowed parent), economic and psychological distress (of parents and children), schooling challenges (not attending or falling behind in school). There is special focus on pre-school age children and teenagers.

Comprehensive care and support

The MCCC operates as a day care centre, taking in children for half days or full time and supporting them in the following areas:

- Medical and nutritional – Where necessary, affected children are monitored medically and provided with cost-free medication and hospitalization. Infected children are put on ART and are monitored by the paediatric department of a public hospital. Doctors and nurses from this hospital do consultations for HIV-positive children at the MCCC. All children receive a daily nutrient provision.

Children infected and affected by HIV and AIDS need sound coaching in a way that promotes their development and helps them cope with the many obstacles confronting them

- Educational – Pre-school support is given to small children starting at age 2 to stimulate their intellectual curiosity as well as provide them with appropriate means to develop their potential and acquire basic skills for successful schooling and socialization. School support is given from grade 1 to 6 to help pupils maintain their level and make up for falling behind due to repeatedly missing school and thus help curtail the pattern of failure and school dropout.

- Psychological – Special emphasis is put on psychological support but other needs are also addressed to enable the child to develop properly. The support provided at the MCCC is comprised of three key interventions: 1) Therapeutic counselling focusing on therapeutic education and compliance with treatment, 2) Psychological support given to HIV-infected children, those suffering from distress or going through a difficult time in group sessions based on art therapy or on a one-to-one basis, 3) Life skills workshops for information pick up, expression and interchange that help the children to think and acquire knowledge and skills that can help them to avoid certain social risks (drugs, delinquency, AIDS, etc.) and explore work opportunities.

- Social – Personalized follow-up of families, which involves identifying those in need, regular evaluations and immediate intervention in a problem or crisis situation (finding a home, death, abandonment, family abuse or violence, unemployment, etc.) so as to avert the situation whereby their living conditions become even more precarious.

- Leisure activities – One-to-one or group games both indoors and outdoors, computer activities, English, artistic expression and sports are offered. Such activities promote the good physical and mental health of the children and are also outstanding tools for learning and development.

Indicators of success

The programme has not been assessed since it was started up in 2006. It is therefore premature to draw conclusions on its impact. Nevertheless, the results achieved underscore its effectiveness to a certain extent. There is evidence of the programme’s impact on education: we have noticed improved performance at school and at the MCCC and a behaviour change in class (greater attention span, sustained concentration and stimulation of a definite interest in learning). Also, all children who had dropped out of school went back to school while others enrolled for the first time at the beginning of the 2006/2007 school year.

With regards to social risks, we have also seen a decreased number of children and teenagers running away from home, living in the streets or even turning to delinquency. We believe that our focus on improvement of self-worth has led to a decrease in aggressive behaviour patterns, hyperactivity, and symptoms of depression and, most importantly for those children, help to build belief in a possible and positive future. Finally, we have also noticed that relationships in the family have improved. Parents frequently express a sense of relief now that they no longer feel left on their own to care for their children, and they often show their satisfaction once they see that their children are doing well in school and are exhibiting better behaviour patterns.

Offering an educational and therapeutic space

Overall, it can be said that the centre is an educational and therapeutic space where children can find the following:

- A response to their overall basic needs (multidisciplinary offer) as well as their specific
needs through personalized follow-up – For children living with HIV, medical management is made less traumatic and the stress level at consultations is lessened; consultations are conducted by a medical doctor with whom they have daily contact, in a space in which they feel at ease and in which they feel good.

- A space they can trust – The centre reassures them and gives them a sense of security and ‘normalcy’. It is a stable reference in their lives that have continually been in disarray. It is also a facility that sets boundaries for the children, which are often sorely lacking in their families due to having no father or because of parental failure in the home.

- The opportunity to express themselves – Many communication and listening spaces available provide the children with the opportunity to express their fears and anxieties, to ask questions and vent their frustrations, put into words what they are going through, and this helps them to overcome trials (bereavement, being put in a new home, abandonment) and to deal more effectively with painful events.

- The opportunity to advance themselves – All of the activities offered help them become aware of their real potential in learning and progressing, something which they were previously very negative about because of their perceived failures and the negative messages that they internalized.

In conclusion, the positive changes among the children in a relatively short span of time lay the basis for great hope. There is evidence of a great capacity for resilience, of an extraordinary potential if the child is assisted to express itself and most importantly, to effect a possible change in the course of situations sometimes considered as hopeless. Nevertheless, clear thinking and caution are the bywords. The input from the facility seems obvious, but what will eventually become of the children remains somewhat uncertain. Many factors come into play in their development processes that we are not aware of and over which we have no control. The MCCC is helping the children to cope with their traumas and acquire school and personal skills. It cannot guarantee that they will successfully get on top of things economically and socially in the future, but it is giving them a much better chance of doing so.

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Resources on children affected by HIV and AIDS

Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS
L. Richter, G. Foster & L. Sherr, Bernard van Leer Foundation, 2006 (60 p.)

This is an opinion piece developed through a series of four workshops organized by the Bernard van Leer Foundation in preparation for the International AIDS conference in Toronto (2006). It includes a call to action to address the psychological wellbeing of all vulnerable children.

PDF: http://alliance-uk.inforce.dk/graphics/OVC/documents/0000837e00.pdf

HIV & AIDS and safe, secure and supportive learning environments
UNESCO, 2006 (55 p.)

This booklet is the second in a series of publications that address key themes of UNESCO’s work on HIV/AIDS and the education sector. It discusses issues affecting learners in the context of HIV and AIDS, including rights and access to education, protection, knowledge and skills, and care and support. It also includes a bibliography, a list of practical tools and resources, and sources of additional information. Although it is intended mainly for government, donor and NGO policy makers, planners and managers working in the education sector, the booklet will also be useful for school governing bodies, administrators, school principals, teachers and other educators working on HIV and AIDS.

The ages of supported OVC range from six to twenty years. They are supported to attain basic primary education and vocational/apprenticeship skills, life skills, psychosocial counselling and access to HIV testing and medical treatment. Additional skills in business management, credit sourcing, self-protection and management are imparted to the OVC in the training. Girls, who are in many cases neglected, are specifically targeted. Workshops are organized for out-of-school orphans and vulnerable youth to help them appreciate their weaknesses, strengths and opportunities, exploring their career opportunities/options, and building their skills. In addition, they are educated on reproductive health, sexuality, and HIV and AIDS and are encouraged to go for voluntary counselling and testing. HIV-infected OVC receive medical care, including antiretroviral therapy, through the Home Care Programme. Young people are encouraged to set up self-help groups. So far 18 youth groups have been formed for mutual support, self help and cohesion. Furthermore, community sensitization campaigns are run and they aim to empower the community with the skills to deal with OVC. These campaigns focus on facts and myths surrounding HIV and AIDS; will-making and use of memory books, community participation and involvement, child rights, career guidance, effective communication, government OVC Policy and where to seek various services.

Acquiring professional skills
Villa Maria’s approach is placing OVC at apprenticeship sites within the communities to acquire professional skills from craftsmen. For those who have completed Grade 7 and above (15-20 years) who satisfy the requirements of some vocational institutions, we facilitate access to these institutions under a modular training approach where practical rather than academic lessons are offered. We developed a special curriculum for our trainees after a feasibility study. Our support is limited to training/tuition fees, overcoats/uniforms, lunch, psychosocial counselling and HIV testing, practical materials/training tools and medical treatment. The major courses offered include shoemaking, masonry, carpentry, tailoring, welding and hairdressing. Others are electrical machine installation/repair, radio/TV repair, phone repairing, mechanics, home economics and nursing. The duration of the courses range from one to two years apart from nursing, which takes three years.
to complete. The programme is specifically designed to eliminate stereotype mentality which discriminates against girls. Indeed girls are specifically targeted in all the courses and perform well. Currently, 199 OVC (112 boys and 87 girls) are undertaking vocational and apprenticeship training, distributed over 23 apprenticeship sites and seven vocational schools.

When the youth complete their studies and apprenticeships they are given tools to start work. The tool kits, for example, sewing machines, hairdryers, or carpentry tool kits offered to them individually as start up capital have worked as a catalyst and have propelled their individual initiative. Some beneficiaries of the programme train and provide career guidance to their peers free of charge.

A beneficiary’s story

Muyingo Deo, an 18-year-old orphan and head of a household lost his parents to an AIDS-related illness in 2001. When he was in primary school, he struggled to look after his young siblings and to pay his school fees up to grade seven until he dropped out. An opportunity arose in 2004 to be supported by the Villa Maria programme in carpentry training at St. Ponsiano Technical Workshop where he trained for one year. Upon completion, he was given a carpentry toolkit. He felled a mature tree on his farm which he used as start up timber for his carpentry workshop. He currently earns $70-85 per month. This has enabled him to look after himself and his siblings and he can now save some money for development. Appreciative of Villa Maria’s support, he volunteered to train two OVC in carpentry for free.

We believe that our vocational and apprenticeship support approach is effective because it enables OVC to acquire marketable skills that could be applied in their own localities. Supporting orphans through acquisition of practical skills as opposed to academic class work is cost effective in terms of the duration of training and the costs involved.

- To avoid misunderstandings and conflict between families supported and those not benefiting, it is necessary to involve multiple key players in the selection process.
- To ensure that as many OVC as possible benefit from the programme, other organizations need to be stimulated to offer complementary rather than duplicate services.

Challenges and solutions

The direct OVC support programme reaches only a small fraction of the estimated number of children in the catchment area and this brings misunderstandings and conflict between families supported and those not benefiting. To avoid this, several key players are involved, namely, the local community leaders, Community Health Workers and programme staff. A home verification exercise is done on all the identified OVC to ascertain whether they meet the selection criteria. We select children below the age of 20 who have lost one or both parents and are in extreme need of support, e.g., children in child-headed homes, those with helpless grandparents and those who dropped out of school, as well as children infected by HIV and children living with terminally-ill parents. This exercise emphasizes several aspects namely: assessing the background of identified OVC, for example, the physical and socio-economic vulnerability surrounding them, level of discipline, interest, consent by the guardians, ability of the person to undertake the selected discipline of study and no likelihood of duplication of support by other sponsors.

To ensure that as many OVC as possible benefit from Villa Maria’s programme, we have tried over the years to stimulate other players to make complementary efforts. For instance, we have enlisted support from local artisans to train OVC free of charge by appealing to their sense of community responsibility. We are organizing savings and loan associations to save for the OVC and reduce their dependency on adults. Also, we have started an advocacy and networking district committee to ensure that other organizations offer complementary rather than duplicate services.

The strategy of supporting orphans through vocational training and apprenticeships and emphasizing only acquisition of practical skills as opposed to academic class work is cost effective in terms of the duration of training and the costs involved. Vocational training with an element of work experience is skills based and by the time the trainees complete the programme to work on their own, they are competent enough to start their lives.

Lessons learned

- A vocational and apprenticeship approach for OVC is effective because it enables them to acquire marketable skills that could be applied in their own localities.
- Supporting orphans through acquisition of practical skills as opposed to academic class work is cost effective in terms of the duration of training and the costs involved.
- To avoid misunderstandings and conflict between families supported and those not benefiting, it is necessary to involve multiple key players in the selection process.
- To ensure that as many OVC as possible benefit from the programme, other organizations need to be stimulated to offer complementary rather than duplicate services.
According to the latest statistics released by the National AIDS Control Organisation (NACO) and UNAIDS, India has an estimated 2.5 to 3.1 million people living with HIV (PLWH) including children under 15 years and those aged 50 and beyond.\(^1\) The adult HIV prevalence is 0.36% and the majority of HIV infections are in men aged 15 to 44 years. Nearly 40% of PLWH in India are women. It is estimated that some 70,000 children below the age of 15 are infected with HIV and 21,000 children are infected every year through mother-to-child transmission (Updated NACO estimates 2007). The country has an increasing population of children living with HIV and those who have lost either one or both parents to an AIDS-related illness. However, there are no official estimates available on children affected and orphaned by HIV and AIDS in India. Some of the HIV high prevalence states in India such as Karnataka, Tamil Nadu, Andhra Pradesh, Maharashtra, Manipur and Nagaland are grappling with increased numbers of children infected and affected by HIV and AIDS. There is an emerging trend of child-headed households and increasing number of children caring for sick parents and siblings. An increasing number of street and working children over the last decade could also be a reflection of the emerging AIDS crisis.

Often, children from families affected by AIDS drop out of school to care for sick parents or to earn a livelihood for their families. Lack of information on STIs and HIV, peer pressure and lack of access to clinical care increases their vulnerability and risk to HIV infection. Discrimination, combined with a failing public health system, leave many affected children without even the rudiments of healthcare. Girls are especially vulnerable to HIV infection if they are targeted for sexual abuse or have less access to information about HIV prevention and related issues. In addition, there are the direct effects of stigma and discrimination: the denial of health care, education, and family or institutional care.

What is being done in India?
A number of international and local organizations have been working on issues of prevention, care and support for children living with and affected by HIV and AIDS. However, the current programming by these organizations, even though innovative, has had limited geographical coverage. There has been no long-term planning as funding has been time-bound and uncertain. The government has also not addressed this group with focused interventions and as a priority but that is slowly changing. There are also knowledge gaps due to lack of clear understanding of the magnitude of the problem, proven approaches that work, and limited availability of standardized programming tools to enable scaling up.

Programme highlights from one organization and one PLWH network in India working with children infected and affected by HIV and AIDS are given below. These two examples illustrate two different approaches: a) a comprehensive intervention for children in a high HIV prevalence district and b) the efforts of a network of positive women advocating for children.

**St. Paul’s Trust** is an organization based in the HIV high prevalence district of East Godavari in Andhra Pradesh. They work with orphans, children infected and affected by HIV and AIDS and their families. The initiative is comprehensive and includes HIV prevention, care and support programmes within an enabling environment. The

**The national and state governments in India are planning to increase their commitment to strengthen HIV treatment, care and support for children infected and affected by HIV and AIDS and their family members by expanding policy initiatives and committing resources more than ever before.**

The programme has adopted a broad community-based approach to cover all households in the community and reduce stigma and discrimination. The emphasis has been on providing a basic package of services including medical care, nutritional, educational, psychological, legal and livelihood support. The programme also builds linkages between government services and PLWH networks. The approach has helped to lower stigma and discrimination.\(^2\)
 Positive Women Network (PWN+), based in Chennai, Tamil Nadu, is an affiliated organization of the Indian Network for People Living with HIV/AIDS (INP+) and works exclusively for women and children infected and affected by HIV in India. The objective of their work with children is to ensure access to quality education, health and safety for children living with and affected by HIV and AIDS in an environment without bias. Some of the key activities include establishing services for children of women living with HIV including créches; advocating with the Department of Education, schools, parents, teachers associations and youth groups to protect children against discrimination in educational institutions and sexual abuse; advocating for access to medication and pediatric formulations specific for children living with HIV; and child counselling services and life skills education for all children irrespective of their HIV status.

**Challenges and emerging issues**

Two emerging challenges are the issues of child-headed households and understanding the effectiveness of community foster care in the Indian context. In the Indian context, community foster care means that a child is placed in a family to which it is not biologically related. Adoption and fostering of such children has not been a traditional practice in the country. However, this is gradually changing. Most orphaned children are still in institutional foster care (orphanages). The India HIV/AIDS Alliance in collaboration with the Tata Institute of Social Science conducted a research in 2006 to develop greater understanding of the problems, needs and challenges of children heading households and children in community foster care in India. The study shows that especially children who head households face tremendous challenges and are vulnerable to exploitation. Though inadequately prepared, they have to move into adult roles. It also brings to the attention the advantages and disadvantages of community foster care. The fact that the community is coming forward to take care of the needs of orphaned children is definitely a positive sign. The findings accentuate the need for immediate responses at all levels in order to protect children from abuse and exploitation. The report concludes that there is a need to strengthen the support systems for PLWH and children affected by AIDS. Also, the physical and mental health needs of PLWH and their children need to be identified and addressed.

A lot needs to be done in a country as vast and diverse as India with high levels of stigma and discrimination. Government policies are gradually being formulated and the issue of children infected and affected by HIV and AIDS is being recognized as critical. For the first time, through the third phase of the National AIDS Control Programme (NACP-III) launched in July 2007, the national and state governments are planning to increase their commitment to strengthen HIV treatment, care and support for children infected and affected by HIV and AIDS and their family members by expanding policy initiatives and committing resources more than ever before. For instance, 39,000 children living with HIV will be able to access ARVs for free. The Ministry of Women and Child Development will be the focal point for children affected by AIDS bringing them within the child protection umbrella. Also, minimum standards of care and protection will be established for institutional and community-based foster care systems.

**Resources on children affected by HIV and AIDS**

**Information sources:**
- International HIV/AIDS Alliance’s support toolkit on orphans and other vulnerable children: [http://www.ovcsupport.net](http://www.ovcsupport.net) (also available on CD-ROM, order online or via publications@aidsalliance.org)
- Bernard van Leer Foundation: [http://www.bernardvanleer.org/publications/browse_by_topics](http://www.bernardvanleer.org/publications/browse_by_topics)
- Ccaba – The Coalition on Children affected by AIDS: [http://www.ccaba.org](http://www.ccaba.org)
The role of the media in disseminating HIV and AIDS information in Somaliland

Eliezer Wangulu

Somaliland is situated in the eastern Horn of Africa. It was part of the wider Somalia until it declared itself an independent state after the collapse of the autocratic rule of Mohammed Siad Barre in 1991. Statistical evidence on the extent and spread of HIV in Somaliland is seriously lacking, but data from the blood banks, testing of suspected cases of people living with HIV (PLWH) and information from the few studies conducted in Somaliland, suggest an increase in infection rates. A study by WHO and the Ministry of Health showed HIV prevalences of 1.4% among antenatal care patients, 3.5% among sexually transmitted infections (STI) patients and 5.6% among tuberculosis patients in Somaliland. Also, the prevalence of HIV in neighbouring countries and where many Somali refugees live is high. For example, Ethiopia's HIV prevalence rate stands at 6.7% while Djibouti's is 3.5%. Notwithstanding this evidence, there is little general awareness about either the causes of HIV infection or the practices, both medical and social, which can contribute to its prevention or spread.

The media can play a crucial role in creating an enabling and supportive environment where some of the taboo issues and underlying driving forces of the epidemic can be addressed. The media are in a position to create greater public awareness of HIV and AIDS, which is necessary before individuals critically look at the challenges posed by the epidemic to be able to make informed decisions to help prevent infections, protect themselves, and ensure proper care and treatment of PLWH. News coverage reinforces information that people receive about the epidemic from other sources, such as their friends, health care workers, and billboards.

Challenges faced by the journalists in Somaliland

Covering the issues of HIV and AIDS with maximum efficiency requires a clear understanding of the challenges and the obstacles faced by journalists in Somaliland. Media practitioners in general do not have adequate skills in reporting on HIV and AIDS effectively. Myths and misconceptions as well as lack of understanding of the epidemic’s terminologies are portrayed in the media reports in Somaliland. Also, media practitioners do not have skills on how to approach PLWH so as to minimize stigma and discrimination which tends to drive the disease underground. In some cases, reporters use stigmatizing language in reference to PLWH. However, this is out of ignorance rather than the desire by journalists to stigmatize PLWH. There are limited HIV and AIDS resource centres and this makes it difficult for journalists to get relevant and up-to-date information on the epidemic that can be used to come up with informative media reports on HIV and AIDS. Finally, the general standard of journalism in Somaliland is rather low. The challenge has always been limited or lack of skills in the areas of writing, editing and effective dissemination of especially print media products.

Building capacity to report on HIV and AIDS

The contribution of Progressio to three civil society organizations and indirectly to several media organizations, has in a way tried to address the gaps identified in terms of effective reporting on HIV and AIDS. Progressio, formerly known as International Cooperation for Development (ICD), is an international development charity that combines advocacy work to secure equitable policies with the strengthening of community-based organizations. Progressio’s three partner organizations in Somaliland are the Somaliland HIV and AIDS Network (SAHAN), Hargeisa Youth Development Association (HYDA) and Somaliland National Youth Organisation (SONYO). Progressio works with these counterparts, sharing media-related skills, planning, designing publications, coming up with distribution strategies as well as monitoring the effectiveness of the media projects. A Media Advisor – HIV and AIDS Programming, the author of this article, supports partner organizations to develop media strategies based on the local, national as well as organizational context. His other responsibilities include linking HYDA and SONYO with national newspapers, Radio Hargeisa and Somaliland National Television and organising national sensitization workshops on the role and importance of the media in disseminating correct and precise information on HIV and AIDS.
The Media Advisor, in collaboration with the partner organizations, has undertaken four workshops, between August 2006 and April 2007, aimed at building the capacity of SAHAN member organizations to be able to produce their own Information Education and Communication (IEC) and advocacy materials on HIV and AIDS. Participants were drawn from all the six regions of Somaliland. Already, many of the workshop participants are assisting their organizations to come up with IEC and advocacy materials and also contributing articles to SAHAN’s newsletter. So far, 55 participants have attended the trainings. Also, a total of 27 journalists from across the country reporting for both print and electronic media were invited for a national workshop on the role of the media in the dissemination of HIV and AIDS information which was held in Hargeisa in August 2006. In April 2007, two additional workshops were held for media practitioners to further build their capacity to report on the issue of HIV/AIDS effectively.

### Journalists Associations Against AIDS

Journalists Against AIDS (JAAIDS) is a concept that was initiated by the media in Nigeria after realizing the need to be involved in the dissemination of timely and accurate information to enable people make informed decisions that could lead them to avoid HIV infection. JAAIDS Nigeria is a media-based NGO working in the field of HIV and AIDS and development.

Through its basic training programmes, SAHAN’s (Southern Africa HIV and AIDS Information Dissemination Service) found that many journalists in sub-Saharan Africa were interested in starting similar groups that would enhance the capacity development of local journalists and identify information gaps within their own countries. With support from SAHANs, JAAIDS groups have been developed in Botswana, Malawi, Mozambique and Zambia.

In Kenya, UN agencies have been training journalists to report effectively on health, especially HIV and AIDS. For example, the United Nations Population Fund (UNFPA) has trained 23 Kenyan journalists in Accra, Ghana as well as locally at Moi University. The journalists have now founded an association called Kenya Media Network on Population and Development (KEMEP), whose mandate is similar to that of JAAIDS in Nigeria and southern Africa.

More information:
- JAAIDS Nigeria: jaaidsng@nigeria-aids.org, http://www.nigeria-aids.org
- SAHANs: info@sahans.org, http://www.sahans.net
- KEMEP: kemeporg@yahoo.co.uk

For example, one of the trained journalists, Mr Ahmed Sahadil, who works for the Somaliland National TV (SLNTV), said in an interview that he now reports more on HIV and AIDS. “We now mainstream HIV and AIDS across a number of programmes. Right now I am moderating a TV panel discussion whose subject is HIV and AIDS.”

After the training, the journalists promised to give the epidemic prominence in their media, dedicate airtime/space to HIV and AIDS issues and also come up with special broadcasts and columns on HIV and AIDS. For example, one of the trained journalists, Mr Ahmed Sahadil, who works for the Somaliland National TV (SLNTV), said in an interview that he now reports more on HIV and AIDS. “We now mainstream HIV and AIDS across a number of programmes. Right now I am moderating a TV panel discussion whose subject is HIV and AIDS.”

Another beneficiary of the training, Mr Mohammed Gaas, editor of the weekly Horn Tribune and chairperson of SHARA, said: “I have made it my responsibility to carry an article on HIV and AIDS every week.” They are also committed to increasing their knowledge on the issues surrounding HIV and AIDS and sharing facts and figures on the status of HIV and AIDS at the global, regional and country levels to become more effective in reporting on the epidemic. The network would like to establish linkages with already established networks of Journalists Associations Against AIDS (JAAIDS) in Eastern and Southern Africa and even in Nigeria where the concept was introduced (see the Box). They also want to see the establishment of an HIV and AIDS media helpdesk in one of the agencies, preferably SAHAN, where journalists can get the latest information on the pandemic.

Progressio’s collaboration with the three organizations has also drawn the interest of funding agencies like UNDP and UNICEF to realize that their funding is making a difference in reaching communities in all the six regions of Somaliland through IEC and advocacy information on HIV and AIDS produced by the three organizations such as newsletters, posters, stickers, reports and websites.

The role of the media is so critical if HIV and AIDS is to be effectively tackled. This was aptly captured by the former UN Secretary General, Mr Kofi Annan, who stated that: “When you are working to combat a disastrous and growing emergency, you should use every tool at your disposal… Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV and AIDS. We must seek to engage these powerful organizations as full partners in the fight to halt HIV and AIDS through awareness, prevention and education.”

### Eliezer Wangulu

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Namibia has a relatively young population; close to 40% of the whole population is younger than 15 years according to the National Population and Housing Census 2001. Adolescents in Namibia represent a large, significant, and growing number nationally. In 2005, the country had a Gross National Income per capita of US$ 2,990 with relatively good health and education indicators. However, there is unequal distribution of wealth among the different population groups. The San have the highest rate of illiteracy and are statistically the poorest language group. San children frequently drop out of school because of their economic position as well as their semi-nomadic lifestyle in search of food and water. The majority of San live in the regions of Omaheke and Otjozondjupa in the northeast of the country.

Consistent with their culture, San adolescents marry young. San women are commonly sexually abused by members of more affluent tribes. This would suggest that the risk for HIV is probably highest amongst this group, with adolescents being the most vulnerable. Results of an HIV sero-prevalence survey of pregnant women in 2002 indicated that Grootfontein district (Otjozondjupa region) had an HIV prevalence of 30%, the second highest in the country, while Gobabis district (Omaheke region) had an HIV prevalence rate of 13%. In both regions, teenagers comprise 18-22% of all antenatal care clients, indicating that adolescent pregnancy is common among the San and by extension, the need for adolescent sexual and reproductive health services is high. A Namibia Planned Parenthood Association report reveals low contraceptive use rates and limited knowledge about reproductive health among adolescents.

Volunteer peer counsellors
Health Unlimited is a not-for-profit UK-based NGO that works with marginalized communities in 15 countries of Africa, Asia and Latin America, to help them achieve their right to health. In 2001, Health Unlimited began to implement the Teen Health Project in Epako Clinic in Omaheke Region. This three-year EC-funded project aimed to reduce teenage pregnancies and address the high rates of school dropouts as well as AIDS-related deaths among the youth in a squatter area inhabited by the San called Epako. The pilot project supported the establishment of one adolescent-friendly health clinic within an existing clinic and also trained volunteer peer counsellors (VPCs) to provide information on the importance and use of contraceptives. Seventy of the 110 VPCs aged between 10 and 19 years were drawn from seven primary schools in the target area while forty were out-of-school youth from Epako. The out-of-school youth were selected by community members in the target area.

Lessons learned during the implementation of the Teen Health Project to date include:
- The project had a way of motivating the VPCs to the extent that they all wished to go back to school to attain better education and skills.
- Most of the trained VPCs realized that they had untapped potentials and talents.
- The peers who got in contact with trained VPCs wished to be health educators like VPCs, whom they considered as role models.
- Pilot projects have a potential to influence policy makers and also contribute more to directing the policy development. The Teen Health Project has contributed to the development of the Namibia Adolescent Friendly Health Services (AFHS) policy and guidelines. During the implementation of the project in 2001, the Ministry of
Namibia Adolescent Sexual Reproductive Health Programme

Several challenges were experienced in implementing the pilot project. This included a shortage of MOHSS staff in general. Namibia is faced with a problem of skilled nursing staff to work in the government clinics particularly in remote areas such as where the San live. This meant that while the project had aimed to train health staff to provide continued support to the VPCs, they were not always available to do so. The VPCs felt that they did not have opportunities to provide suggestions and/or complaints to health staff. An additional challenge was that the MOHSS staff were unaware of the existing AFHS policy and its contents. This was because the policy and guidelines had not been effectively disseminated from the national level to the peripheral staff, particularly those in remote areas.

To address these challenges, Health Unlimited designed a new sexual and reproductive health project. This EC-funded project, which runs from 2006 to 2009, will also focus on HIV and AIDS as a sexual and reproductive health project. This EC-funded project, entitled ‘Namibia Adolescent Sexual Reproductive Health Programme’ (NASRHP), is being implemented in Omaheke and Otjozondjupa regions where the majority of San live and where health services are difficult to access. It is implemented in partnership with the health department and focuses on four main issues. These are:

1. Promoting access to and utilization of adolescent-friendly sexual and reproductive health services to in-school and out-of-school adolescents using a peer counselling approach. This will be achieved through training of 130 out-of-school adolescents and 130 school-going adolescents aged between 10 and 24 years.
2. Strengthening the ministry’s capacity to provide AFHS through improved infrastructure at 13 clinics and training of health workers to provide appropriate adolescent-friendly services.
3. Community outreach through working with community members to create a supportive environment amongst parents, teachers, religious leaders and other opinion leaders.
4. Advocacy with and for adolescents to clinic staff to ensure that services provided at the adolescent-friendly clinics meet the needs of adolescents. Adolescents use theatre and hold regular meetings at youth centres established at the community level to discuss and advocate for their reproductive health rights.

NASRHP is designed to address the specific challenges identified during the implementation of the pilot project while building on the lessons learned. Rather than work with MOHSS staff only, this project has incorporated teachers, religious leaders, parents and community-based volunteers. This ensures that adolescents can receive support and advice from any of these groups and the reliance on health workers is reduced. Health Unlimited is also providing training for these groups on the AFHS policy and guidelines, which ensures that all actors are familiar with the procedures of working with adolescents and providing relevant services for them.

In addition, the project has a strong advocacy component that uses mass media (in local San languages), and quarterly meetings of adolescents, health staff, teachers and community health volunteers where adolescents can provide feedback, suggestions and/or complaints on the established services. All programme components have begun, including the training of clinic nurses, VPCs, teachers, community-based resource persons, clinic health committees and adolescent consultative committees in the target areas. Ten health clinics have also been refurbished to ensure that adolescents have privacy during their consultations with health staff.

Although the results of the October 2007 mid-term review are not yet available, feedback from San adolescents indicates that they appreciate the project. For instance, during the inauguration of an adolescent-friendly health clinic, out-of-school adolescents said:

“we like this programme, it has given us something to do and hope for the future”. Others said: “I now know what I want in life, I am going back to school” and “I can now realize that I have the potential to be a football player and I am taking it on.”

Reaching San adolescents in the sensitive areas of sexual and reproductive health will continue to be a challenge, but the methodology described in this article appears to be one that is not only acceptable to the San, but one they can embrace as it is rooted in their culture and their people.

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2. According to the 2006 national HIV sentinel survey the prevalence among young people aged 15 to 19 is 10.2% nationally while that of youth aged 20 to 24 is 16.4%.
Participation Guide. Involving those directly affected in health and development communications programs.

M. Tapia, A. Brasington & L. Van Lith, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 2007 (40 p.)
PDF: http://www.hcpartnership.org/Publications/Field_Guides/participationguide.pdf

The Participation Guide provides simple tips and tools to involve affected individuals and groups in the various stages of health and development communication programs. The guide provides examples of how to include those most marginalized, including low-income women of reproductive age, youth, orphans and vulnerable children, and people living with HIV. The guide’s intended audience includes programme officers, programme staff and development practitioners interested in effectively involving those directly concerned in the health and development communication programs they support.

Legal education and will writing for the support of orphans and vulnerable children, persons living with HIV and other persons affected by HIV – Facilitator’s Guide

PDF: http://www.fhi.org/en/HIVAIDS/pub/res_OVC_Legal Education.htm

This resource encourages inheritance planning through will writing. The publication is designed to train those who influence behaviour in communities; create awareness of human rights, especially children’s rights; build skills in will writing; mobilize community support for legal education and will writing; and facilitate creation of local legal support structures for affected children and their families. The manual also aims to motivate civil society organizations to bring discrimination and other legal abuses to the attention of human rights organizations.

Training guide on stigma and discrimination in relation to HIV and AIDS.

Kenya AIDS NGOs Consortium (KANCO), 2007 (36 p.)

This is a guide for organizations involved in HIV and AIDS stigma and discrimination reduction activities. It offers participatory training to increase knowledge and understanding about stigma and discrimination and to increase stakeholders’ capacity to deal with and monitor stigma and discrimination in the community.

Factsheets & Issues briefs
The multisectoral impact of the HIV/AIDS epidemic

The Kaiser Family Foundation, 2007 (11 p.)
PDF: http://www.kff.org/hivaid/7661.cfm

This primer explains the concept of multisectoral impact and summarizes key research assessing impacts to date in many of the worst affected countries, including effects on population structure and demographics, individuals and households, the public and private sectors, health, education, agriculture and food security, and the economy.

Towards a stronger response to HIV and AIDS:

Challenging stigma. International Center for Research on Women (ICR-W), 2007 (9 p.)

This is an internal paper for DFO that looks at information and evidence for the global prevalence of HIV stigma and how it is damaging people living with HIV and AIDS and their families.