UK Consortium on AIDS and International Development

Symposium on Sharing of Best Practice in Orphans and Vulnerable Children Programming Workshop Report November 2004

Co-convened by
Working Group on Orphans and Vulnerable Children and Department for International Development

UK Consortium on AIDS & International Development
Orphans and Vulnerable Children Working Group
& Department for International Development

Symposium on Sharing of Best Practice in OVC Programming, 2nd November, 2004
Workshop Report

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SYMPOSIUM CONTACTS

ACRONYMS

CBO	Community Based Organisation
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
DFID	Department for International Development
FBO	Faith Based Organisation
GoG	Government of Ghana
GoZ	Government of Zimbabwe
HAI	HelpAge International
IEC	Information, Education and Communication
NGO	Non-Governmental Organisation
NPA	National Plan of Action
OVC	Orphans and Vulnerable Children
RAAAP	Rapid Assessment, Analysis & Action Planning
PLWA	People Living with AIDS
PRSP	Poverty Reduction Strategy Paper
PSIA	Poverty and Social Impact Analysis
UK	United Kingdom
UN	United Nations
WHO	World Health Organisation

INTRODUCTION

The symposium was co-convened by the Orphans and Vulnerable Children Working Group and the UK Department for International Development. The Orphans and Vulnerable Children Working Group is a sub-group of the UK Consortium on AIDS and International Development and was formed in March 2004. The Working Group currently comprises nineteen UK based international agencies[1] working, inter alia, for the rights of children and their families and carers affected by HIV/AIDS around the world. The group aims to lobby and provide technical support to the UK Department for International Development (DfID), the European Union, the United Nations, and bilateral donors in the development of HIV/AIDS related policies and strategies, as well as to share programme experiences among its members and other interested parties.

The aim of this symposium was to share experiences and programme approaches among practitioners working with orphans and children made vulnerable by HIV and AIDS and their carers. There were presentations to highlight lessons learnt and best practice related to the five approaches identified in 'The Framework for the Protection of Orphans and Vulnerable Children Living in a World with HIV and AIDS.' The presentations facilitated discussion and assisted with identifying approaches, which can be scaled up and replicated.

Following an overview of '*The Framework,'* the symposium consisted of five sessions: one on each of the five approaches in the Framework. Each included one or two examples of programme experience based on recent research or evaluations, followed by plenary discussion time. The day concluded with a round up session to summarise core lessons and identify some next steps.

We would like to thank the staff of the UK Consortium Secretariat for helping us organise this event, in particular Penny Bloore for her tireless efforts.

Stuart Kean & Christina D'Allesandro, Co-chairs of the OVC Working Group &
David Clarke, Senior Education Adviser, DFID AIDS Team

February, 2005

[1] The Working Group on Orphans and Vulnerable Children members include: AMREF, British Red Cross, CAFOD, Christian Aid, European Forum on HIV/AIDS, Children, Young People and Families, Healthlink Worldwide, HelpAge International, Hope HIV, International HIV/AIDS Alliance, Mildmay International, Plan UK, Religions for Peace (UK), Save the Children UK, Tearfund, UNICEF UK, USPG, Uganda AIDS Action, VSO and World Vision UK.

OPENING

The symposium was opened by the Right Honourable Hilary Benn, MP, Secretary of State for International Development. His opening remarks confirmed the commitment of the UK Government to raising the profile of the needs of orphans and vulnerable children. He reiterated the various UK government commitments and thanked participants for their continuing work on this important issue.

Pete McDermott, the Head of the HIV/AIDS section at UNICEF then presented the Framework for the Care, Support and Protection of Children Living in a World with HIV and AIDS. This internationally agreed Framework outlines the aspects of a response for addressing the needs of OVC and the five tenets of the Framework outlined the discussion for the day.

SESSION 1 – STRENGTHENING THE CAPACITY OF FAMILIES

Strategy 1: Strengthen Capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support.

The following two organisations shared their experience in supporting OVC through work with families:

- Healthlink Worldwide
- HelpAge International

Healthlink Worldwide: Communicating to Strengthen Family Capacity

The session opened with a presentation from a Healthlink Worldwide evaluation of their programmes currently operating in East and Southern Africa. This Comic Relief-funded programme utilised a variety of communication techniques to support children and their families. These included the use of memory work, child-centred and participatory approaches including drama, community theatre and peer education.

Following a description of the overall programme, Healthlink looked in detail at the memory approaches, and in particular work with memory books. The memory work was key to improving the resilience of children through:

- open communication between children and guardians;
- offering children an opportunity to express both fears and positive goals;
- tracking memories and maintaining key family records;
- children actively helping others.

Healthlink cited a number of challenges to expanding this work, including:

- Increasing the involvement of men;
- Recognising that psychosocial interventions must be supported by expertise;
- Need for new communication strategies based on learning;
- Linkage with existing systems - in particular, education and the involvement of teachers.

Healthlink concluded with a number of recommendations. They stated that when utilising communication approaches it is necessary to work directly with family and community structures to create and foster a supportive enabling environment. Furthermore, they concluded that psychosocial support has the potential to

strengthen family coping strategies in unexpected ways, for example through this programme, the health of women living with HIV improved. Finally, involving the children as stakeholders is crucial. The child-centred participatory approaches utilised by the programme allowed programme staff to map existing support and gaps for future planning.

<u>HelpAge International: Living Together</u>

HelpAge International (HAI) presented an evaluation of "Living Together" a programme in Tete province in Mozambique, which works through community structures using widely defined vulnerability criteria. HAI has been implementing a rural development programme in 24 villages in Changara, Tete province, Mozambique since 1996. This region has been increasingly affected by HIV/AIDS, and as a result in 2001, HAI added components to the programme to respond specifically to the needs of OVC and their older caregivers.

The programme aims to: strengthen the ability of OVC and older caregivers to meet immediate needs; raise awareness of HIV/AIDS and link in key support agencies, facilitating the inclusion of older people, the sick, and OVC in community activities.

Using local structures, the project provided for the basic needs of OVC and their older carers through: a combination of credit, income generation, the distribution of a local social assistance fund and food support for the most vulnerable; training local 'activists' and 'counsellors' to raise awareness on HIV/AIDS and assist families with home care, counselling and psycho-social support; integrating OVC into schools through provision of materials and waiving of school fees.

This programme underwent a participatory evaluation in June 2004, to establish lessons learnt and make recommendations for the planned scale up of the model. Key successes included: building on and strengthening community structures to identify and target support with the most vulnerable families; the alleviation of immediate needs of poor and AIDS affected families with OVC and older carers; the integration and retention of OVC at school (including girl children) leading to reduced child labour and suppression of early marriage; and substantial increase in knowledge about HIV/AIDS among older carers and orphaned children as well as other community members.

Core to the success of the programme was placing OVC and their older carers at the centre of project activities as agents of change.

Recommendations for replication and scale up include the need to further support the independence and autonomy of community structures and ensuring downward accountability to project beneficiaries. This includes looking at the sustainability of school access for OVC beyond the project period and the implications of integration for family livelihood strategies, integration of more targeted support for PLWA and access to treatment and care, and the need to develop capacity for responding to evolving needs and problems for vulnerable families.

<u>Conclusions</u>

The following conclusions resulted from the open discussion following the presentation. The group agreed that memory work is an **entry point** into communities, and can be effective at bringing both children and men into discussion. It is also effective at engaging older people, an often-neglected target, and educating them about HIV and AIDS. There are many benefits to engaging older people in

memory work, not only do they often have a great deal of knowledge of the family history, the process also helps them to cope with their loss.

Memory work improves communication between children and adults. There was some discussion about the potential limitations of memory books with some families, such as those who are illiterate, however the approach is defined family needs and often begins with oral traditions and visual representations. It is the process of communicating which is important, and for this reason the process is best identified as memory work, rather than focussing on a specific outcome, for example a memory book or box.

The group concluded that despite different contexts, processes are transferable and replicable. For example, the participatory tools that facilitate communities to reflect on themselves and identify their strengths and gaps, will have use with many communities, and this success in identifying these processes and applying them to local community structures that ultimately determines the success of a project.

SESSION 2 – MOBILISE & SUPPORT COMMUNITY BASED RESPONSES

Strategy 2: Mobilise and Support Community Based Responses.

The following shared their experience on the support of OVC through the mobilisation and development of community-based responses to OVC:
- World Vision UK
- AMREF

Promising Practices in OVC Responses

World Vision conducted qualitative research exploring and documenting communities' experiences and reflections of OVC programming in six countries – Kenya, Malawi, Rwanda, Swaziland, Uganda and Zambia, particularly looking at the role of Community Care Coalitions.

Community Care Coalitions with a broad spectrum of stakeholders were viewed very positively in OVC programming. The central role of coalitions is to mobilise and co-ordinate OVC care activities. Typical members of the coalitions include: churches and FBOs, teachers, community leaders such as chiefs, PLWHA, traditional birth attendants, home-based care providers, health care providers, OVC carers, women's groups, and development committee members. In one case the coalition had a sub-committee consisting of orphans and vulnerable children, and their inclusion was seen as a positive innovation.

Coalitions are a powerful conduit for advocacy, particularly regarding OVC access to education, and child abuse including child labour, and coalitions also provided a means for greater accountability in the use of resources. Faith-Based Organisations in particular are central to the OVC response and provide a range of services individually, as well as core members of community care coalitions. Strengths of FBOs are their wide reach, volunteerism and mobilisation of existing resources.

In terms of mobilising resources for community responses, the primary source of resources was from within the community itself. Although resources within the community are inadequate, care needs to be taken that the provision of external resources is done in a manner that does not undermine, but rather supplements and

enhances traditional coping mechanisms. Community care coalitions can provide a structure and means of channelling external resources into communities. The coalition members can develop community plans with specific resource requirements and evaluation, ensuring transparency to the wider community. Where there is a need for further training, NGOs are natural allies and can provide both capacity building and resources to coalitions.

There are many unmet training needs, and when training such as proposal writing, home-based care and counselling was offered, it enhanced coalitions. Educating the community on the roles and objectives of the coalition was essential to avoid unrealistic expectations from the community.

Child participation enhanced the planning, implementation and monitoring of OVC activities and should become the norm for all coalitions. Child/youth clubs and church activities lend themselves to greater child participation and this opportunity should be utilised. Such clubs are enhanced by endorsement and appropriate support from adult patrons. Child-to-child approaches to care need to be identified and enhanced with appropriate support.

Finally, community-to-community learning demonstrates potential to contribute to the scaling-up of OVC response. The methodology should be documented in a user-friendly toolkit and trainings, including documentation of best practice, and monitoring and evaluation.

Strengthening Community Structures

AMREF's programme in Luwero District, Uganda, presents a successful example of community-based responses to reducing the vulnerability of orphans and vulnerable children. Luwero District has a population of 474,626, and was among the districts most affected by the civil war and currently suffers a greater burden of poverty than most of Uganda. The civil war led to family breakdown and mass orphaning of children, and this situation was worsened by the onset of HIV/AIDS.

The community initiated a community-based response supported by AMREF, that included mobilisation of the community, founding of solid community partnerships, integration with existing structures and a holistic approach working with both vulnerable children and their carers. The initial challenge was to mobilise the community around OVC within Luwero district. Within a context of extreme poverty this task required extensive dialogue with community leaders and groups. AMREF then engaged existing community structures to enhance sustainability and ownership. In this case, Parish Development Committees were the key entry point, with Parish Orphan sub-Committees being strengthened to support the community to support OVC. By working closely with Parish Development Committees, Village, Sub-County and District Development Teams to ensure that OVC care and support was integrated into District Development Plans, AMREF ensured that the project was sustainable and budgeted for by the district itself. Finally, AMREF and the community recognised that, in addition to OVC, carers and guardians also needed support. All were supported to initiate income-generating activities with some very significant achievements.

AMREF cited a number of lessons learned from the project. Explicitly, the decentralised system of governance in Uganda provided an enabling environment for community-based approaches. By working in close partnership with District Administration and lobbying for integration of best practices they were able to influence the District Development Plan. However, it is the mobilised communities

that ultimately serve as the safety net for OVC. It is possible to support successful income-generating activities in a situation of extreme poverty, and economic empowerment is an essential component of any programme as HIV/AIDS impoverishes further the already poor households. Finally, the holistic approach to OVC support undertaken by AMREF, involving guardians, carers and the whole community, is essential if challenges of lack of participation are to be overcome and stigmatisation is to be avoided.

Conclusions

It was clear from both presentations that community structures for supporting children affected by AIDS exist – even in difficult and conflict/post-conflict environments. These structures are diverse and take different forms, but they have substantial knowledge in working with local communities and local people in need. Often, they are poorly resourced, and need both technical and financial support to extend the functions they can perform. They often have the expertise to advocate for vulnerable children, and broad community wide coalitions have enormous potential for co-ordinating, planning, monitoring, reporting, and mobilising resources for the care and support of vulnerable children

The interventions can take many forms, however there are a number of key principles that should underpin any response: holistic approaches are favoured over discrete responses; community to community learning provides benefits for all responses; child participation is key to all responses; there is a need for more social supports; and mobilisation of the community as a whole can reduce stigmatisation of the vulnerable groups.

Linking community-based programmes with policy development and decision making at district, national and international levels, is essential for real change. The advocacy themes at local and district level mirror the larger advocacy debates, accountability, capacity and resourcing. Advocacy must be a considered part of programme design and promoting local ownership of change, while ensuring that this advocacy feeds into the larger advocacy debates will maintain local ownership while leveraging on the group experience.

SESSION 3 – OVC ACCESS TO ESSENTIAL SERVICES

Strategy 3: Ensure access for OVC to essential services, including education, healthcare, birth registration and others.

Save the Children UK shared experiences from Acham, Nepal, to illustrate learning on OVC access to essential services.

- Save the Children UK

Access to Essential Services

Acham has one of the lowest human development indices in Nepal. There are very high rates of migration, with a large proportion migrating to India. In an assessment conducted in 1999 the impact of HIV/AIDS was becoming visible, but there was no community ownership of the issue. It was seen an issue of concern only for migrants. Acham is also impacted by the Maoist insurgency.

The OVC response in Asia is very low in the list of government/key player priorities because Asian countries have low HIV prevalence. This premise is misleading. In some areas of India and Nepal, the numbers of families headed by women, as a result of AIDS related deaths, and orphans are increasing. A more proactive OVC response must be advocated to avoid the situation in these areas escalating.

The project focused on helping the community understand the short and long-term implications of HIV/AIDS and acting as change agents without delivering direct services. Volunteer community members drove the project. They were able to achieve: waiving school fees for children orphaned by AIDS; waiving of registration fees in the primary health posts; greater acceptance of people living with HIV/AIDS and reduced stigma and discrimination.

Initially, the volunteers conducted an assessment of the numbers of children and families affected by AIDS with the support of staff from partner organisations. The information was used to mobilise support of key members of the community and make use of local resources. As a result, four schools waived schools fees, resources have been mobilised to provide schools uniforms and books, and women for affected families are accepted in credit groups. Most importantly, the project was empowering, and children and women from affected families became effective agents of change.

Conclusions

The discussion following the presentation acknowledged the difficulty of community-based work in conflict situations. Success of such work is dependent on a sense of ownership – if the problem is widely recognised and acknowledged by the community, then work can be initiated to confront it, irrespective of situational difficulties. A common notion of key issues and a shared institutional response is crucial.

The participants also discussed the issue of scaling-up approaches. Wider effectiveness is not merely a question of scaling up and replicating community-based successes. The failures are not simply caused by HIV, but rather often by bad policy. Responsibility for the success of projects cannot always be referred back to communities: a social welfare structure is absolutely necessary. Restoring the structure of such systems is of fundamental importance, while in the short term there is a need for new structural ideas on social development, in a context where the goal of genuine social development is recognised as distinct from social welfare. Advocacy must be an integral part of all project development, from assembling evidence base to empowering local actors.

The definition of 'sustainability,' was explored, an entire country system can now be understood to be 'unsustainable'; conversely, an intervention which on the face of it is short-term and limited can be seen to have an *effect* sustainable long after it is over – questions were raised as to how this should impact scaled up programming.

Lastly, the challenge for NGOs to persuade policy makers of the key issues remains a challenge as some felt that NGO expertise is not currently sufficiently acknowledged by governments. NGOs must advocate from arguments based soundly in on-the-ground experience to maximise their influence.

SESSION 4 - GOVERNMENT PROTECTION OF VULNERABLE CHILDREN

Strategy 4: Ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to communities.

The session was led by two presentations

- DFID Ghana
- DFID Zimbabwe

<u>Developing a national social protection strategy in Ghana</u>

The strategy for social protection currently being developed in Ghana focuses on how social protection will work, how it will be targeted, and the trade-offs, or costs and benefits with reference to the government's focus on the growth agenda and budget - the relative costs of 'prevention' vs. 'protection'.

The Strategy aims to improve definitions of vulnerability across government, and enable a more co-ordinated policy response. Key to this agenda is mainstreaming support for vulnerability into core Ministries, including Health, Education and Employment.

DFID supported the government to identify indicators of poverty reduction and to develop a monitoring and evaluation plan for Poverty Reduction Strategy Plan (PRSP) policies. Reaching agreement on which indicators were most relevant for the final plan required a long consultative process between government ministries, and highlighted areas where policies were weak and their impact on poverty reducing outcomes unclear.

The study identified a clear need for more consistent definitions of vulnerability across government, and for better programme co-ordination under an overarching policy framework for social protection. The social protection approach identifies 'shocks' such as drought and illness, which can push households into poverty, and interventions focus on three elements: promotion (of incomes and capabilities), prevention (e.g. through insurance and micro-finance), and protection (through safety nets and transfers). The most vulnerable are those at risk of multiple shocks, and most likely to become impoverished as a result. Strategies thus focus on addressing the causes of shocks and ability of particular groups to respond to them.

The government has tasked the Ministry of Manpower Development and Employment with turning the findings of this study into a budgeted strategy for social protection, and the National Planning Commission to assist with co-ordination across government. The biggest challenge is developing links between economic and social policy. All economic policies have social implications, and the practice of PSIA needs to be mainstreamed to assess the relative costs for social protection of different policy options.

Analysis by UNICEF and UNDP shows that carers of OVC are usually poorly educated, come from the more marginalised groups, and that almost half are widows. Women in general earn half the salaries of men, widows are often denied property rights, and the elderly population is rising, ageing and increasingly unable to meet basic needs in the absence of family support.

Responses have largely come from outside government, and target small and specific groups, rather than their communities. No earmarked budgets exist within government for women and children in difficult circumstances, no policy exists for the aged, and few efforts have been made which address CSWs. Programmes, such as those set up to supply credit to vulnerable women, have been poorly targeted. Vulnerability is seen as an issue of welfare rather than rights, and has been delegated to small and marginalized Ministries with few resources. Programmes attempt to identify an ever-increasing number of highly specific vulnerable groups, and usually focus on the symptoms rather than the causes of vulnerability.

A social protection strategy focuses on the same issues – promotion, prevention and protection – and addresses the ability of families to cope with shocks and avoid high-risk livelihood strategies. Analysts and lobby groups agree that vulnerability needs to be better integrated into mainstream policy, with programmes and budget lines to enable vulnerable groups to access services such as health, education and employment. Policies and programmes proposed for the next PRSP need analysis on their impact on vulnerability and the avoidance of vulnerability, how marginalized groups can benefit from mainstream programmes, and the additional capacities they need to do so. Some progress been made on introducing grants for girls to attend schools in poorer areas, health insurance and new exemptions policies, and improving the delivery of credit.

Specific safety nets for OVC are not in place, but they are identified as a core group for the social protection strategy. Success depends on the continued engagement of Ministry of Finance, and a rationale that includes the potential costs and benefits to the economy of social protection, including the need to modify economic objectives and structural reforms where these have a high social cost. This will be easier to do within the context of a policy framework, and within which the costs and benefits of policy options can be discussed.

Separate support is provided to CSOs, enabling the representation of vulnerable groups in policy-making processes, encouraging the government to adopt a rights-based approach to policy implementation, and lobbing for a greater focus on legislation which protects the rights of citizens to access goods and services.

<u>Responding to OVC in a humanitarian aid context in Zimbabwe</u>

The exponential increase in orphans and vulnerable children in Zimbabwe is presenting an enormous threat to child welfare, and a daunting challenge to development overall. Zimbabwe remains one of the countries most acutely affected by the AIDS crisis. Prevalence rates indicate 24.6% of the adult population are HIV infected. 17-18% of children under the age of 15 in Zimbabwe had lost one or both parents by 2001. There are an estimated 1.3 million orphaned children in Zimbabwe (out of an estimated population of 5.8 million children), with 160,000 children orphaned in 2003 alone. In addition, Zimbabwe is also believed to have 240,000 children living with HIV/AIDS, 600,000 internally displaced children; 150,000 children living with disabilities; 22,000 children living on the streets; and 26% of children aged 10-14 engaged in harmful child labour.

The National Plan of Action (NPA) for OVC was finalised in 2004 after a consultative process between UN, Government, and NGOs. The NPA highlights seven critical areas of intervention over the next 3 years. The priority areas are food, education, health, psychosocial support, financial assistance, legal/protection and capacity building.

To take forward the NPA a Rapid Assessment, Analysis and Action Planning Process (RAAAPP) was undertaken and released in August 2004. In addition, a Working Party of Officials (WPO) was established for OVC representing Government, donors and NGOs. GoZ has adopted a decentralised approach to care and support for vulnerable children, and is aiming to empower local authorities to respond to the needs of OVC.

The Zimbabwean response has been undermined by poor macro-economic policies and deteriorating governance. Government institutions have also been overwhelmed by the increase in the numbers of OVC. An example of this is Zimbabwe's residential institutions are caring for over 100% more children than 10 years ago. Unlike many of its neighbours in the sub-region, Zimbabwe is not receiving Global Fund, PEPFAR or World Bank MAP funds for HIV/AIDS. Furthermore, Zimbabwe attracts only a few major donors, whose response has been focused on narrowly defined and short-term humanitarian interventions. Therefore there are limited resources for OVC programming.

DFID has been a major contributor to the HIV/AIDS response in Zimbabwe with programmes worth £50m for strengthening the international response to HIV/AIDS (working closely with UNAIDS, WHO, UNFPA and UNICEF), procurement of condoms, behaviour change, and promoting positive living for people living with HIV and AIDS. Key partners include JSI (UK) and PSI. Particular emphasis has been placed on youth involvement in prevention, care and support activities.

2001 marked a significant shift for donors towards more humanitarian programming. So far DFID has spent over £67 million on humanitarian interventions in Zimbabwe, much of which has been in the form of food aid. An evaluation and participatory workshop with NGOS in early 2004 concluded that emergency feeding programmes had contributed to low levels of Global Acute Malnutrition for under fives, and had possibly helped ensure more regular school attendance. But there were concerns about the appropriateness of short-term food interventions for what is a protracted crisis, and one that requires more integrated, sustainable and community-owned approaches.

As a result of the evaluations, DFID-Zimbabwe has shifted to a multi-year response to the humanitarian crisis, which recognises the long-term impacts of the AIDS pandemic. An £18 million Protracted Relief Programme (PRP) was approved in July 2004 to protect the livelihoods of most vulnerable households, particularly those affected by HIV/AIDS. The emphasis of the programme is to improve food security, a cause and consequence of the HIV/AIDS pandemic. PRP partners often link up with local networks of home-based care organisations and provide a mixture of targeted food aid, agricultural support, water and sanitation, some psychosocial support and limited school fees assistance.

The PRP has started to mainstream the needs of OVC through improved analysis of vulnerability and better targeting, e.g. focusing more on households with high dependency rations, elderly headed and child headed households. Some of the PRP partners, e.g. SC (UK), has also established child protection committees to ensure vulnerable children are not excluded from programming and to monitor and respond to cases of child abuse.

In addition to the PRP, DFID is exploring with UNICEF opportunities to increase support to Zimbabwe National Plan of Action on OVC. Although the needs are clearly huge in Zimbabwe there are challenges including;

1) Ensuring a well co-ordinated national response that co-ordinates support from all stakeholders (GoZ, UN, NGOs, donors).
2) Finding channels to fund effective community-level programmes, including through NGOs and CBOs.
3) Providing effective capacity building for decentralised implementation.
4) Lesson learning from existing OVC models.

Conclusions

Key issues highlighted through the presentations and following discussion mentioned specifically that, for significant government change, there is a need for a holistic and systemic approach that is well integrated into existing policy instruments and bodies. Furthermore, for successful government advocacy, a national approach to social protection must be:

- *Comprehensive*, involving the full range of partners, including, quite crucially, the Ministry of Finance;
- I*ntegrated* into existing macro policy instruments and bodies, e.g the PRSP;
- *Country-driven*, with harmonised support from development agencies;
- *Long-term* in scope.

Experience in Zimbabwe demonstrates that government advocacy is possible even in contexts where collaborative work with national governments is problematic. In these cases, it is likely that other agencies must take the lead, co-ordinating role, e.g. UN agencies. Finally, it is essential that social protection strategies are based on a wide understanding of vulnerability that is rooted in local context.

SESSION 5 – ADVOCACY & SOCIAL MOBILISATION

Strategy 5: Raise awareness at all levels through advocacy and social mobilisation to create a supportive environment for children and families affected by HIV/AIDS.

The following shared their experience in raising awareness through advocacy and social mobilisation:

- International HIV/AIDS Alliance
- Tearfund

Social Inclusion for OVC: Learning from Africa and Asia

The International HIV/AIDS Alliance demonstrated the importance of addressing the impact of stigma and discrimination on the lives of children and their families, as well as considering stigma and discrimination in the context of policy and legislation. The Alliance argued that social inclusion includes recognising and upholding people's rights within a legal framework.

The Alliance supports organisations working with communities on integrated HIV/AIDS prevention, care, treatment and support. Through this work, they found that successful prevention campaigns and care efforts work together with rights-based social inclusion programmes. They also recognised that HIV/AIDS-related discrimination may also interact with gender-based discrimination. However, to achieve successful social inclusion, many communities require technical support and

funding. Social inclusion is a complex issue that requires sensitive handling to support analysis, reflection and action by community members.

The Framework outlines three steps involved in creating a supportive environment. An enabling environment is created by supportive policies and legislation, including commitment of funds for continued work. At the community level, it is valuable to conduct a collaborative situation analysis. To this end, the Alliance and its partners developed a series of participatory activities to stimulate community-based analysis, reflection and action to address stigma and discrimination, and promote social inclusion. These activities form part of the "Building Blocks" series for community support to orphans and vulnerable children, available from the Alliance at www.aidsalliance.org.

Secondly, influential leaders must be mobilised to reduce stigma, silence and discrimination. It is significant to remember that community leaders can take a variety of different actions to reduce stigma and discrimination. Additionally, leaders can be very different in different contexts, and it is important to consider young people as part of the solution.

Finally, we must strengthen and support social mobilisation activities at the community level. Community leaders and NGOs can work with community members to support the rights of families affected by HIV/AIDS. An example of this comes from Southern India, where a family of four girls who had lost their father to AIDS were unable to make a living from using his fishing-net, due to gender-based social norms. The community was able to find a solution, renting the fishing net from the family, thus giving them a small income. While this does not address the underlying gender based restrictions, it recognises that changes occur in small steps, and finds a pragmatic, short-term solution in the interim. This solution was possible because of the long-term relationship between the NGO and the community leader, and his own understanding of HIV and its impacts, including his belief in defending the families' right to an income.

Strengthening Social Mobilisation Efforts at the Community Level

Tearfund discussed its distinctive role in responses to children affected by HIV and AIDS through direct contact with Christian grassroots organisations, highlighting lessons learned from initiatives in Kenya, Mozambique and Zimbabwe on mobilising communities and building on existing community initiatives in responses to children affected by HIV and AIDS.

As part of a community based nutrition programme in Kenya, Tearfund studied the effectiveness of social mobilisation at community level that sought to prevent the urban migration of orphan adolescent girls. The programmatic research focused on strengthening communities' ability to use their own resources and to improve their access to a range of resources for themselves. Community action plans were successfully used for identifying problems and mobilising collective action to address impacts of the epidemic for local communities. As a result of the increased recognition of the social disruption caused by migrating orphan girl adolescents, groups now focus on maintaining support for them within the community.

Lessons learned by Tearfund partner organisations in a number of different contexts also point to the importance of external support strengthening and supporting social mobilisation at the community level for sustainable responses to children and communities affected by HIV and AIDS.

Communities are concerned about orphans and vulnerable children and are responding. Most communities are willing to do more, but lack the financial resources. A little technical assistance and training can support communities to do more. External financial and material support should be provided to affected countries and channelled to communities to build on local capacity and structures. External agencies must focus on strengthening and supporting the ongoing efforts of communities themselves. There is an urgent need to increase the ability of civil society to access resources by increasing their ability to negotiate bureaucracy and by stripping away bureaucratic hurdles.

Conclusions

Much of the work needs to be done at community level. There is a need for capacity building for CBOs, FBOs, and capacity building requires greater funds. Significantly, there is leadership present at community level, including churches, and the children themselves. Most communities willing to do more but lack the funds. Investment in communities can have wide reaching results. Tearfund cited an example where they supported a small Christian organisation in Zimbabwe, which trained volunteers and worked through 347 churches to reach 150,000 orphans in community based care.

Need to address the complex issues of social inclusion/exclusion. This requires adequate technical support and the endorsement of a rights based approach.

CLOSING

The meeting was considered very useful. It was agreed that there is a need to understand what scaling up really means in the context of community responses. There was clear consensus on the need to develop a common language and understanding between organisations with regard to the OVC that we work with. The participants identified gaps in programmes, in particular asking that more gender analysis was required in all programme approaches.

It was agreed that the OVC Working Group and DFID should co-host an annual Symposium providing a forum for constructive dialogue between donors and civil society. Finally, Symposium attendees agreed that civil society must continue to represent the voices of communities and challenge donors to help to deliver a sustained effective response.

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Symposium on Sharing Best Practice in Orphans and Vulnerable Children programming

The Orphans and Vulnerable Children Working Group is a sub-group of the UK Consortium on AIDS and International Development and was formed in March 2004. The Working Group currently comprises nineteen UK based international agencies working inter alia, for the rights of children and their carers affected by HIV/AIDS around the world. The group aims to lobby and provide technical support to the UK Department for International Development, the European Union, United Nations, and bilateral donors in the development of HIV/AIDS related policies and strategies as well as to share programme experiences amoung its members and other interested parties.

Aim of the Symposium

The aim of the Symposium was to share experiences and programme approaches among practitioners working with orphans and vulnerable children and their carers.To facilitate this discussion, presentations were made to highlight lessons learnt and best practice related to the five approaches identified in 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children'. It is anticipated that this discussion will assist with identifying approaches which can be scaled-up and replicated.

The Symposium was co-convened by the Orphans and Vulnerable Children Working Group and the UK Department for International Development.

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The UK Consortium on AIDS and International Development is a group of more than 70 UK based organisations working together to understand and develop effective approaches to the problems created by HIV epidemic in developing countries.It enables each agency to bring its own experince to be shared and used to help all the members improve their responses to the epidemic, through:information exchange – networking – advocacy and campaigning.