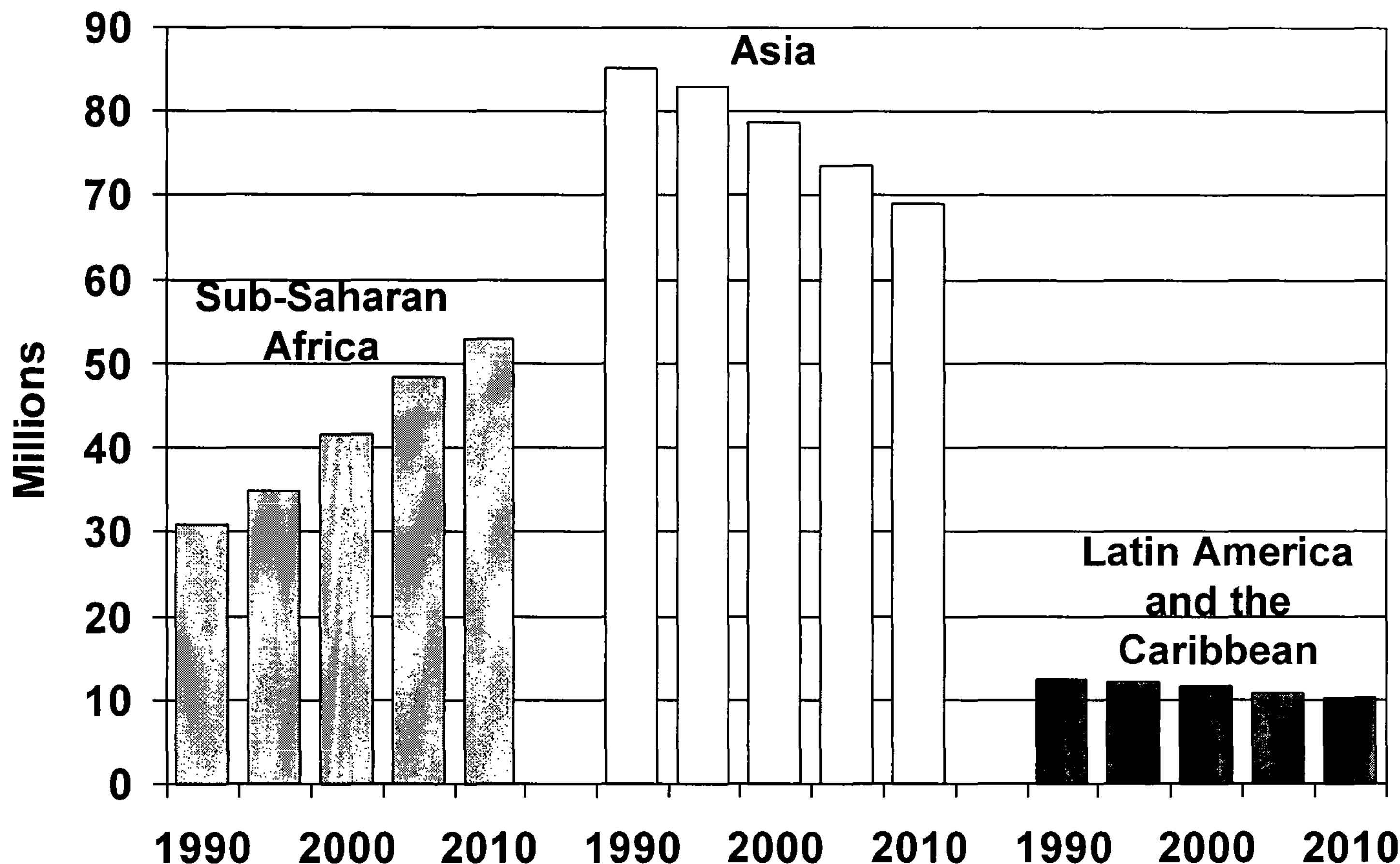
From the individual to the system: The coming of age of programmes for Children affected by HIV and AIDS in Africa

Douglas Webb, PhD
UNICEF,
Copenhagen, October 2008

unicef

Focus is on Africa: Where rates of orphaning are increasing

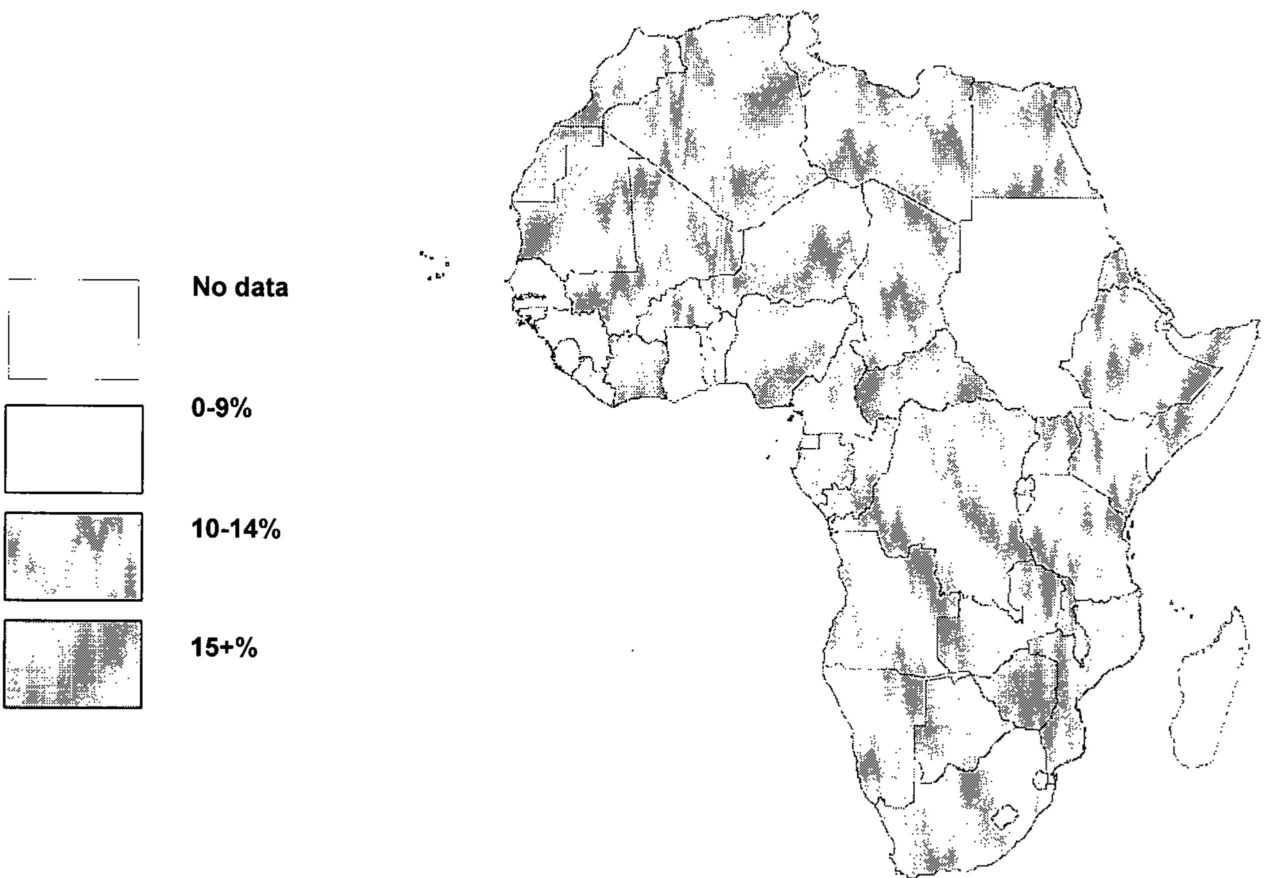
Estimated number of orphans ages 0 -17 by region



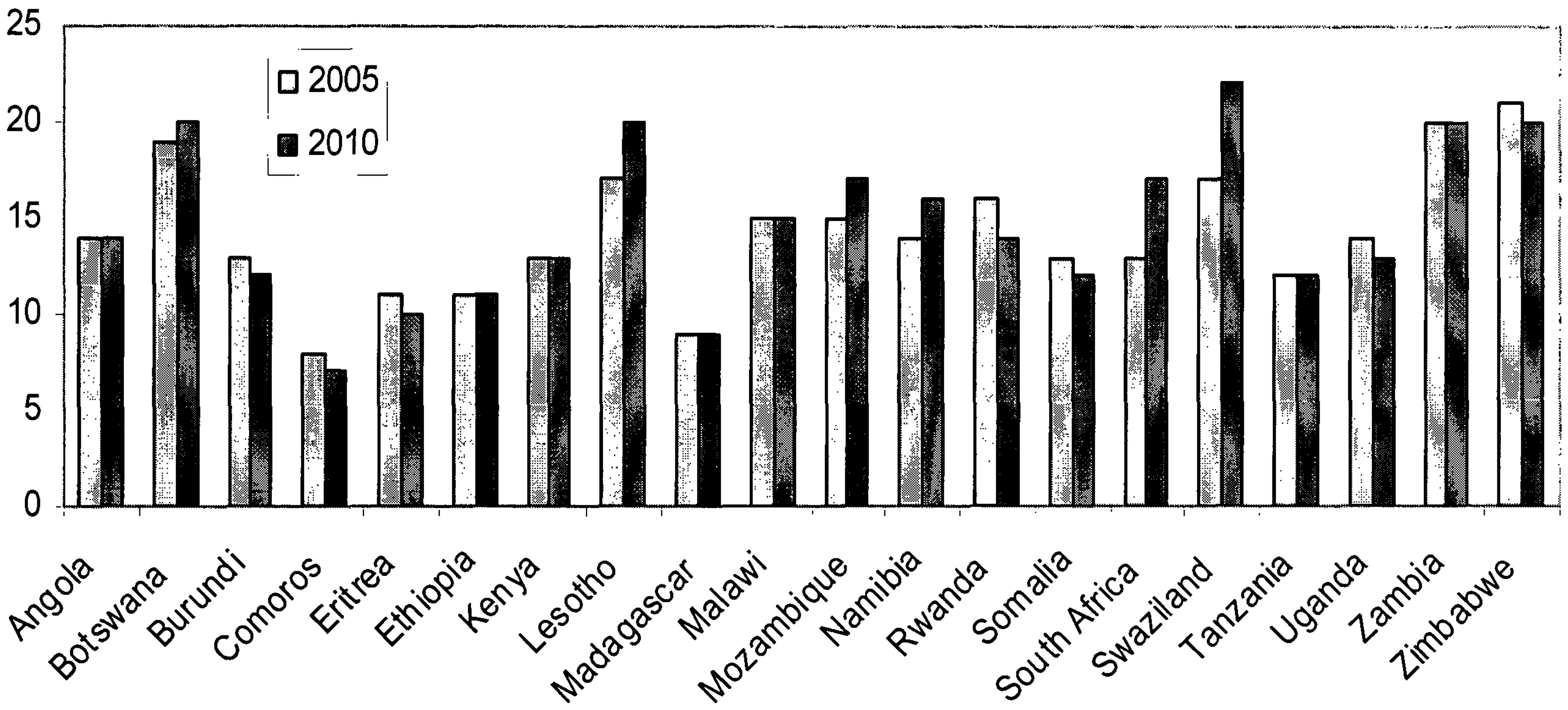
Source: UNAIDS and UNICEF estimates, 2006

Unlike the rest of of the world, more than half of all orphans in ESA are orphaned due to AIDS

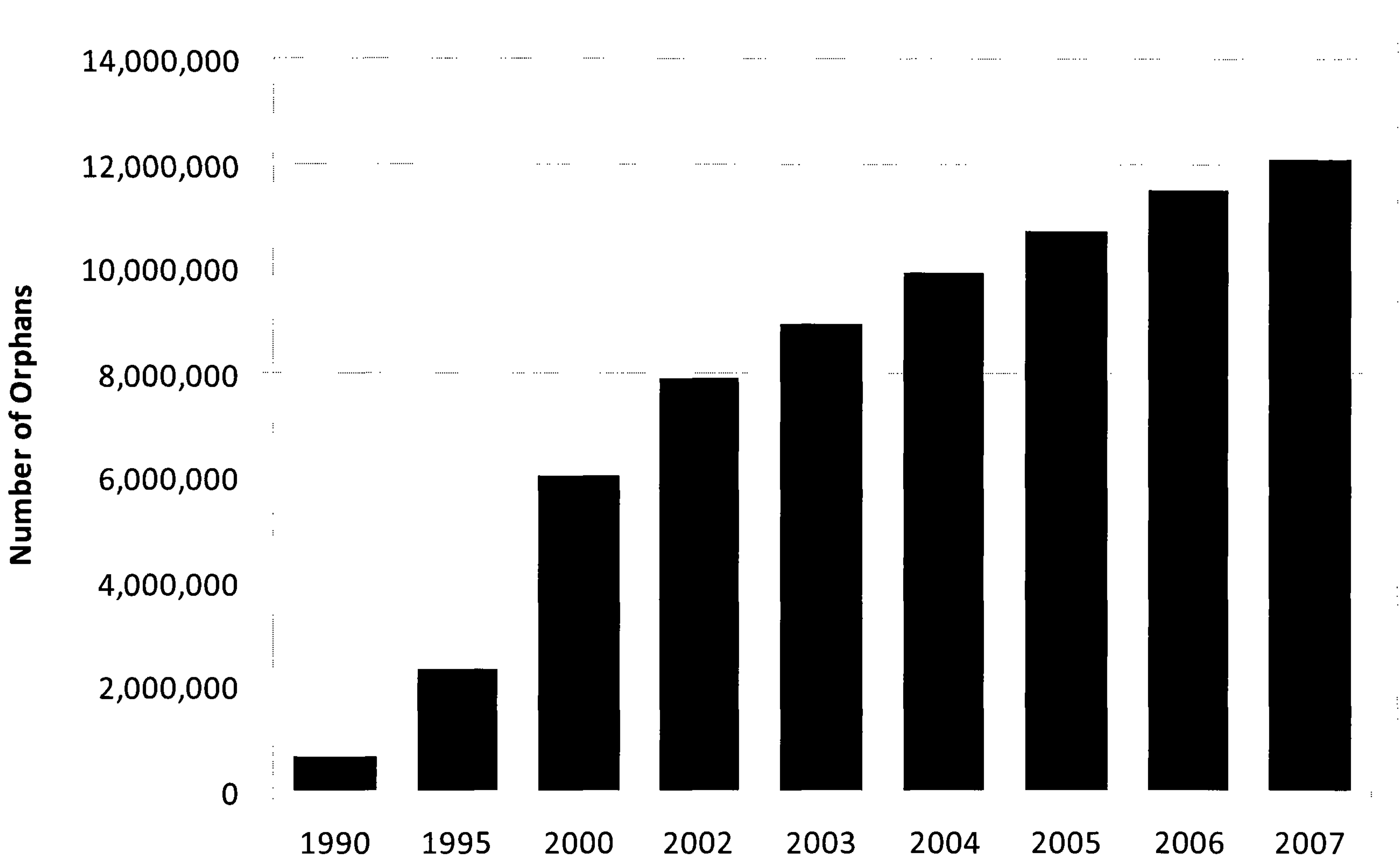
Rates of orphaning in sub-Saharan Africa (by end 2005)



Source: UNAIDS and UNICEF estimates, 2006

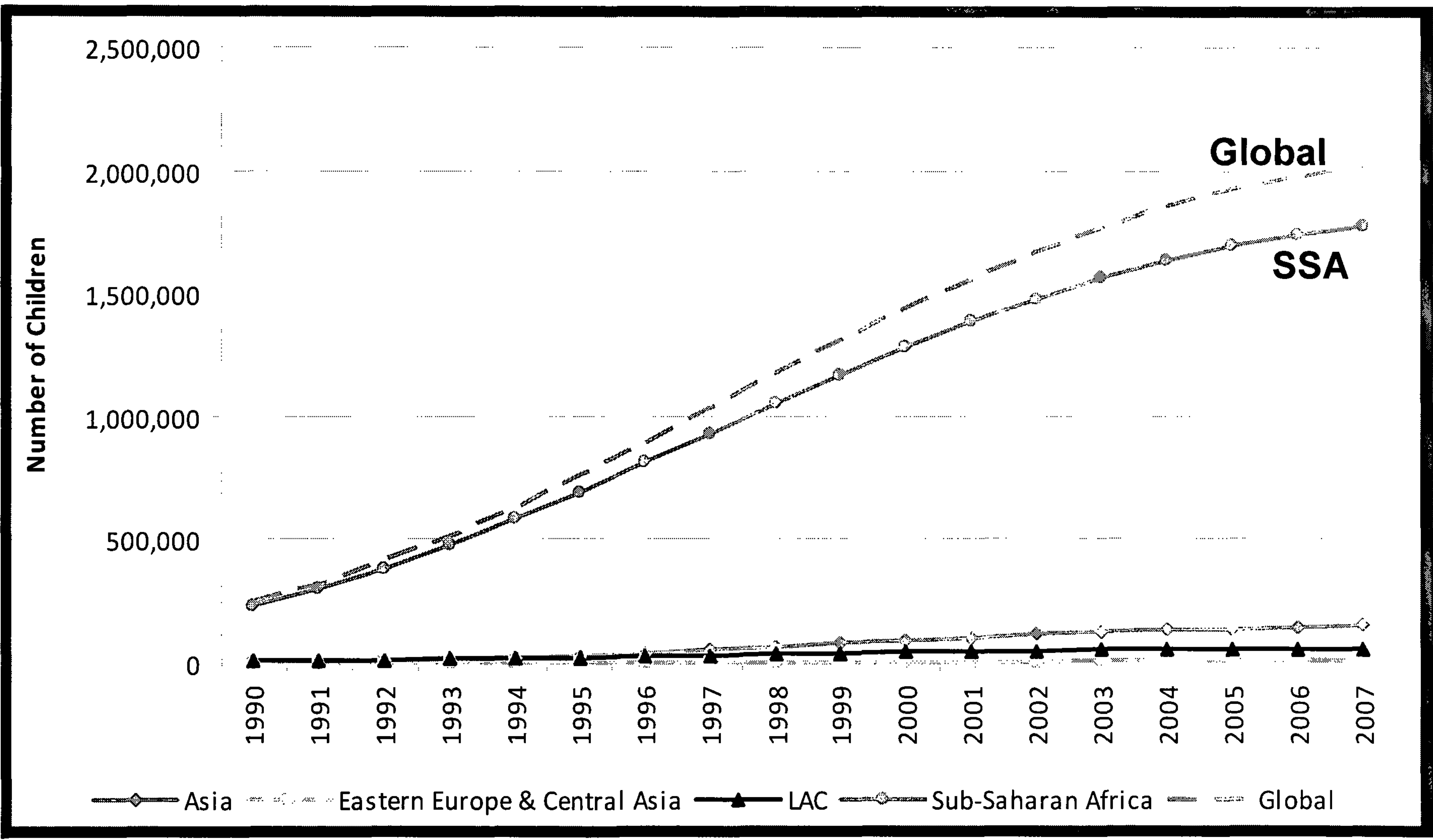

Percent of Children Who Are Orphans
25
20
15
10
5
0
2005
2010
Angola
Botswana
Burundi
Comoros
Eritrea
Ethiopia
Kenya
Lesotho
Madagascar
Malawi
Mozambique
Namibia
Rwanda
Somalia
South Africa
Swaziland
Tanzania
Uganda
Zambia
Zimbabwe

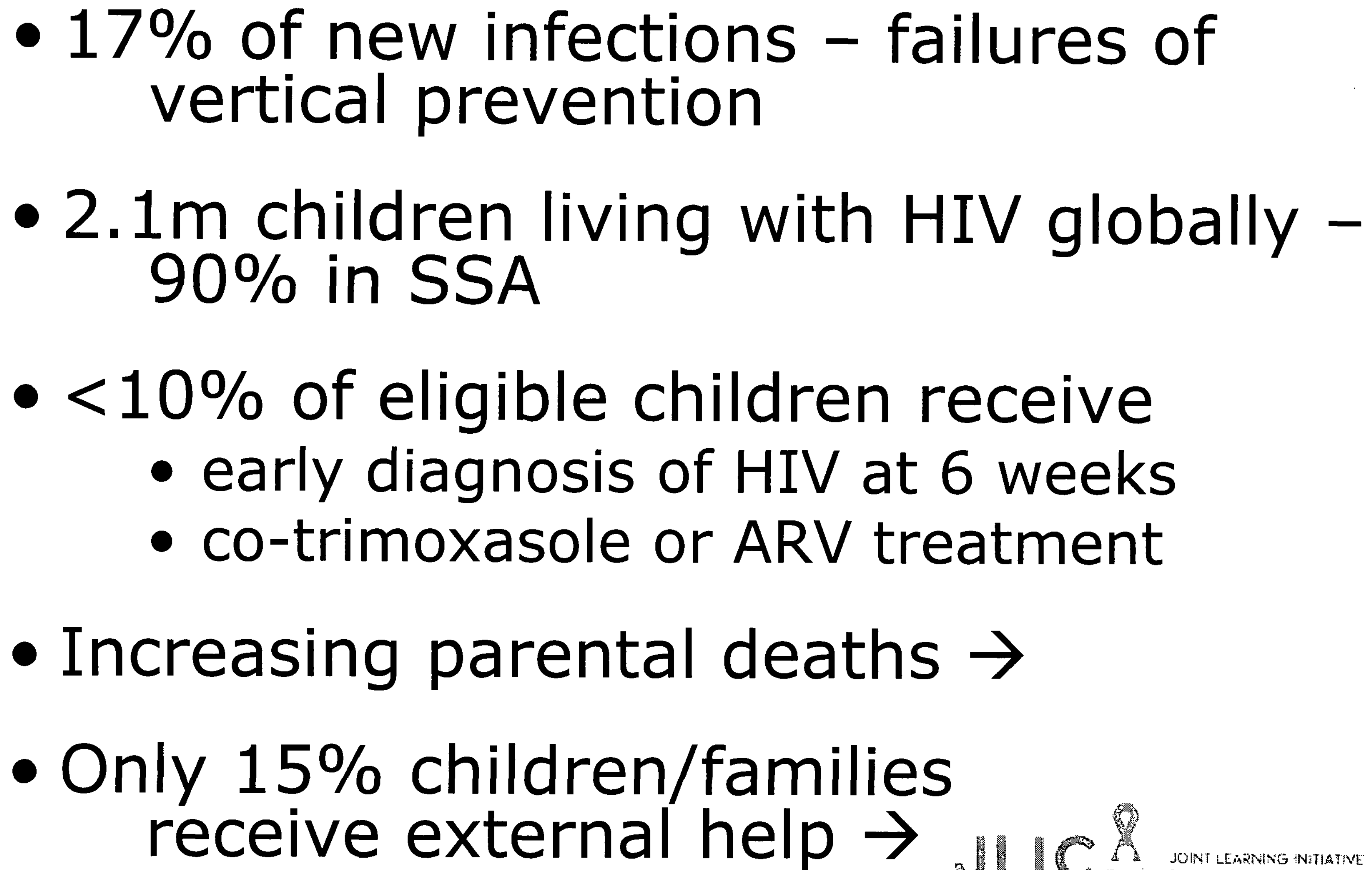
Orphaned children in SSA



JLICA JOINT LEARNING INITIATIVE ON CHILDREN AND HIV/AIDS

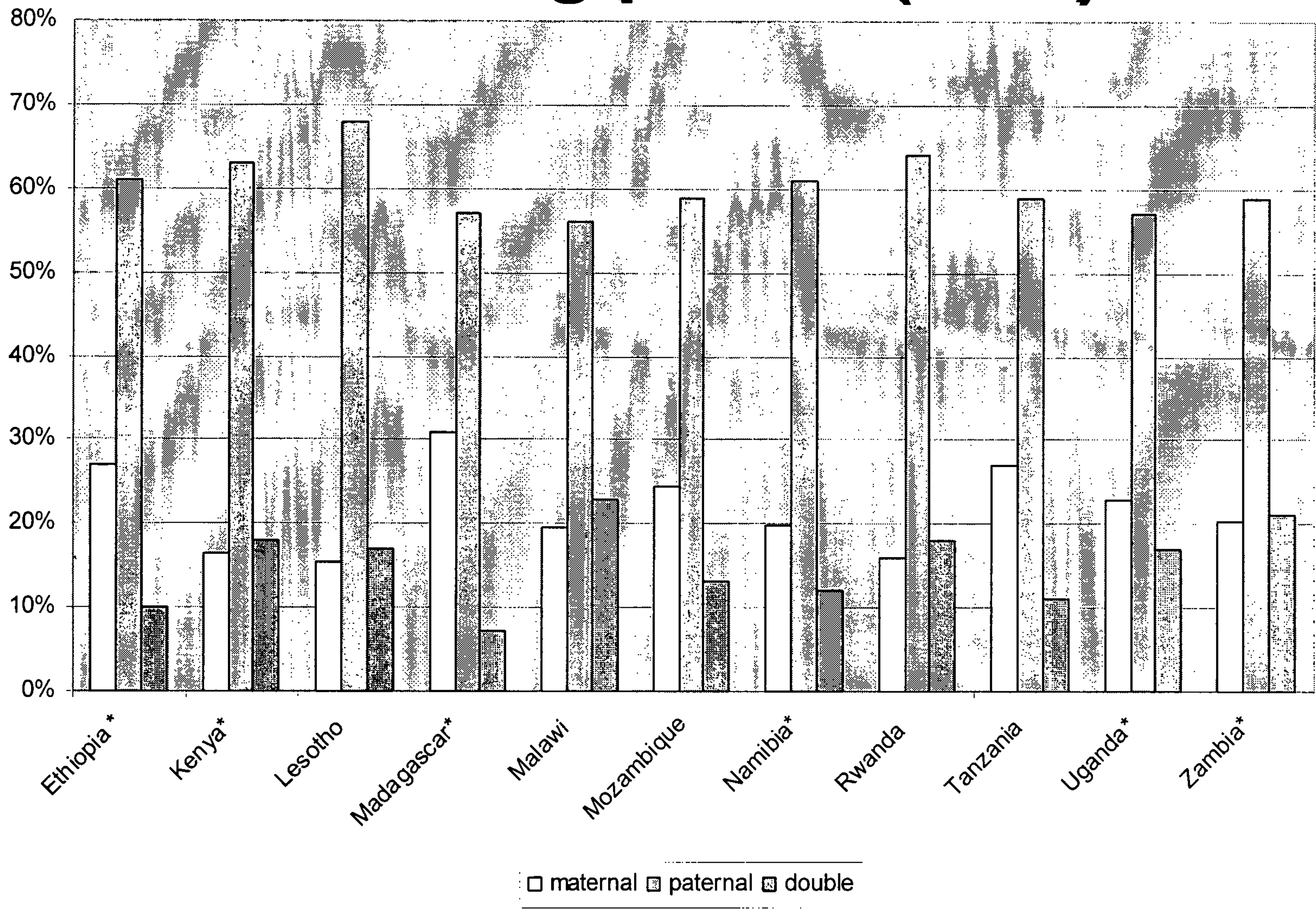
Children living with HIV globally 1990-2007





Accepting Failures - 2007
• 17% of new infections – failures of vertical prevention
• 2.1m children living with HIV globally – 90% in SSA
• <10% of eligible children receive
• early diagnosis of HIV at 6 weeks
• co-trimoxasole or ARV treatment
• Increasing parental deaths →
• Only 15% children/families receive external help →
JLICA
JOINT LEARNING INITIATIVE ON CHILDREN AND HIV/AIDS

Large majority have at least one surviving parent (80%)



So, what have we been doing until now?

- Orphaning and living arrangements
  - the most frequently-used markers of child vulnerability…
  - …however, empirical evidence supporting their use has been equivocal.
- Chronic illness or HIV serostatus of adult household members
- Intuitively appealing, but can they help identify children at risk of poor outcomes?

Data: Sources and selection criteria

- Data sources
  - MICS (Multiple Indicator Cluster Surveys) → **UNICEF**
  - DHS (Demographic and Health Surveys) &
    AIS (AIDS Indicator Surveys (AIS) → **USAID/Macro**

- Selection of countries to focus on those most affected:
  - orphan prevalence > 8 percent OR adult HIV prevalence > 1 percent

    and
  - conducted a DHS/AIS in 1995 or later, or conducted a MICS-3 (2005-06)

    and

Definition of child outcomes

- **Wasting (weight-for-age).**

  Among children aged 0-4 years old, whether they are considered underweight, i.e., <2 standard deviations below the median of the new WHO Child Growth Standards. (0/1)

- **School attendance.**

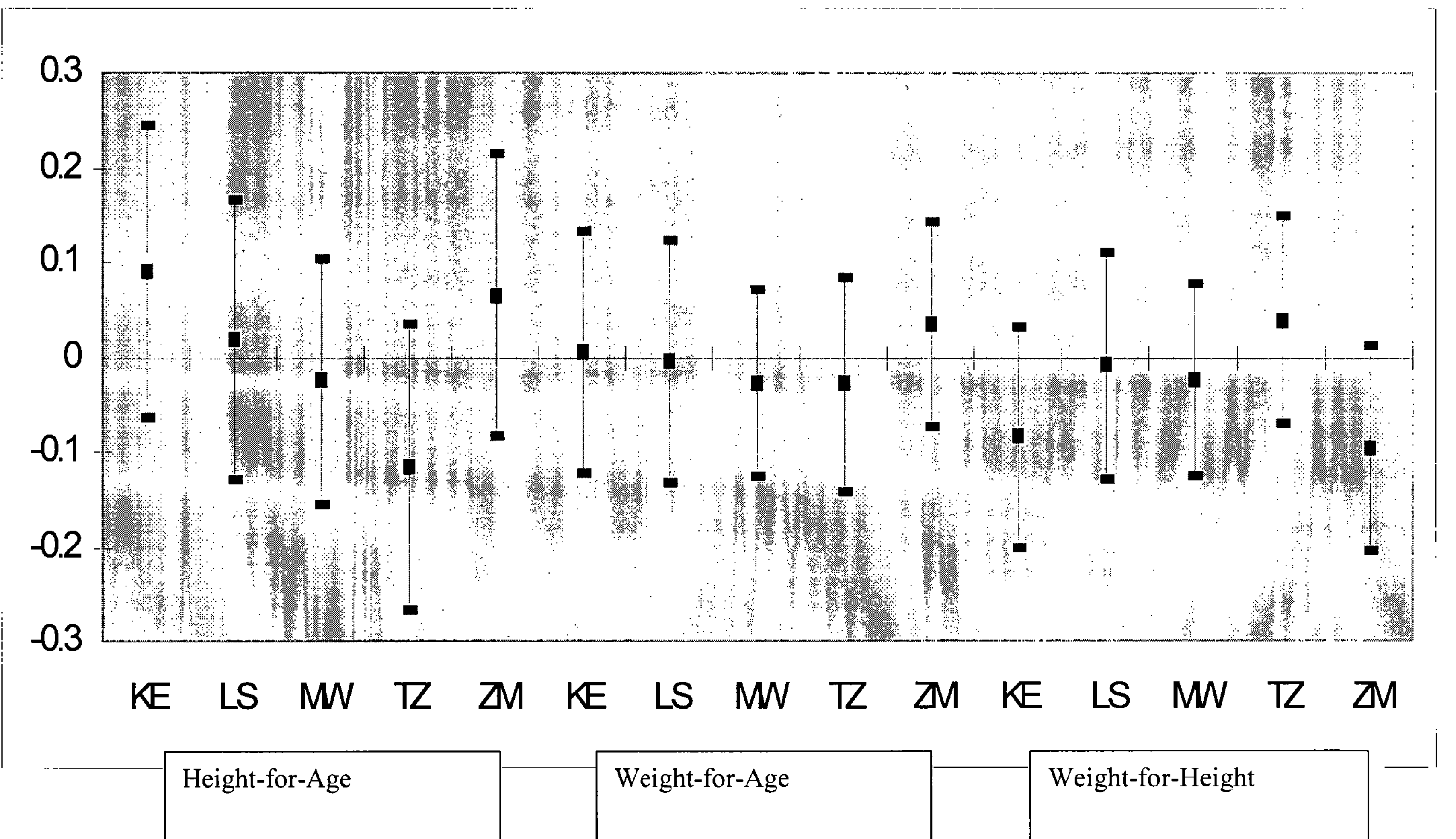
  Among children aged 10-14 years old, whether they have attended school in the past year. (0/1)

- **Early sexual debut.**

  Among girls and among boys age 15-17, whether their first sexual intercourse occurred before age 15. (0/1)

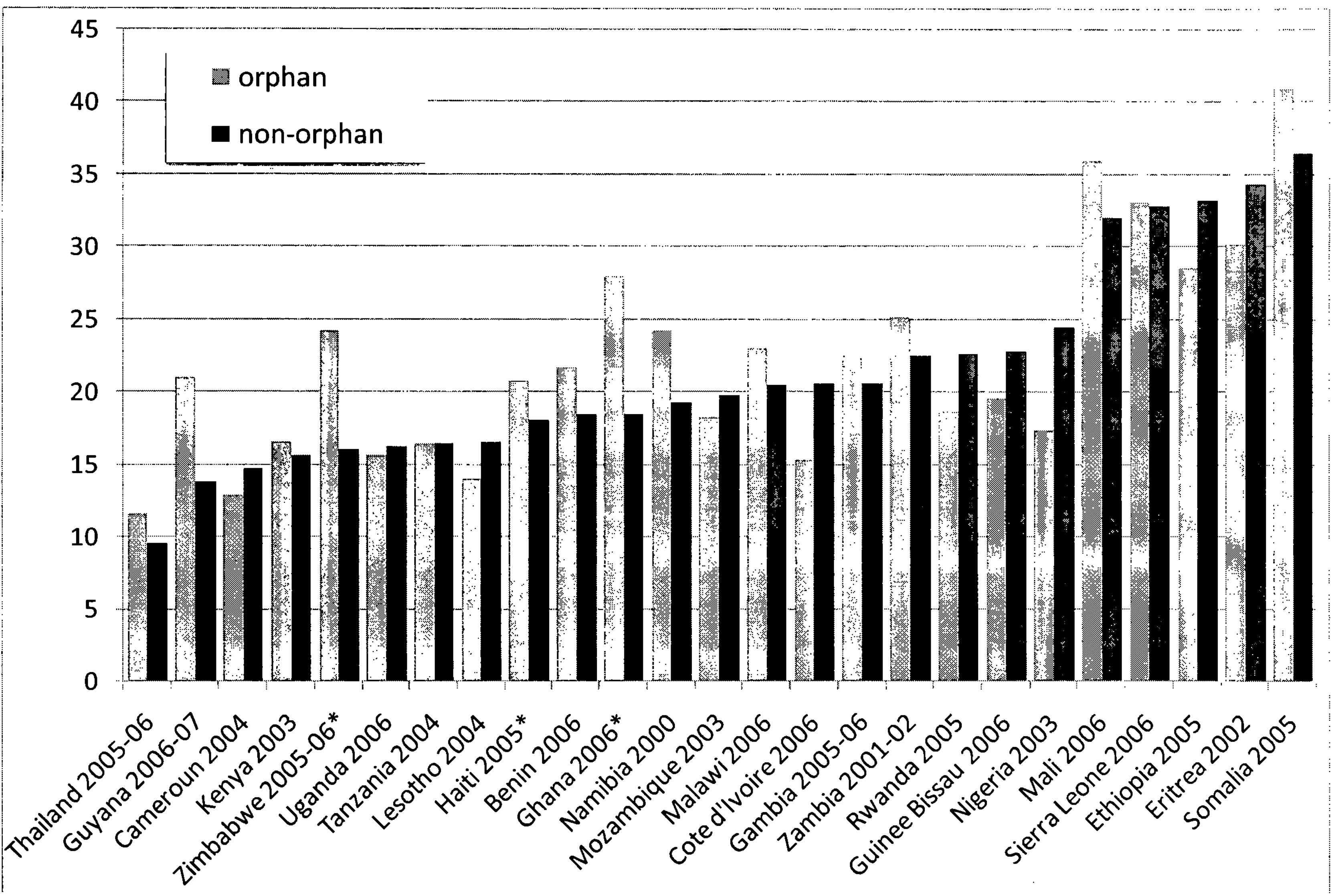
No worse than their peers?

Young orphan to non-orphan malnourishment rates

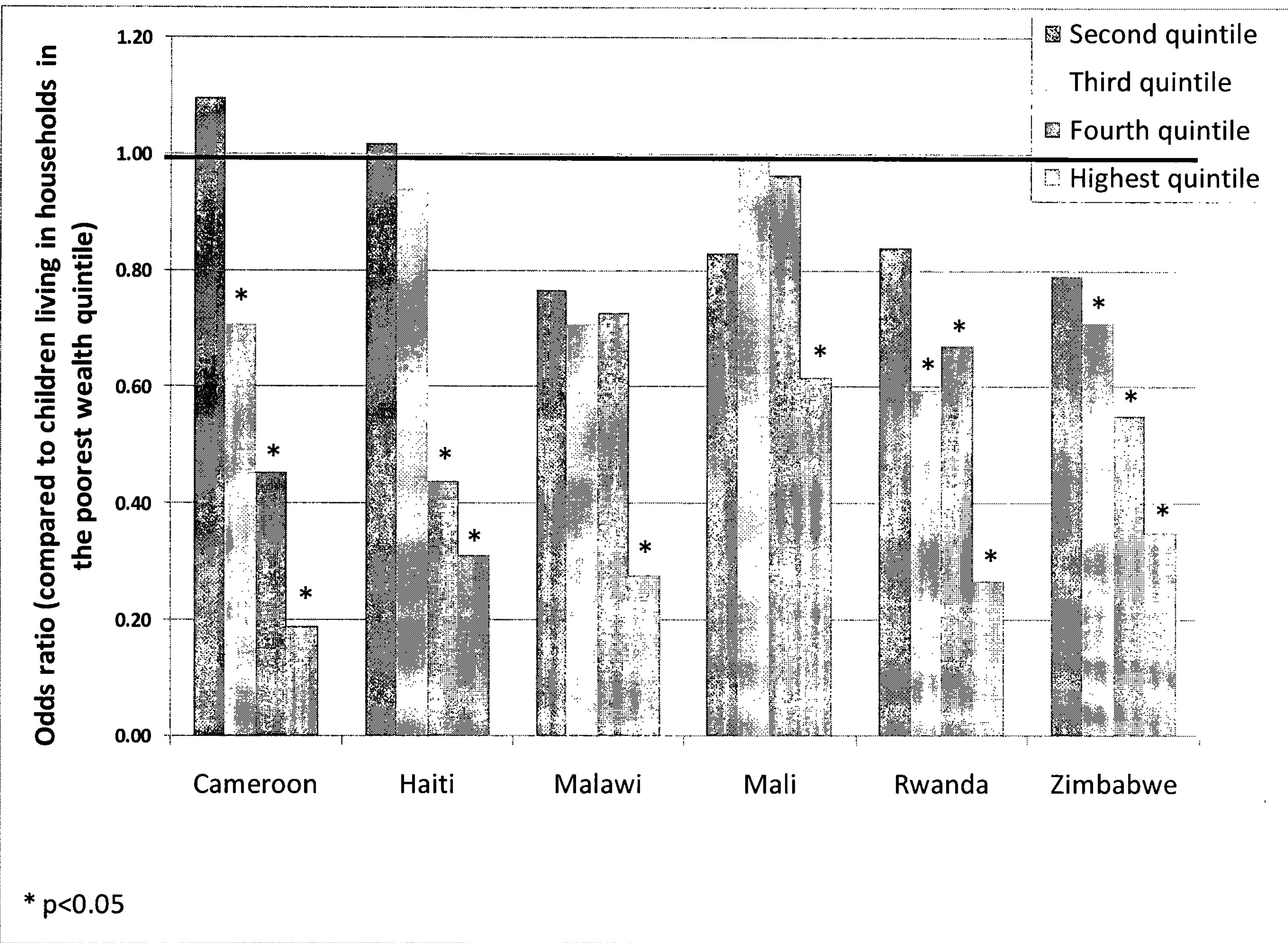


Nutritional status: Percent wasted **(<-2SD from WHO ref median)**

Percent of children age 0-4 who are wasted, by orphanhood status, MICS & DHS 2001-2007

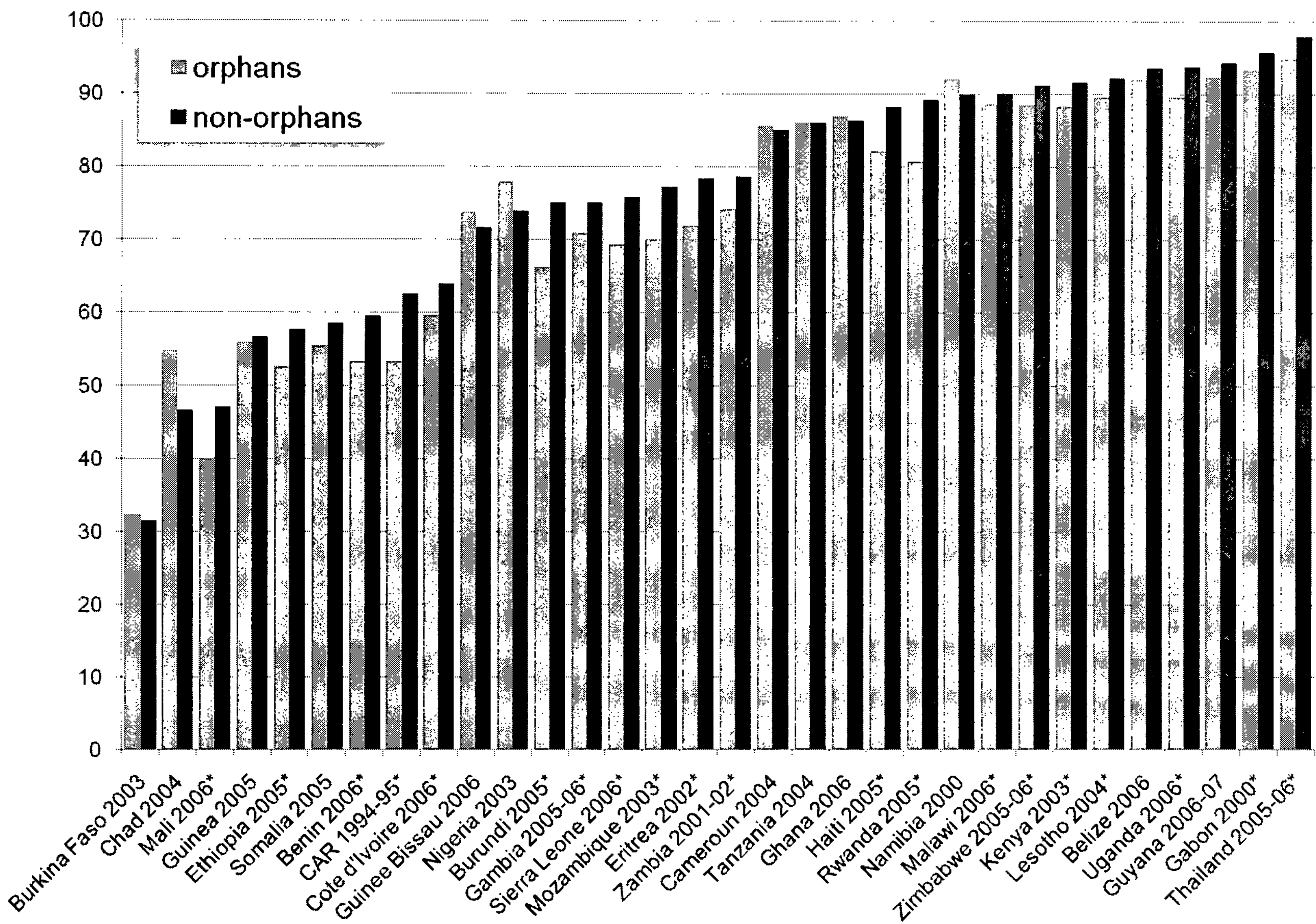


Odds of wasting: wealth quintile
Among children age 0-4, DHS 2004-2006



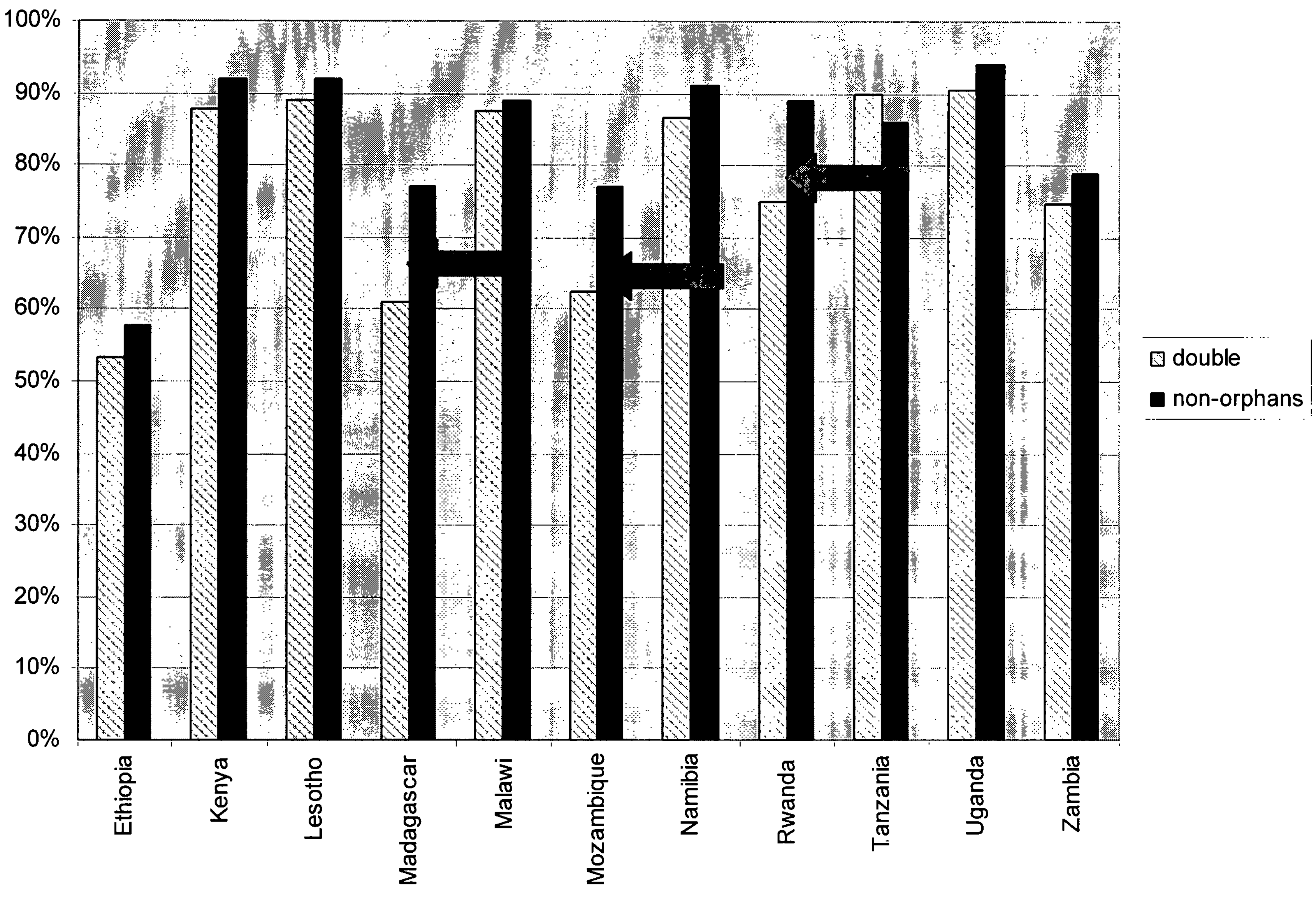
School attendance: Percent attended school in past year

Percent of children age 10-14 who attended school in the past year, by orphanhood status, MICS & DHS 2001-2007

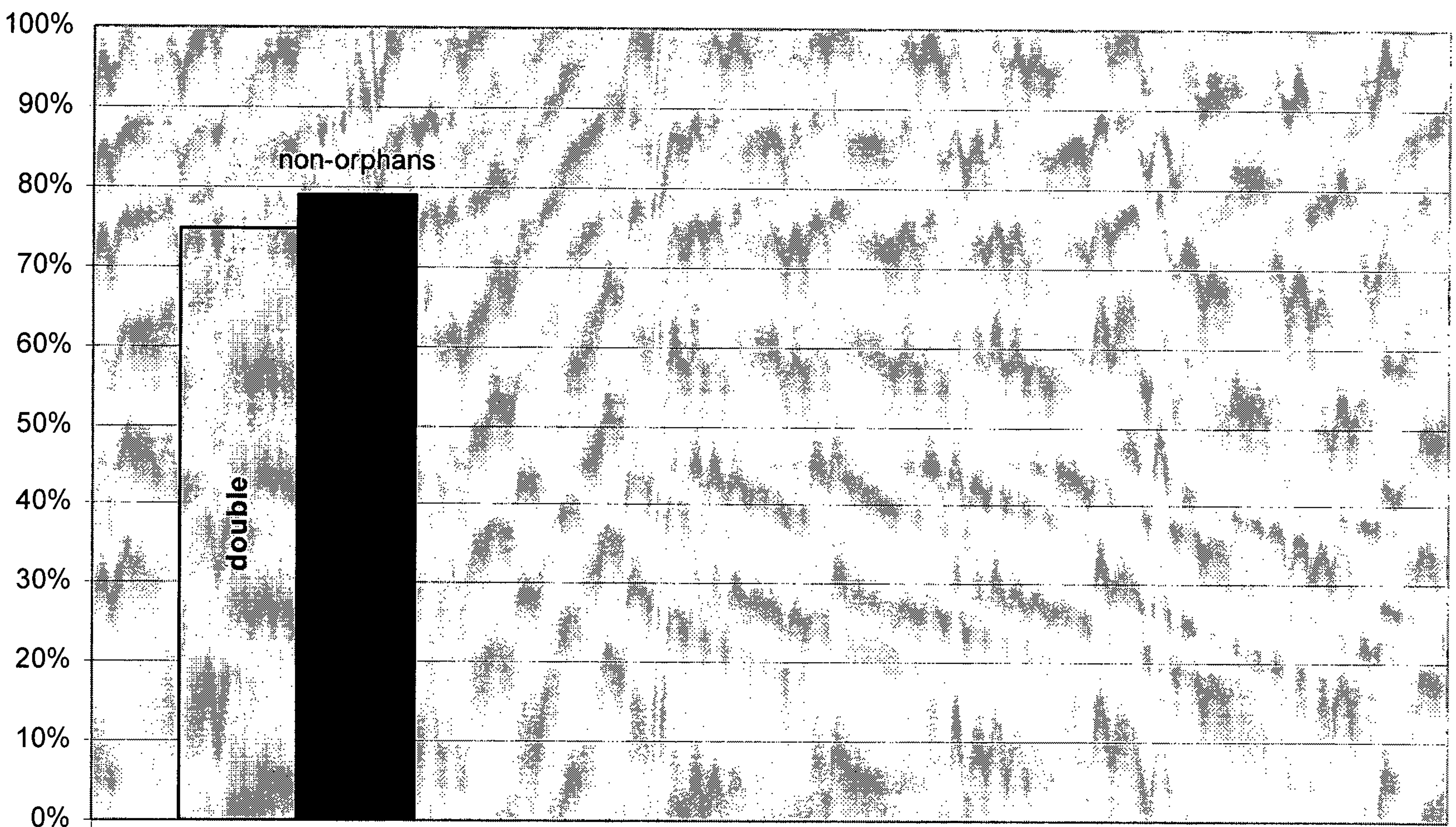


Orphan to Non-orphan Primary School Completion Rates (ages 13-15)

Double orphan/Non-orphan School attendance rates



School Attendance in Zambia
(ages 13-15)



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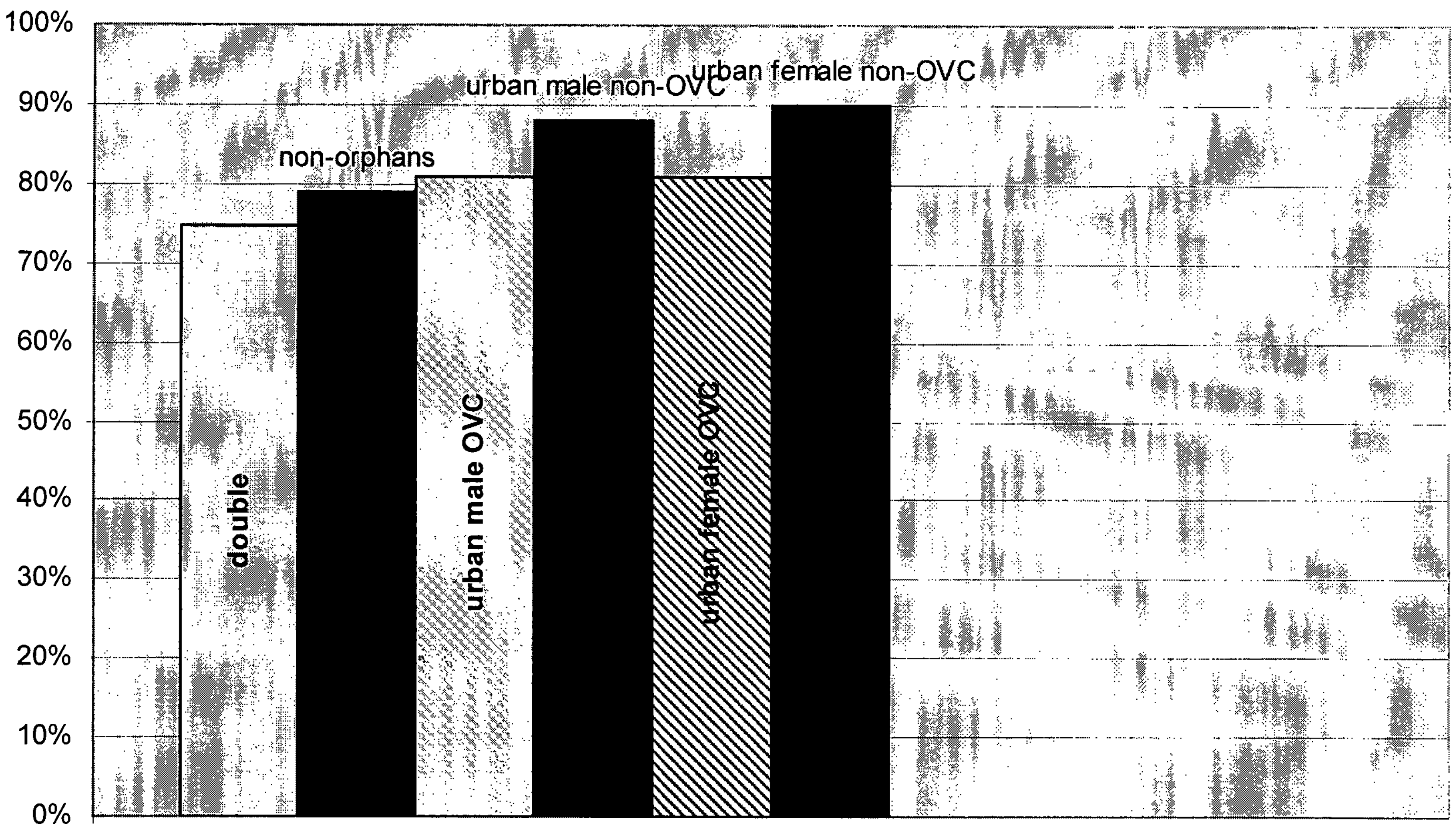
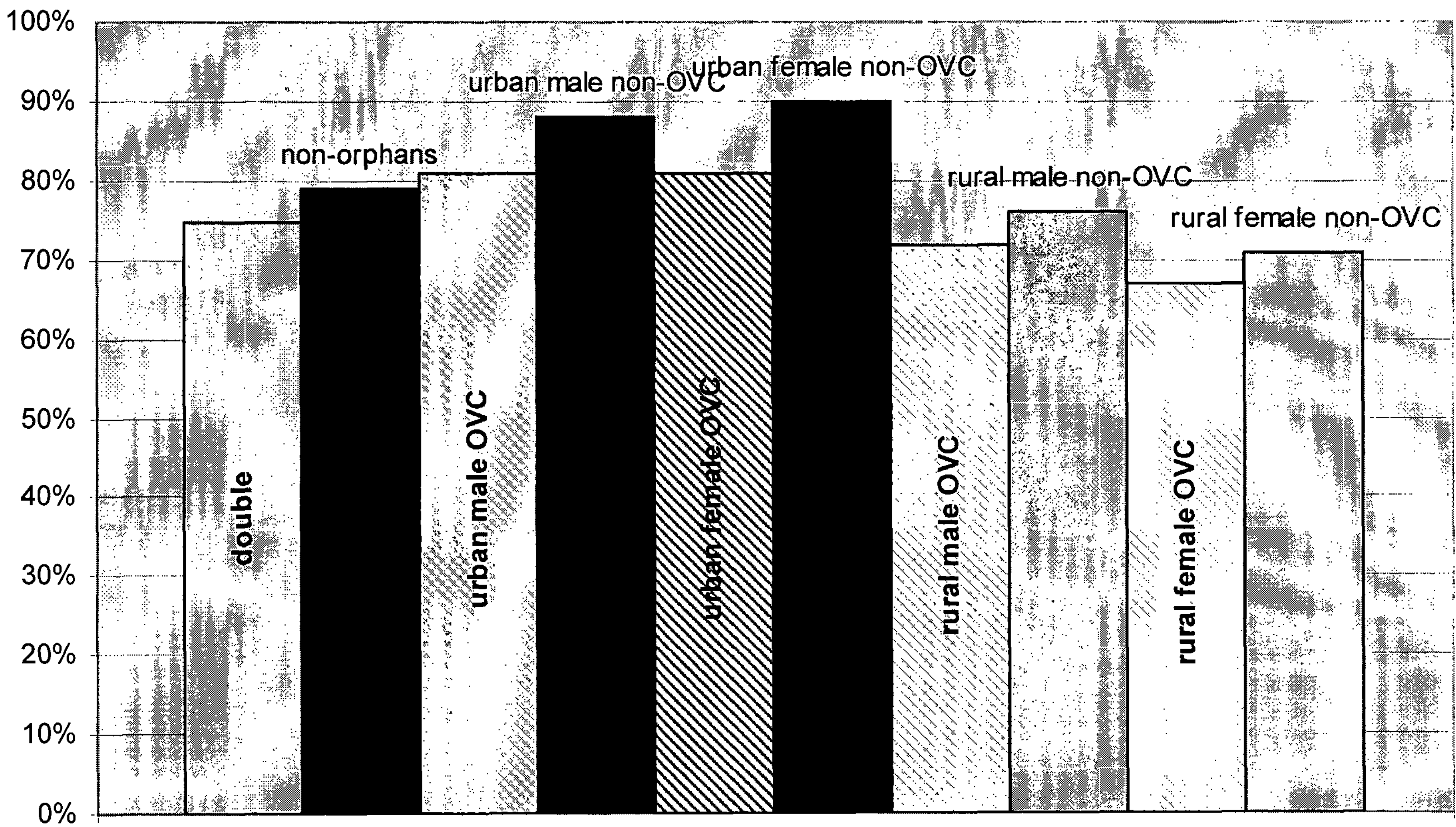
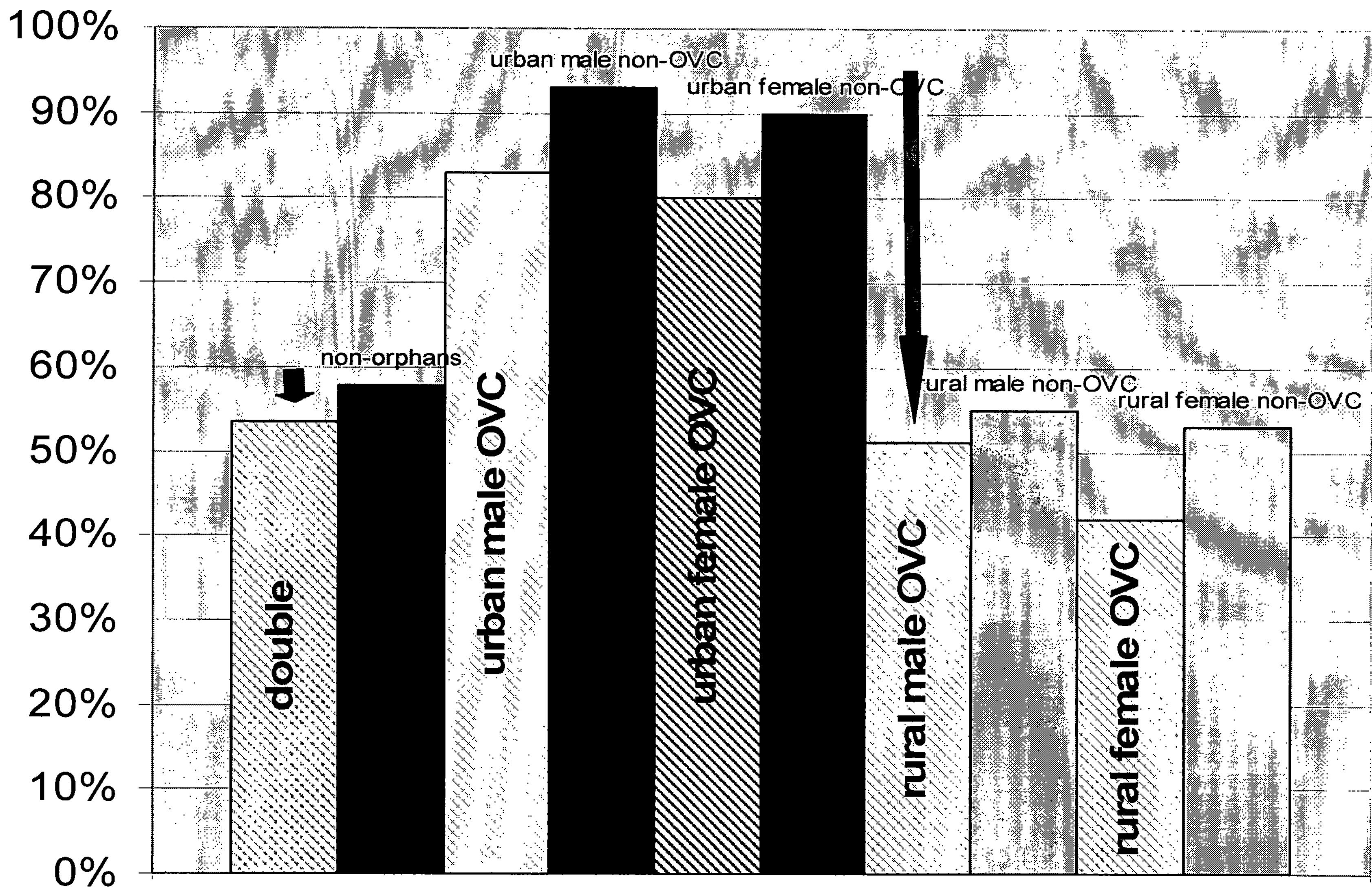


School Attendance in Zambia
(ages 13-15)



School Attendance in Ethiopia
(ages 13-15)



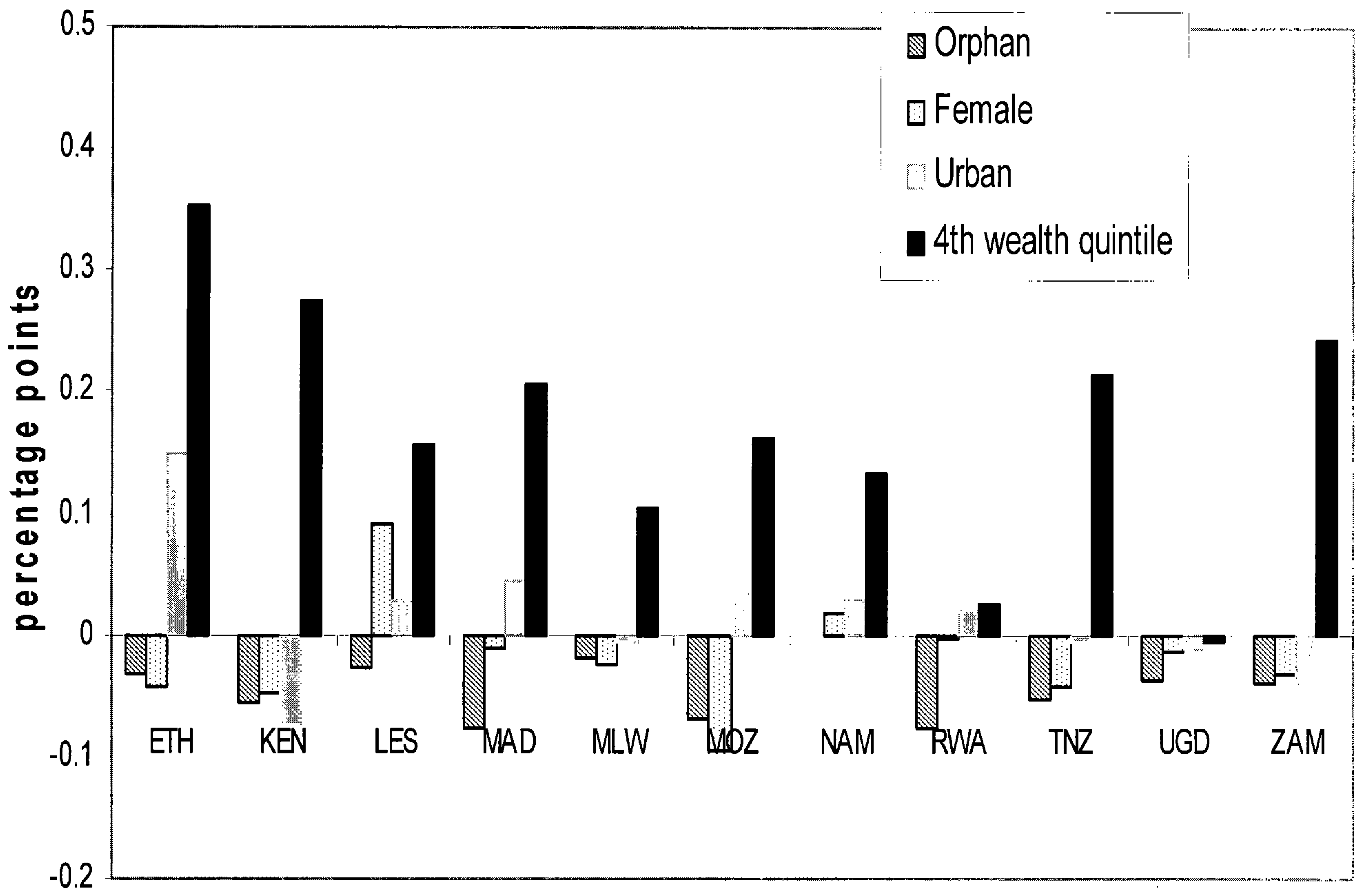
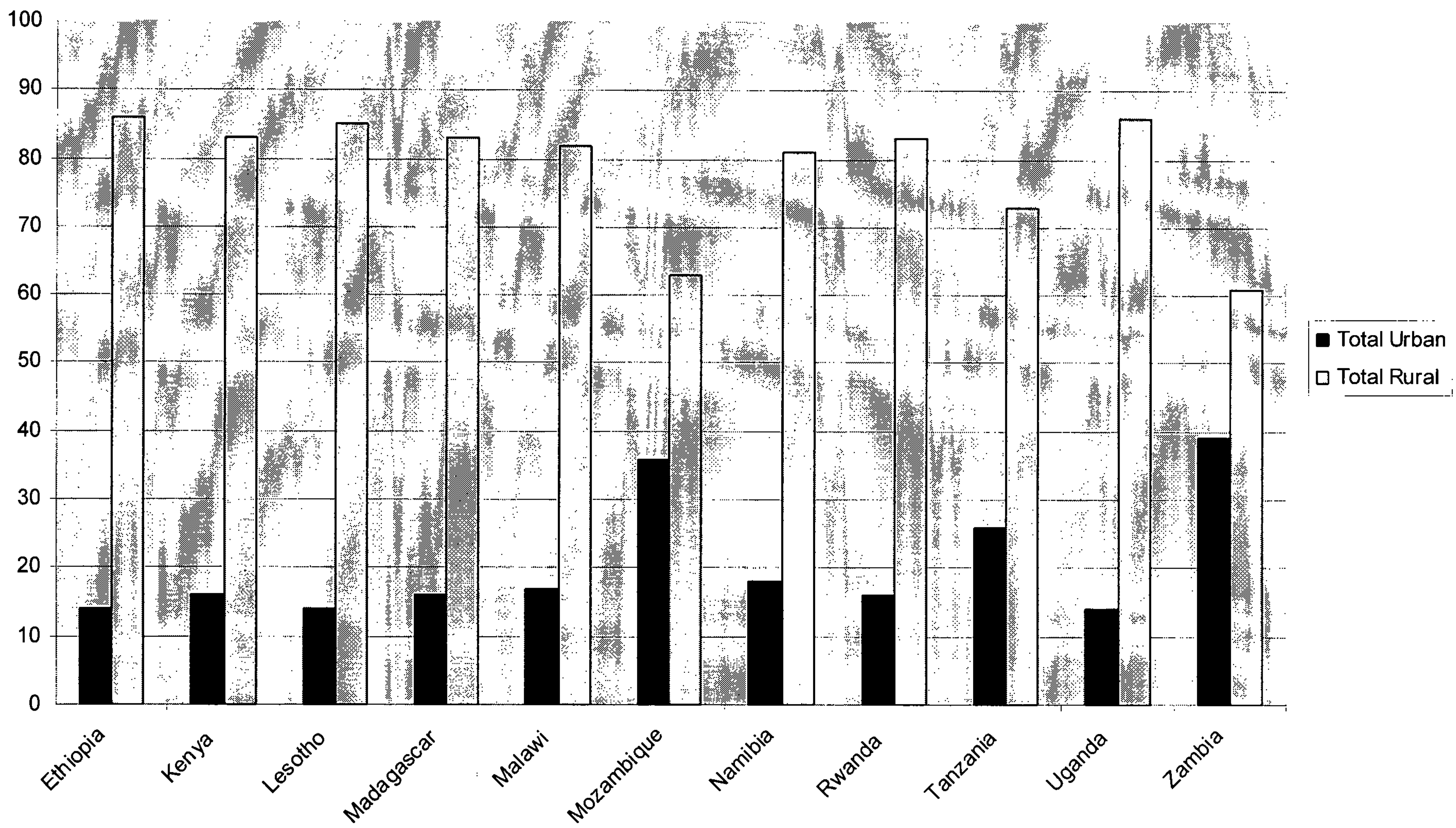


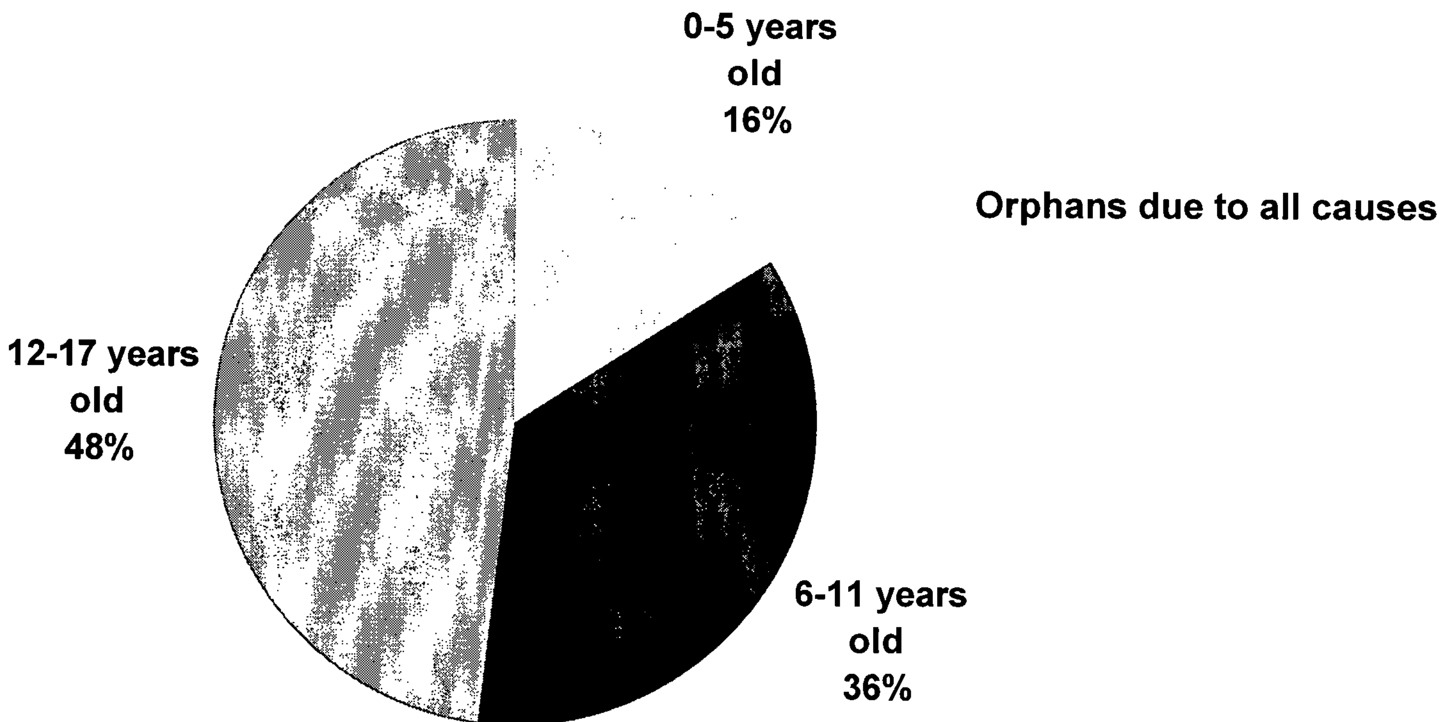
Fig. 1: Regression estimated determinants of school attendance
percentage points
0.5
0.4
0.3
0.2
0.1
0
-0.1
-0.2
ETH
KEN
LES
MAD
MLW
MOZ
NAM
RWA
TNZ
UGD
ZAM
Orphan
Female
Urban
4th wealth quintile

Urban/Rural Distribution of Orphans
Most live in rural areas



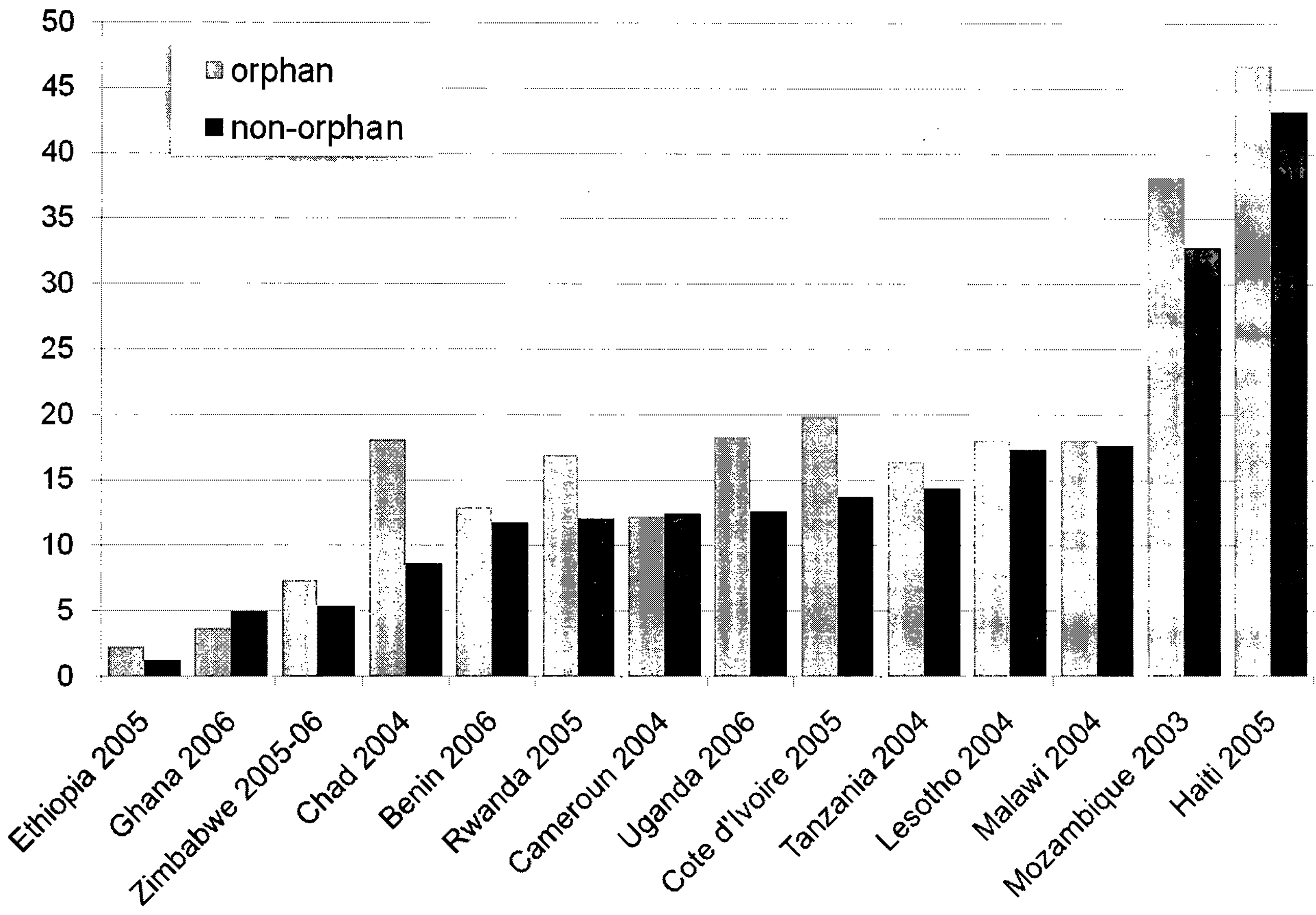
Older Children more likely to be orphaned

Percentage of children ages 0-17 who are orphaned by age group, 2005, Sub-Saharan Africa

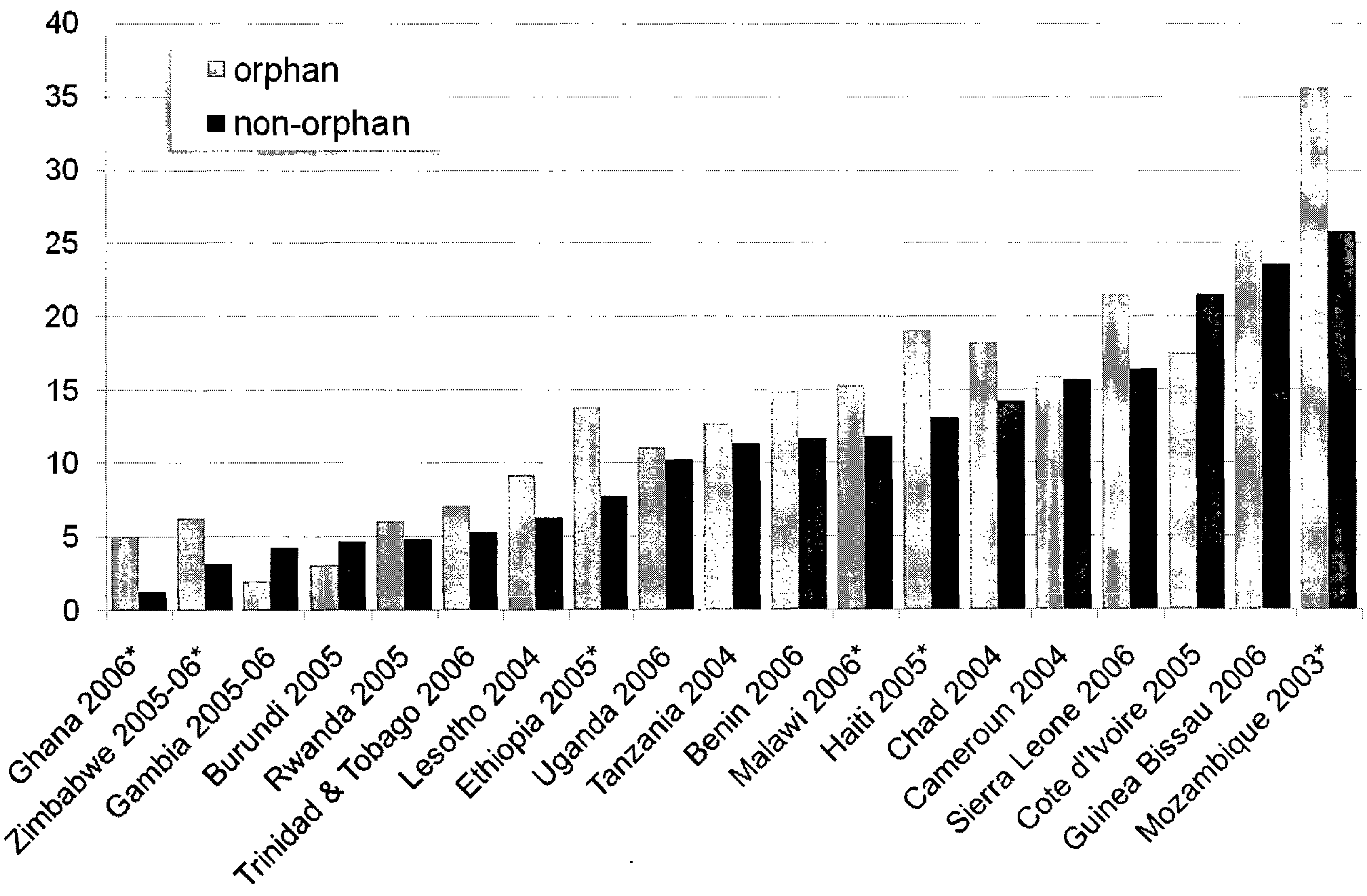


Source: UNAIDS and UNICEF estimates, 2006

Boys: Percent with early sexual debut
Percent of boys age 15-17 who first had sex before age 15, by orphanhood status, MICS & DHS 2003-2006

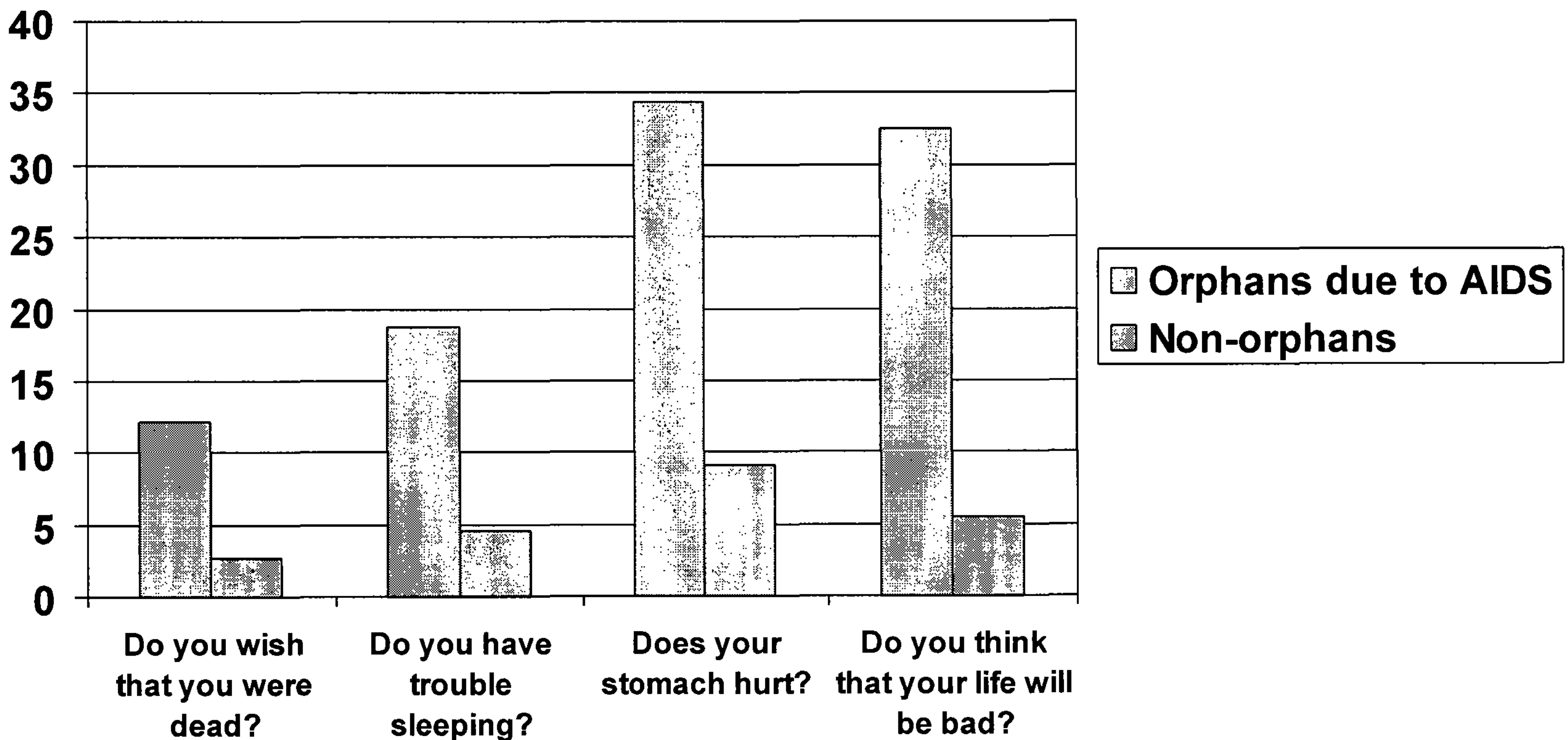


Girls: Percent with early sexual debut
Percent of girls age 15-17 who first had sex before age 15, by orphanhood status, MICS & DHS 2003-2006



Psycho-social evidence of impact

Percent of children 11-15 responding positively to questions related to distress, rural district in Uganda



Source: Atwine, B. E. Cantor-Graae, F. Bajunirwe. 2005. "Psychological distress among AIDS orphans in rural Uganda". *Social Science and Medicine* 61:555-564.

Are AIDS affected children more vulnerable to HIV infection? (Cluver and Operario, JLICA, 2008)

- Comprehensive and systematic review of research on HIV risk among orphaned children

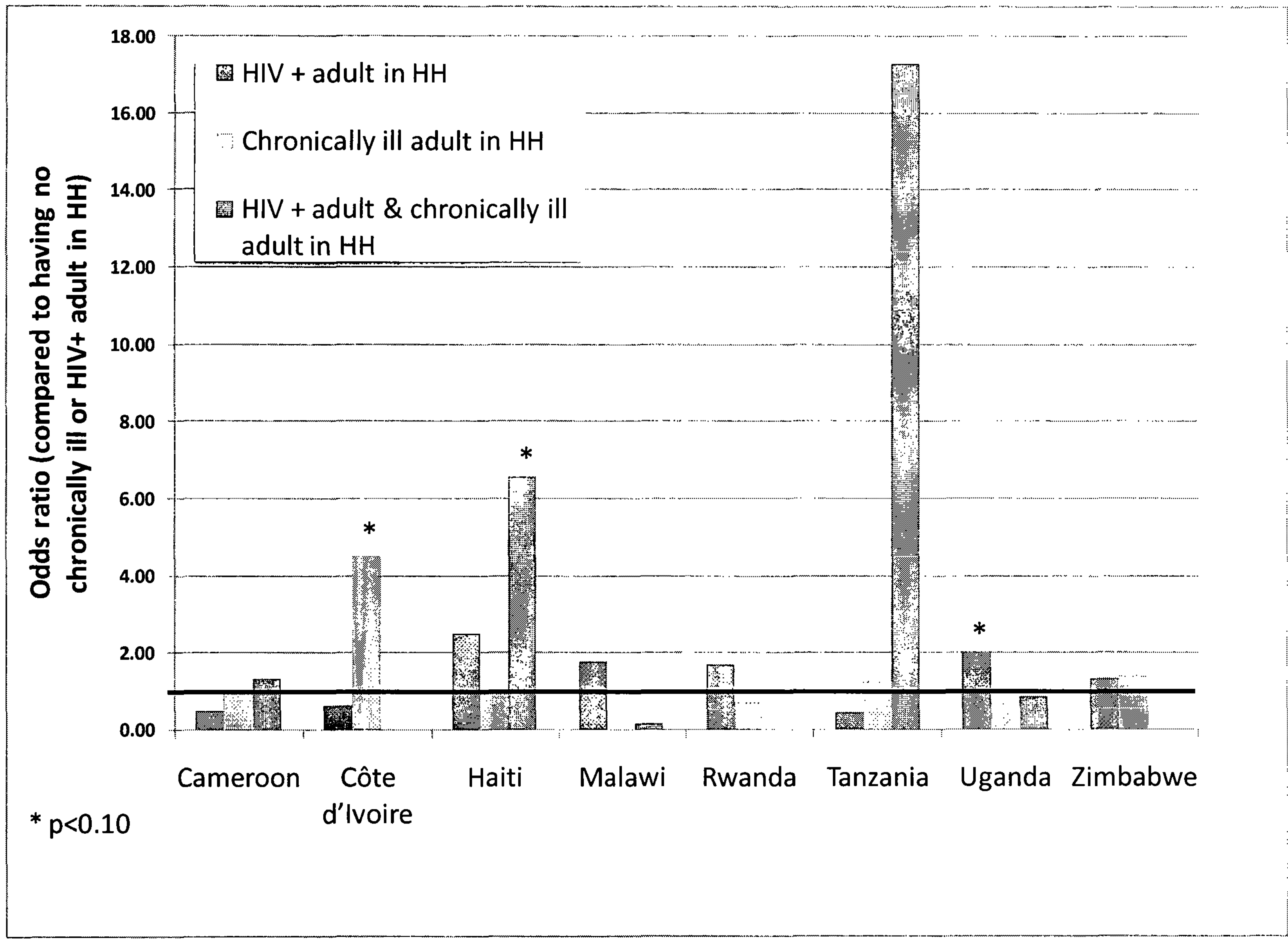
Findings

- Large cross-sectional studies show higher HIV prevalence among orphaned compared with non-orphaned children
- Orphanhood can increase risk for:
  - ever having sex,
  - early sexual debut,
  - multiple partners,
  - unprotected sex
  - sexual abuse in the home
  - sexual abuse outside the home
  - living on the streets, forced sex
  - sex work
  - transactional sex
  - older sexual partners

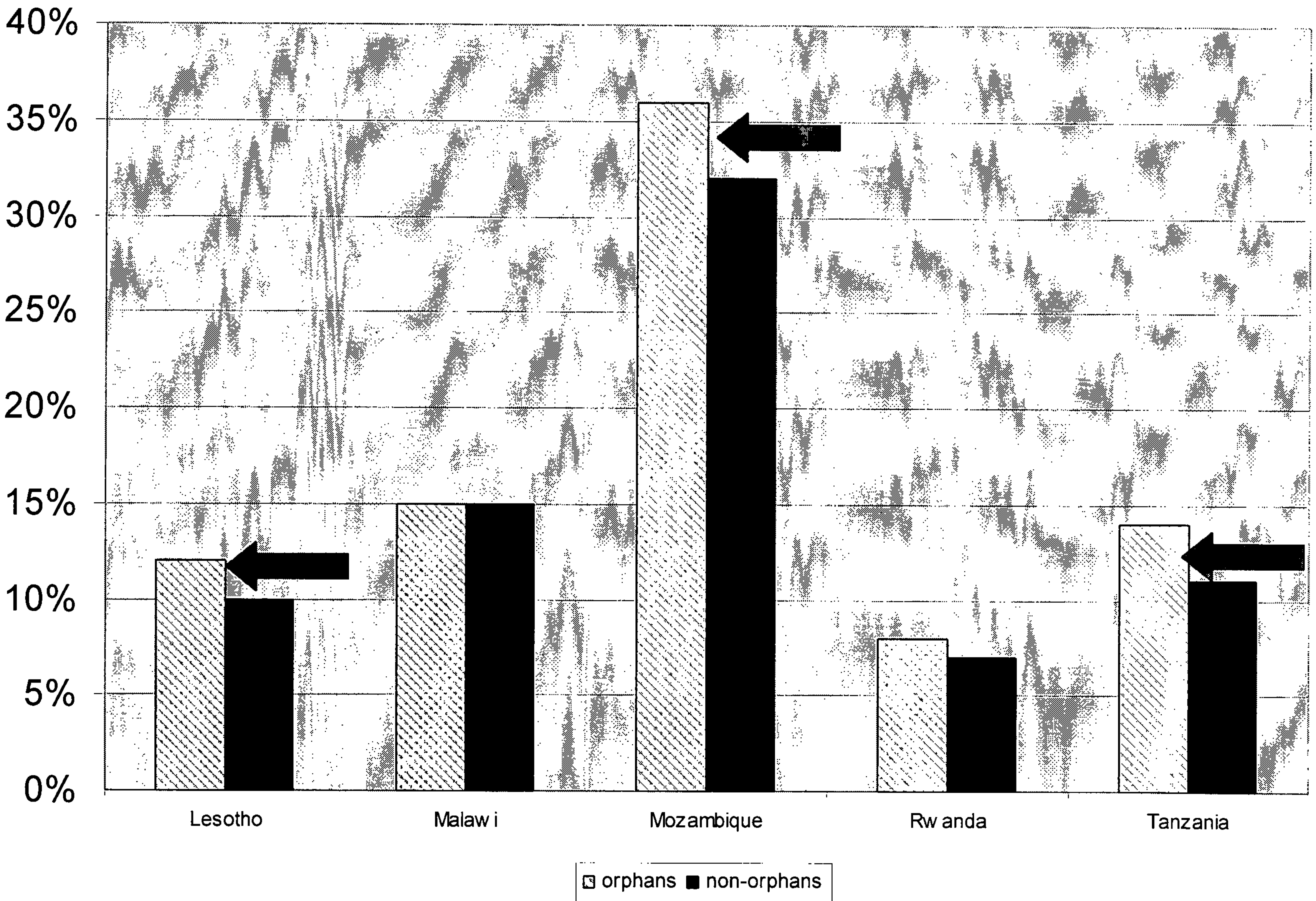
- Clinical-level mental health problems amongst orphans

Odds of early sexual debut (girls)

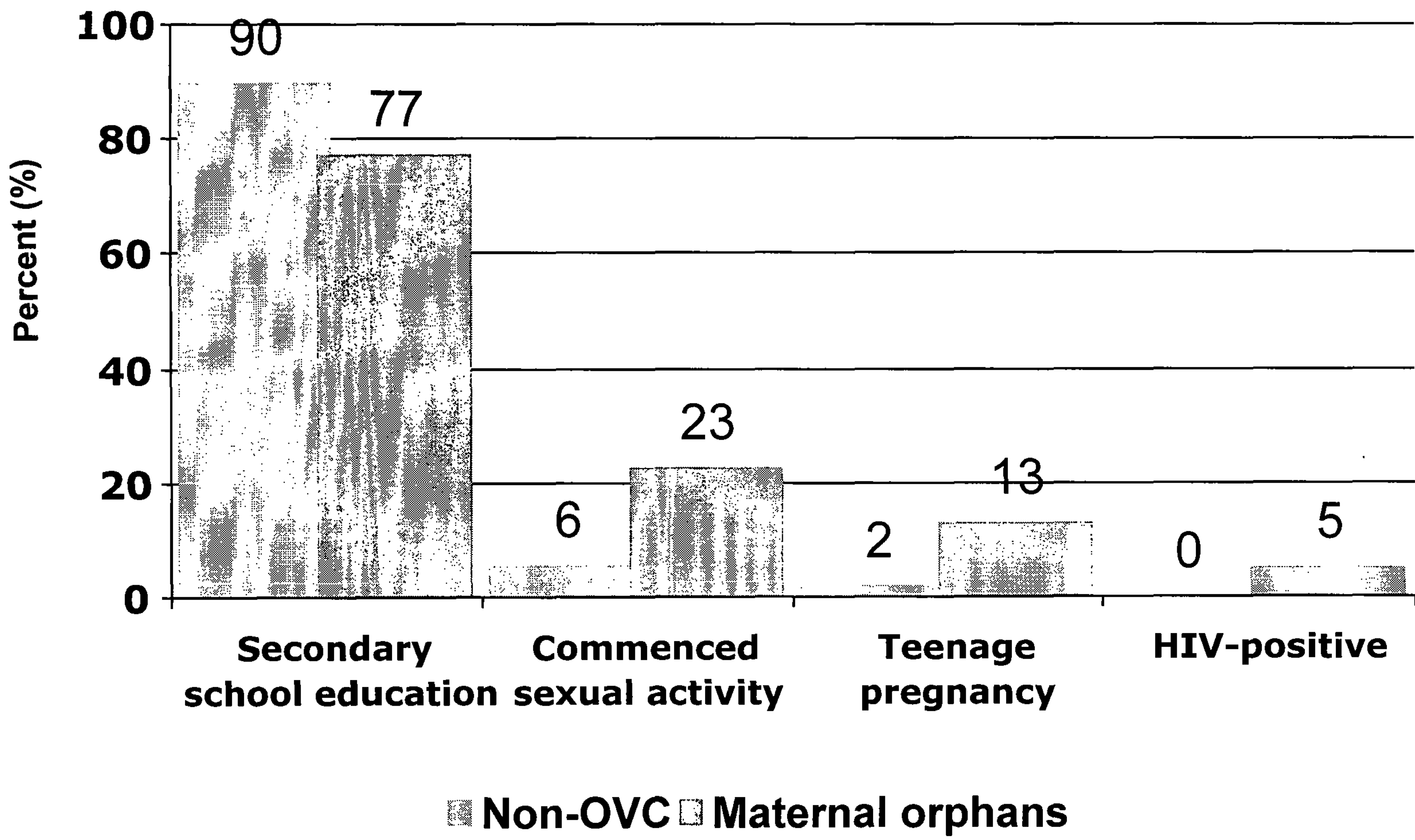
Among girls age 15-17, DHS 2004-2006



Orphan/Non-Orphan (aged 15-17) Early Sex Debut Rates



Fine Grained Analysis Important
In Zimbabwe girls who lost their mother are most vulnerable to HIV



Are orphans worse off than non-orphans?

- **Wasting:** There is very weak if any evidence that guardianship or orphaning are important determinants of wasting in children age 0-4 years. **Wealth** was consistently significantly associated with wasting in all six countries analyzed.
- **Schooling: Lack of guardianship by a blood relative** is the factor that is most frequently correlated with lower school attendance. In nearly all countries, **wealth** was strongly and significantly associated with school attendance, as was **education of the head of the household or of the eldest female household member**
- **Early sexual debut: Few to none** of the orphaning and living arrangement variables were associated with early sexual debut among boys or girls; the models do not explain variation in early sexual debut well.

- Orphans are not significantly worse off than non-orphans on all three outcomes of child well-being
- Small differences may nevertheless be meaningful
- National context matters

Policy Implications & Recommendations

- Growing body of evidence does not clearly demonstrate that orphans (especially single orphans) suffer greater deprivation
- Poverty, region (urban/rural), gender is often a more significant variable
- Avoid single minded focus on orphans (move from individualistic to broader systemic approaches that are AIDS sensitive)
- AIDS orphan targeting to achieve progress on global indicators may detract from targeting to meet local/national needs of most vulnerable children
- Combine AIDS specific activities (e.g. PSS to HIV affected families) within broader sectoral policies and programmes.

Targeting Recommendations

- No single targeting approach is appropriate for all settings. Instead, programmatic targeting must be contextualized.
- Broader targeting is called for and appropriate in high prevalence settings
- Simple Composite of Vulnerability factors (poverty, region, gender) should be included in targeting criteria – essential for ensuring that MVC (regardless of cause) are not excluded

Results: Alternative measures of vulnerability

Household wealth and **education of adults in the household**

→ **almost invariably positively related with good outcomes for all three indicators of vulnerability**

- lower probability of wasting
- higher school attendance
- reduced early sexual debut

Evolution of labels

- 1991 AIDS orphan
- 1995 - Orphan
- 1997- Orphans and (other) vulnerable children
- 2005 – (most) vulnerable children
- 2007 ‘Children of the community’ / ‘children in the context of HIV/AIDS’ / ‘our children’ ‘leaders of tomorrow’

Evolution of labels

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- 2007 ‘Children of the community’ / ‘children in the context of HIV/AIDS’ / ‘our children’ ‘leaders of tomorrow’

- Individual cases, disease specific
- Individual, ‘psycho-pathological’ approach
- Encompassing broader determinants of vulnerability
- Focus on most vulnerable, independent of cause
- Systemic, universal, poverty reduction as entry point

Three essential elements: family, civil society, and state

- Current response system based on (extended) family, with limited but vital support from civil society organisations
- Viability has been demonstrated but coverage remains limited
- Missing piece is a functional, state driven social welfare structure
- Social protection has been missing from international policy debates with regard to sub-Saharan Africa

Types of social protection interventions

- Social/Cash transfers (South Africa)
- Food and nutrition transfers
- School bursaries
- Fees waivers education and health services
- Non contributory pensions
- Livelihoods and microcredit
- Agricultural subsidies
- Public works, employment and training
- Insurance
- Child protective services

Malawi pilot cash transfer scheme: Changes in child's health status (reported by household head from March to September 2007)

*Anthropometric scores measuring differences in the rate of growth between Round 1 and Round 2 will be available by late December 2007.

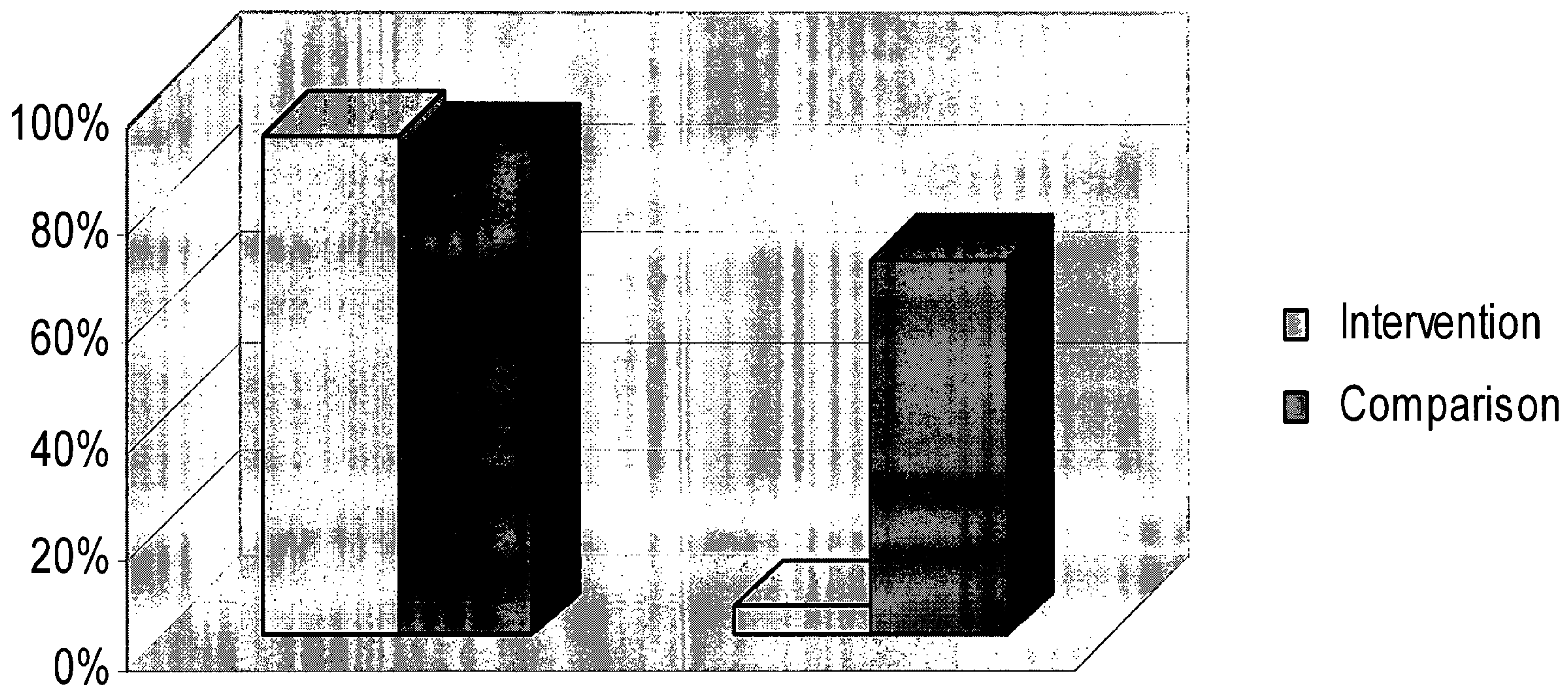
Child labour

Percent of Households reporting that children in the household work for income	March 2007	September 2007
Intervention	53%	**18%** *
Comparison	39%	**40%**

*P<.05

- 67% of households said that children are less likely to work because of cash transfer

Households reporting on food n=789



*P<.05

Food stores n=789

	Comparison	Intervention
6+months	0.25	4.4
3-6 months	7	19.7
1-2 months	14.7	34.5
1-4 weeks	21.7	32.4
Less than 1week	21.7	5.7

*P<.05

Changes in diet over time

	Intervention (n=789)		Comparison (n=811)	
	March 07	Sept 07	March 07	Sept 07
Dried fish$^{\Delta}$	12%	63%	5%	9%
Fresh fish$^{\Delta}$	11%	19%	6%	4%
Beef	2%	8%	1%	<1%
Goat	2%	21%	1%	2%
Pork	1%	24%	1.5%	3%
Chicken$^{\Delta}$	3%	18%	1%	5%

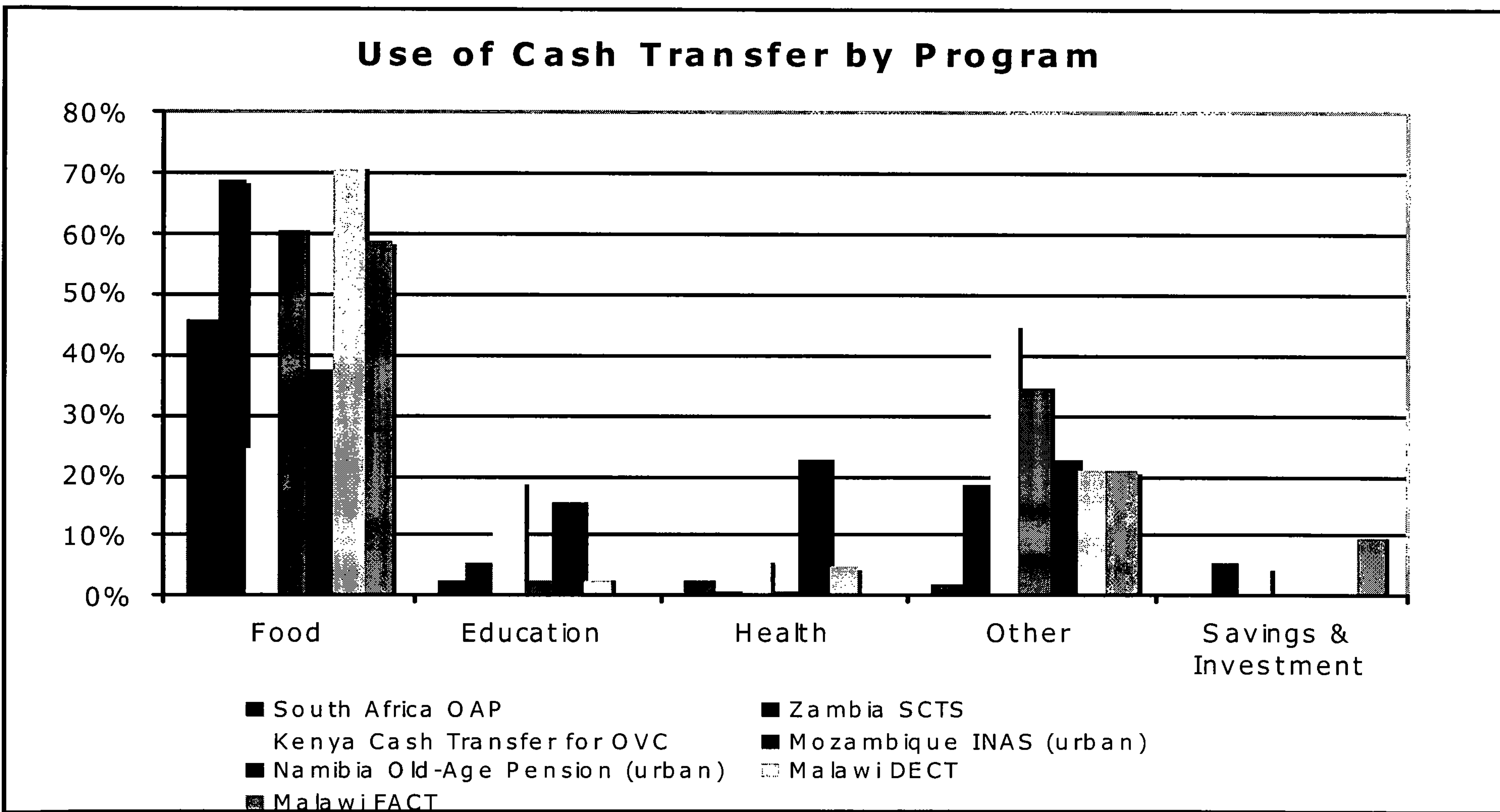
Asset ownership: n=789

Minimal differences in Round 1, By September 2007, recipients more likely to own:

	Intervention (=387)	**Comparison (n=401)**
Metallic plates	91%	56%
Pounding mortar	52%	31%
Pails, buckets	90%	59%
Hoes	92%	84%
Axes	48%	17%
Sickles	54% (26%**)	13% (17%**)
Knifes (panga)	38%	9%
Metallic pots	91%	72%
Mats	96%	72%
Chickens	56%	<1%
Goats	43%	0%
Pigs	16%	0%

*P< 05

Transfers increase spending on children's basic needs



Source: Adato and Bassett, 2008 JLICA

Together for Children

COMMUNIQUE

Fourth Global Partners Forum
The Royal Hospital Kilmainham, Dublin, Ireland
6-7 October 2008

Priority actions:

1. Keep children and parents living with HIV alive and well.

- Support and expand access to anti-retroviral treatment and prevention and treatment of opportunistic infections for children, parents and caregivers, using family centred approaches and improve access to early infant HIV diagnosis as well as nutritional support, including in emergency settings;
- Accelerate scaling up prevention of parent to child transmission programmes.
- Improve linkages between clinic based and community based care.

2. Strengthening families and communities as units for prevention, care and support

- Scale up and link programming on care, prevention, treatment and support, including promoting integrated family-centred programming. Encourage the use of different entry points to identify vulnerable families
- Scale up access to primary prevention within families, including HIV status awareness through couple counselling and testing and age appropriate messaging;
- Use the resources and programmes focused on children affected by HIV and AIDS to reach communities and families and build/strengthen systems for strengthening overall child well-being. In areas of widespread poverty and high HIV prevalence, there is high convergence of these sources of vulnerability. In this regard, promote and advocate for AIDS sensitive, rather than AIDS exclusive programming.

3. Increase effectiveness of programmes, services and funding

- Develop professional human resources for public sector social welfare;
- Support the development and implementation of comprehensive national social protection programmes:hold African governments accountable to the Kampala commitment of 2% of GDP allocated for social protection.
- child friendly legal protection accompanied by legal aid.
- Improve the effective use of existing resources through better harmonisation and coordination and alignment to national responses,
- Ensure existing resources reach the most vulnerable communities, households and children, including review of the incentives for community providers;
- Strengthen care options such as kinship care, foster care and domestic adoption so that institutional care is the last resort for children and a temporary solution;

4. Human rights for vulnerable children

- Support the development and implementation of comprehensive national and community strategies and actions that will combat violence, stigma and discrimination directed at children and young people living with and affected by HIV and their households;
- Support development of mechanisms and institutions for active participation of children and young people in prevention programmes and services that support orphans and children who are made vulnerable by HIV and AIDS,
- Increase access to youth friendly services and quality education, especially for girls.
- Advocate for legal protection of human rights of children, particularly children of marginalised populations and children infected with HIV, and work to remove legal barriers.

End thoughts: From the individual to the system

- Child vulnerability related to AIDS will increasingly be concentrated in the hyper-endemic countries in southern Africa
- Orphan are relevant as a ‘proxy’ of impact but not a valid programming or targeting concept
- Vast majority of orphans have adult care/supervision and socialisation but the quality of that care is compromised
- Need to focus on systemic support to poor and vulnerable families/households through social protection mechanisms that supplement community based action
- Fine grain variations, that do exist in child status, can be captured in community targeting within broader systemic approaches
- Move from responses that are AIDS specific to those that are AIDS sensitive
- Move from charity driven responses to entitlement based access to universal social protection.