Children on the Brink 2004

A Joint Report of New Orphan Estimates and a Framework for Action

July 2004

Joint United Nations Programme on HIV/AIDS
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Cover photos:

In Lesotho, a boy embraces his grandmother in their home in a village on the outskirts of Maseru, the capital. He is one of three grandchildren she is caring for following the death of their parents from AIDS.
UNICEF/HQ02-0567/Giacomo Pirozzi

An 11-year-old girl in Tanzania sits smiling against a tree at a center that provides assistance and counseling to children orphaned by AIDS and to people who are HIV- positive in Morogoro, 229 kilometers west of Dar-es-Salaam. She lived on the streets after her parents died of AIDS and now attends a primary school that is part of the center.
UNICEF/HQ00-0017/Giacomo Pirozzi

A 23-year-old man who is HIV-positive sits on the doorstep of his house beside his wife and their 10-month-old baby in Thailand. His wife and baby have not been tested for the disease.
UNICEF/HQ97-0080/Jeremy Horner

Holding her toddler son, an HIV-positive young woman in Mother and Child Hospital in Recife, Brazil, reads a poster informing how HIV/AIDS is and is not contracted. The poster ends with the words "Stay alive."
UNICEF/HQ00-0411/Alejandro Balaguer

UNICEF/HQ97-0083/Jeremy Horner

A 2-year-old orphaned boy in Thailand sits on a swing outside his aunt's house in Chiang Rai province, where he now lives.

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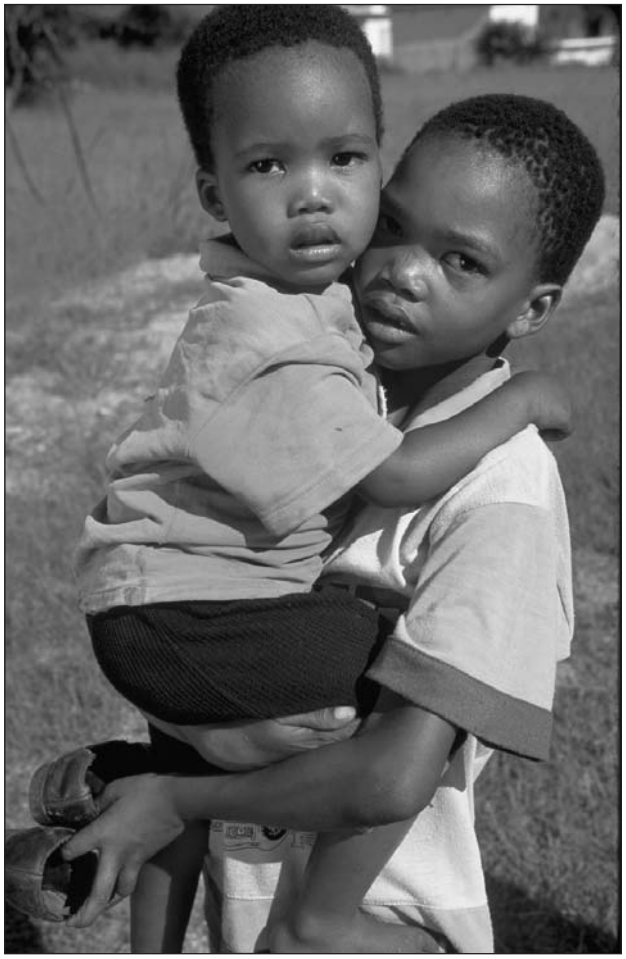
Introduction

HIV/AIDS is recognized worldwide as a threat to children and their families. AIDS is the leading cause of death worldwide for people ages 15 to 49. In 2003, 2.9 million people (estimate range, 2.6–3.3 million) died of AIDS and 4.8 million people (4.2–6.3 million) were infected with HIV. While most of the estimated 37.8 million people (34.6–42.3 million) living with HIV/ AIDS in the world are adults, the pandemic's devastating effects on families and communities reach down to the most vulnerable among us – our children.

Millions of children have been orphaned or made vulnerable by HIV/AIDS. The most affected region is sub-Saharan Africa, where an estimated 12.3 million children have been orphaned by AIDS. This orphan[1] population will increase in the next decade as HIV-positive parents become ill and die from AIDS. While sub-Saharan Africa has the highest proportion of children who are orphans, the absolute numbers of orphans are much higher in Asia, which had 87.6 million orphans (due to all causes) in 2003, twice the 43.4 million orphans from all causes in sub-Saharan Africa.

As was reported in the 2002 *Children on the Brink* report, the data in this report reconfirm that:



UNICEF/HQ01-0183/Giacomo Pirozzi

In Botswana, an 8-year-old boy holds his younger brother outside a drop-in center for orphaned children in the village of Molepolole, 50 kilometers west of Gaborone.

- Sub-Saharan Africa has the greatest proportion of children who are orphans.
- While the proportion of orphans in Asia is much less than in sub-Saharan Africa, the absolute number of orphans in Asia is much larger.
- The number of children orphaned by AIDS will continue to rise for at least the next decade.

Orphaning is not the only way that children may be affected by HIV/AIDS. Other children made vulnerable by HIV/AIDS include those who have an ill parent, are in poor households that have taken in orphans, are discriminated against because of a family member's HIV status, or who have HIV themselves. Consequently, programs should not single out children orphaned by AIDS but should direct their efforts toward communities where HIV/AIDS is making children and adolescents more vulnerable. Generally, the people who live in these communities are in the best position to determine which children are at greatest risk and what factors should be used to assess vulnerability and set priorities for local action.

HIV/AIDS has joined a host of other factors – including extreme poverty, conflict, and exploit-

[1] For the purposes of this document, "orphan" refers to any child under age 18 who has lost one or both parents.

ation – to impose additional burdens on society's youngest, most vulnerable members. To the children and households in communities affected by HIV/AIDS, addressing only AIDS-related problems and ignoring other causes of children's vulnerability does not make sense. Programs should target geographic areas seriously affected by HIV/AIDS and then support the residents of these communities in organizing to identify and assist the most vulnerable children and households, regardless of the specific causes of vulnerability.

If programs need to target the much broader vulnerable children population and not just orphans, why then does the *Children on the Brink* series present estimates of orphaning? While not all orphaning is due to HIV/AIDS, orphaning remains the most visible, extensive, and measurable impact of AIDS on children. To date, no methodology is available for estimating the number of other children made vulnerable by AIDS. Orphans are not only of great concern, their presence reflects a much larger set of problems faced by children.

The large majority of orphans and other children made vulnerable by HIV/AIDS live with a surviving parent and siblings or within their extended family, and the overwhelming thrust of an effective response must be to give direct substantial support to the millions of families who continue to absorb children who have lost parents. After losing parents and caregivers, children have an even greater need for stability, care, and protection. Family capacity – whether the head of household is a widowed parent, an elderly grandparent, or a young person – represents the single most important factor in building a protective environment for children who have lost their parents to AIDS and other causes. There is also an urgent need to develop and scale up family- and community-based care opportunities for the small but highly vulnerable proportion of boys and girls who are living outside of family care.

Children on the Brink 2004

This report contains the most current and comprehensive statistics on children orphaned by AIDS and other causes (appendix 1). Unlike previous editions of *Children on the Brink*, which included data for children under age 15, this edition provides data for children under age 18. This change brings the statistics in line with the international definition of childhood. It also recognizes that orphans and vulnerable children are not necessarily young children and that problems caused by orphaning extend well beyond age 15. The available data in fact suggest that adolescents make up the majority of orphans in all countries. As another new feature, this report also includes estimates of the number of children who became orphans in the last year. The methodology explaining how all estimates are calculated is described in appendix 2.

UNICEF/HQ98-1118/Giacomo Pirozzi

A peer educator reads aloud from a comic book about HIV/AIDS at a prevention center in Nairobi, Kenya. The comic provides information and positive messages on issues affecting African adolescents, including HIV/AIDS and gender equality.

This edition of *Children on the Brink* also examines the changing developmental needs of orphans and other children made vulnerable by HIV/AIDS as they progress through childhood. From infancy through age 17, a child passes through a number of life-cycle stages. HIV starts to affect a child early in a parent's illness, and its impact continues through the course of the illness and throughout the child's development after the parent's death. Children who are deprived of the guidance and protection of their primary caregivers are more vulnerable to health risks, violence, exploitation, and discrimination. Policymakers, leaders and practitioners in public health and other development sectors, and communities and families need to provide care and support to orphans (from all causes) and children made vulnerable by HIV/AIDS with an understanding of their stages of development and changing needs.

The report also provides an overview of the *Framework for the Protection, Care and Support of*

Orphans and Vulnerable Children Living in a World with HIV and AIDS. The *Framework* represents the best hope for pulling orphans and other vulnerable children back from the brink. It is now recognized as the normative basis for responding with increased urgency to the needs of the growing numbers of orphans and vulnerable children and for protecting their rights. It has been endorsed by all United Nations agencies that are cosponsors of UNAIDS and welcomed by many of the international partners working to address the complex and far-reaching impacts of HIV/AIDS on millions of children and adolescents. The *Framework* is a key outcome of the first Global Partners' Forum convened by UNICEF, with support from UNAIDS, in October 2003. The *Framework* is structured around the goals set for orphans and other children made vulnerable by HIV/AIDS at the 2001 United Nations General Assembly Special Session on HIV/AIDS. Implementation of the *Framework* will also bring significant progress toward the Millennium Development Goals and other global commitments such as Education for All and the Elimination of the Worst Forms of Child Labor.

The five key strategies of the *Framework* (summarized in the body of this report) are:

- Strengthening the **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
- Mobilizing and supporting **community-based responses** to provide both immediate and long-term assistance to vulnerable households
- Ensuring access for orphans and vulnerable children to **essential services**, including education, health care, birth registration, and others
- Ensuring that governments protect the most vulnerable children through **improved policy and legislation** and by channeling resources to communities
- Raising awareness at all levels through advocacy and social mobilization to create a **supportive environment** for children affected by HIV/AIDS

Summaries of the *Framework*'s monitoring and evaluation indicators (appendix 3), programming principles (appendix 4), and recommendations for national action (appendix 5) are also included in this report.

With new funding commitments from the 2004 start-up of the President's Emergency Plan for AIDS Relief of the United States government, the World Bank, UNICEF, UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, resources for providing support to orphans and other children made vulnerable by HIV/AIDS have increased in recent years. While these additional resources represent an outstanding commitment, funding in general for programs for orphans and vulnerable children nonetheless remains small compared with other HIV/AIDS funding.

More importantly, an enormous gap remains between what has been done and what needs to be done to protect the rights and address the needs of orphans and vulnerable children. At the end of 2003, only 17 countries with generalized epidemics reported having a national policy for orphans and vulnerable children to guide strategic decision-making and resource allocation. Closing the gap is possible, but it will require the combined efforts of all those able to respond – governments, donors, nongovernmental organizations, faith-based organizations, the private sector, and the thousands of community groups already struggling on the front line of response. Through committed partnerships and collaboration, millions of children and adolescents will have a chance of a better future.

Terms

Children on the Brink 2004 uses the following terms for statistical purposes in estimating orphan subpopulations. The terms are not meant to define target populations of programs to assist all orphans and vulnerable children.

Maternal orphans are children under age 18 whose mothers, and perhaps fathers, have died (includes double orphans).

Paternal orphans are children under age 18 whose fathers, and perhaps mothers, have died (includes double orphans).

Double orphans are children under 18 whose mothers and fathers have died.

Total orphans are children under age 18 whose mothers or fathers (or both) have died. The total number of orphans is equal to the sum of maternal orphans and paternal orphans, minus double orphans (because they are counted in both the maternal and paternal categories).

New orphans are children under age 18 who have lost one or both parents in the last year.

Vulnerable children, as used in this document, refers to those children whose survival, well-being, or development is threatened by HIV/AIDS.

Children on the Brink avoids using the term "AIDS orphan" because it may contribute to inappropriate categorization and stigmatization of children. Instead, the report uses such terms as "orphans due to AIDS" or "children orphaned by AIDS." The phrase "children affected by HIV/AIDS" refers to orphans and other children made vulnerable by HIV/AIDS.

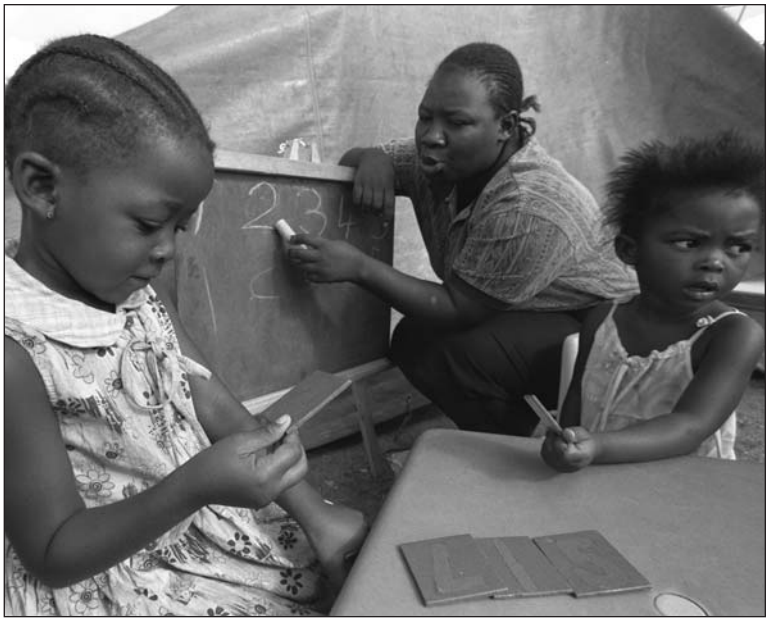
Children on the Brink also avoids using acronyms such as "OVC" (for orphans and vulnerable children) or "CABA" (for "children affected by HIV/AIDS"). Experience has shown that such jargon eventually becomes used at the community level to identify particular children. When asked what they prefer to be called, children have said, "Just call us children."

UNICEF/HQ93-0490/Cindy Andrew

In Kuanda, Malawi, a grandmother cooks on the veranda of her hut while one of her nine grandchildren eats. Her grandchildren's parents died of AIDS.

Regional Overview and Important Orphan Trends

By the end of 2003, it was estimated that there were 143 million orphans ages 0 through 17 years old in 93 countries of sub-Saharan Africa, Asia, and Latin America and the Caribbean. Globally, this is only a 3 percent increase in the number of orphans since 1990. Were it not for the HIV/AIDS pandemic, the percentage of children who are orphans would be expected to decline as improvements in health, nutrition, and overall development lead to a decrease in adult mortality. Unfortunately, in countries where HIV/AIDS has hit hardest, this trend has been reversed, with both the percentage of children who are orphans and the absolute number of children who are orphaned rising dramatically. In just two years, from 2001 to 2003, the global number of orphans due to AIDS increased from 11.5 million to 15 million (estimate range, 13–18 million).



UNICEF/HQ01-0113/Giacomo Pirozzi

Two girls learn to count in a kindergarten class at a center for orphaned children in Francistown, Botswana.

New Estimates of Orphans

The numbers in this report are based on new estimates and projections of orphans in 93 countries in sub-Saharan Africa, Asia, and Latin America and the Caribbean. The estimates and projections show both the historical and future trends of orphaning in the low- and middle-income countries of those regions. These estimates and projections are a follow-up to those reported in previous *Children on the Brink* publications but with several important changes and additions. In the previous reports, estimates were only made for children ages 0 through 15. In this report, estimates are made for orphans under age 18, capturing the large number of older children who have lost one or both parents. Orphan estimates are also reported by broad age categories (0-5 years, 6-11 years, and 12-17 years), because information on the age of orphans can have important programming implications. As a measure of "new" orphans, the report also provides estimates of the number of children who have lost one or both parents in the past year.

The orphan estimates are based on new models and estimates of HIV/AIDS in these countries. The models and estimates of HIV/AIDS have undergone substantial revisions since those made in 2002, reflecting increasing knowledge about the level of the epidemic in many countries. These new models of HIV/AIDS and the estimates of orphans from these models have also been compared with independent estimates of orphans based on household surveys in countries in sub-Saharan Africa.

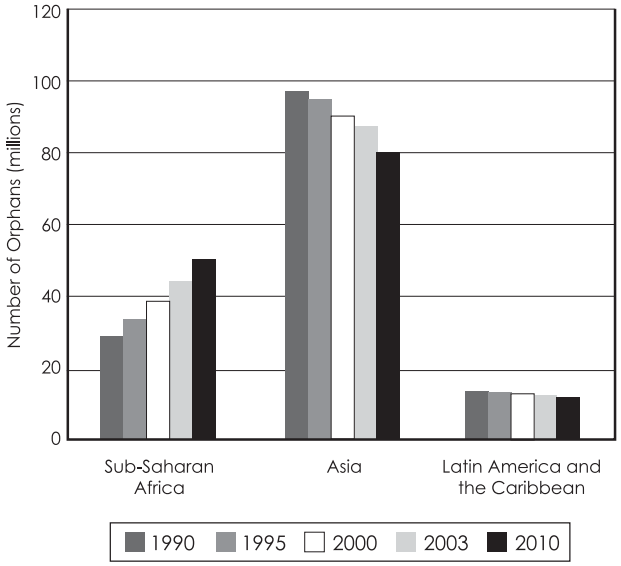
Estimates of "orphans due to AIDS" for countries outside sub-Saharan Africa have not been included in this report because there is not enough accurate information available to prepare reliable calculations for these regions.

Regional Overview

Sub-Saharan Africa

Sub-Saharan Africa is home to 24 of the 25 countries with the world's highest levels of HIV prevalence, and this is reflected in the rapid rise in the number of orphaned children. In 2003, there were 43 million orphans in the region, an increase of more than one-third since 1990 (see figure 1).

Figure 1. The number of orphans is decreasing in all regions except sub-Saharan Africa, where HIV/AIDS has hit the hardest.



In 2003, 12.3 percent of all children in sub-Saharan Africa were orphans. This is nearly double the 7.3 percent of children in Asia and 6.2 percent of children in Latin America and the Caribbean who were orphans.

Even within sub-Saharan Africa, however, there are differences in the rate of orphaning. As the map in figure 2 shows, the highest percentages of children orphaned are in countries with high HIV prevalence levels or those that have recently been involved in armed conflict.

With 20 percent of its children orphaned, Botswana has the highest rate of orphaning in sub-Saharan Africa. In 11 of the 43 countries in the region, more than 15 percent of children are orphans (figure 3). Of these 11 hardest-hit countries, AIDS is the cause of parental death between 11 and 78 percent of the time.

Figure 2. Rates of orphaning in sub-Saharan Africa are highest in central and southern Africa.

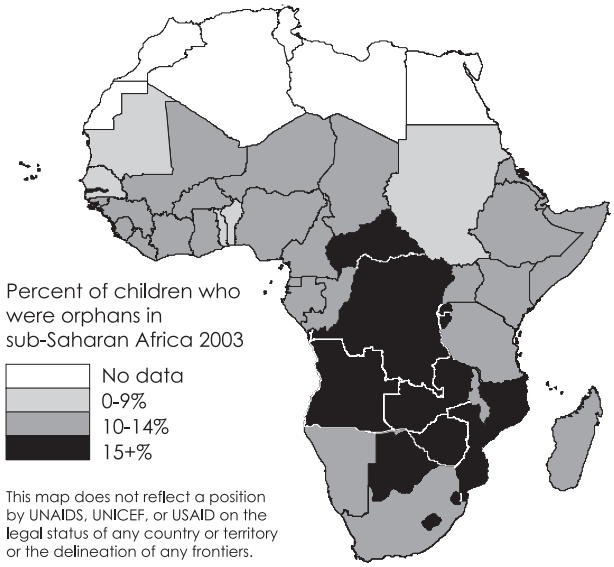
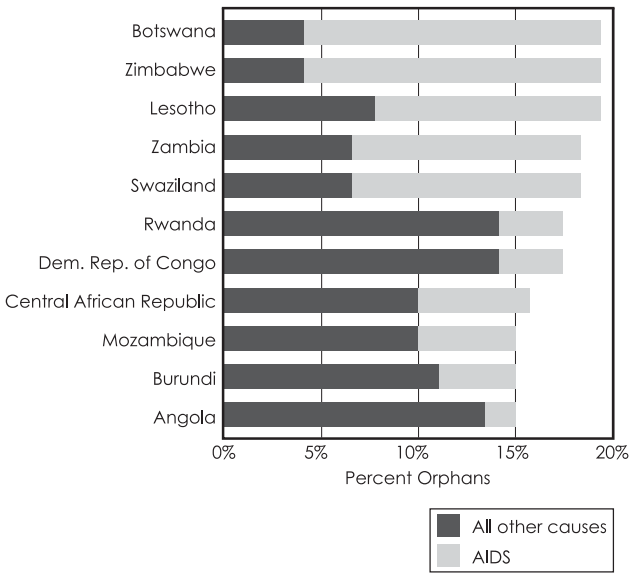


Figure 3. In 11 countries in sub-Saharan Africa, more than 15% of all children were orphans in 2003.

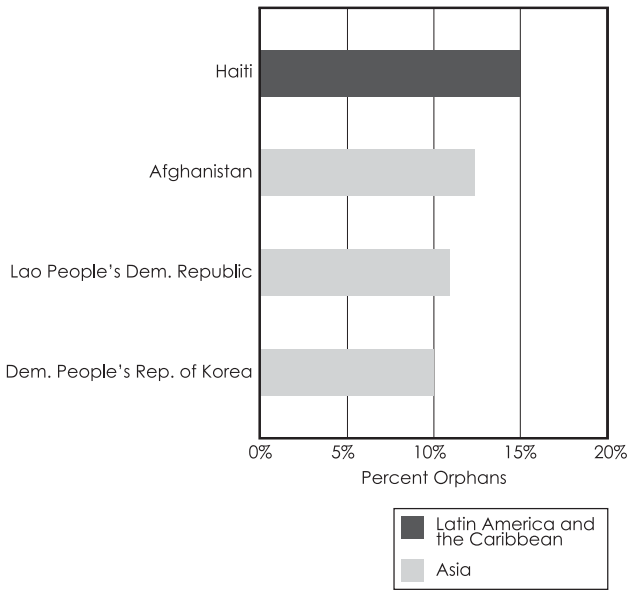


Asia

While Africa is proportionally the region hardest hit by HIV/AIDS, the total number of orphans is largest in Asia. Although the number of orphans in Asia has dropped by almost 10 percent since 1990, and despite lower HIV prevalence rates, Asia had twice as many orphans due to all causes than sub-

Saharan Africa in 2003 (see figure 1). This is due to much larger populations in Asia, which has almost four times more children (1.2 billion) than sub-Saharan Africa (350 million). There are three countries in Asia where 10 or more percent of children are orphaned (see figure 4). Among these countries, Afghanistan has the highest proportion of orphaned children (12 percent).

Figure 4. In four countries outside sub-Saharan Africa,10% or more of all children were orphans in 2003.



It should be noted that the projected number of future orphans in Asia shown in figure 1 assumes that the HIV/AIDS epidemic will not increase significantly by 2010. However, in some Asian countries with large populations (such as China, Indonesia, and Pakistan), the HIV/AIDS epidemic has only recently begun. If the epidemics in these countries expand to the levels of countries such as Thailand and Cambodia, the number of children orphaned by AIDS could grow dramatically.

Latin America and the Caribbean

Even in Latin America and the Caribbean, with both smaller populations and lower prevalence of HIV/AIDS, there were 12.4 million orphans in 2003. The overall number of orphans in the region has dropped by nearly 10 percent since 1990 (see figure 1). In the countries most affected by AIDS, however, there has been an increase in the proportion of children who are orphans. In Haiti, with an adult HIV prevalence rate of about 5.5 percent, over 15 percent of children are estimated to be orphans. This is more than double the regional average.

Trends

These new estimates of orphan populations are important as they provide for a better understanding of the impact of HIV/AIDS on the number of orphans and help identify those countries that will most need strong child protection measures and support in meeting the challenges posed by rising numbers of orphans. In the following section, the report will use these new estimates to examine major emerging trends in orphaning.

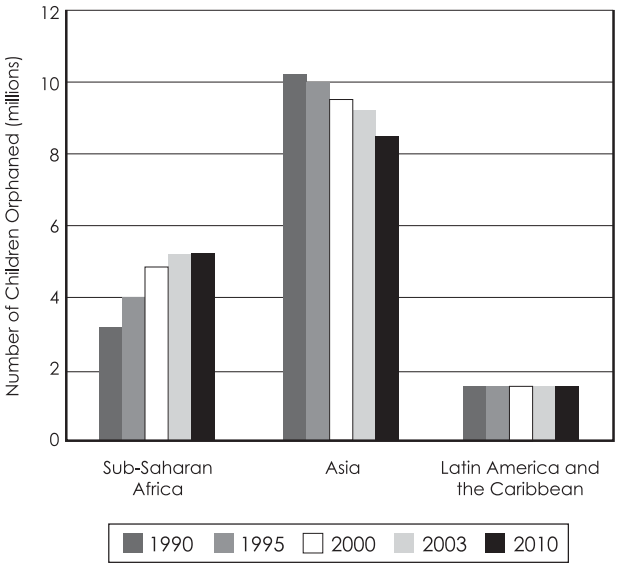
1. Children orphaned in 2003

More than 16 million children were newly orphaned in 2003. While the total number of orphans is a good measure of the cumulative impact of adult mortality over the last 18 years, it does not address the immediate impact of HIV/AIDS on mortality and the increasing number of orphans. One measure that more closely captures recent changes in adult mortality is the estimate of children who became orphans in the last year. This is where the current impact of HIV/AIDS is most clearly evident.

As shown in figure 5, approximately 3.2 million children were orphaned in sub-Saharan Africa in 1990. In 2003, 5.2 million children in the region became orphans, with over 800,000 becoming newly orphaned in Nigeria alone. Over the same period, the number of new orphans dropped in Asia and remained constant in Latin America and the Caribbean.

In five countries in southern Africa (Botswana, Lesotho, Namibia, South Africa, and Swaziland), 15 percent or more of all orphans became an orphan in 2003. The large majority of new orphans in these countries lost their parent or parents to AIDS. Similar numbers of children are currently living with a chronically ill family member (or members) and will become orphans this year. With the traditional support systems in these countries already under severe pressure, many extended families are, or soon will be, overwhelmed and in greater need of external support and protective safety nets.

Figure 5. The number of children orphaned each year in sub-Saharan Africa has continued to rise.



2. Continuing increase in orphans in sub-Saharan Africa

As figure 6 indicates, the impact of HIV/AIDS on mortality and the number of children orphaned by AIDS in sub-Saharan Africa will continue to increase through 2010 (although a massive increase in the availability of antiretroviral therapy could bring the projected figures down to some extent). In Botswana, Lesotho, Swaziland, and Zimbabwe, more than one in five children will be orphaned.

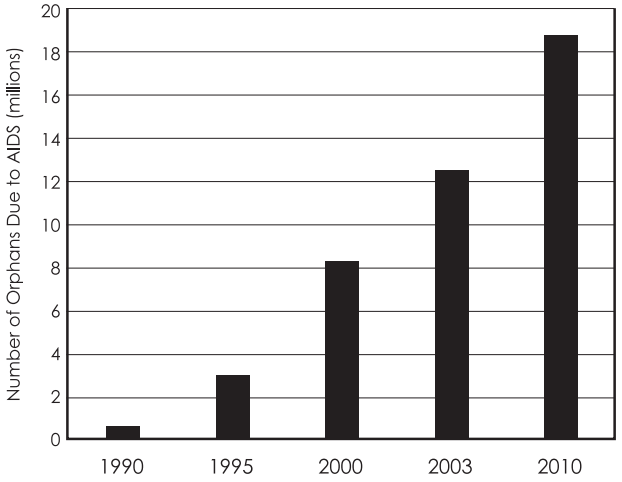
A recent analysis by UNICEF[2] on caring practices in 40 countries in sub-Saharan Africa show that extended families have assumed responsibility for more than 90 percent of orphaned children. Today, 20 percent of households with children in southern Africa are caring for one or more orphans. These family networks will continue to be the central social welfare mechanism in most countries. However, as the number of orphans further increases over the coming decade and an ever larger number of adults is affected by HIV/AIDS, many of these family networks will face even greater burdens.

The burden of orphan care is already shifting in countries with the highest HIV prevalence levels. Orphans are increasingly more likely to be living in female-headed and grandparent households. In Zambia, for example, female-headed households are twice as likely to be taking care of double orphans than male-headed households. Female-headed households also take in more orphans than male-headed households. In South African households that have assumed responsibility for orphans, there are on average two double orphans in each female-headed household, while in male-headed households the average is around one.

While grandparents and other older caregivers already have an important role in the care of orphans, their burden is notably increasing. In Namibia, the proportion of double orphans and single orphans (not living with a surviving parent) being taken care of by grandparents rose from 44 percent in 1992 to 61 percent in 2000. Increases have also been recorded in Tanzania and Zimbabwe.

The same analysis shows that coping strategies in southern African countries differ considerably from other sub-Saharan African countries. High mobility due to male outmigration from Botswana, Lesotho, Namibia, and Swaziland to work in southern Africa's more industrialized areas may contribute not only to high HIV prevalence rates but

Figure 6. Between 1990 and 2003, sub-Saharan Africa's population of children orphaned by AIDS increased from less than 1 million to more than 12 million.



[2] UNICEF. November 2003. *Africa's Orphaned Generations.* New York: UNICEF.

UNICEF/HQ97-1031/Giacomo Pirozzi

In Rwanda, a 63-year-old woman holds her 3-year-old grandson in their house near Kigali. The boy and his two older sisters are orphaned and have lived with their grandmother since their parents died of AIDS.

also to high rates of child fostering and high levels of female-headed households. Coping mechanisms that rely on the extended family may be less resilient than elsewhere in the region.

The increasing proportion of children who are orphans also places a tremendous strain on the social fabric of communities and nations. Even cultures and communities with strong social cohesion and traditions of providing support to orphans and other vulnerable children can be overwhelmed when the rate of increase and the overall number of orphans reach such high levels.

3. Double orphans

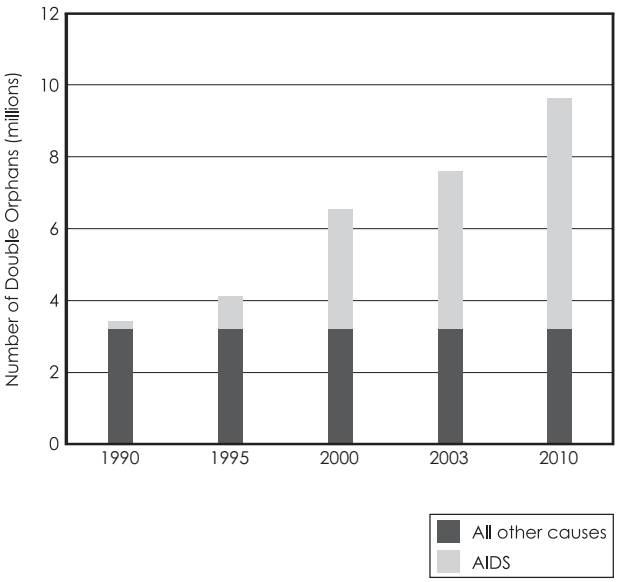
An especially important and distinctive characteristic of HIV/AIDS in regard to orphaning is that AIDS is more likely than other causes of death to create double orphans. With HIV/AIDS, if one parent is infected there is a higher probability that the other parent is or will become infected and that both will eventually die. This means that countries with high levels of HIV/AIDS will also have a disproportionate number of double orphans as the epidemic advances. Surveys consistently show that double orphans are more disadvantaged than single orphans. In Tanzania, the school attendance rate for children whose parents are alive and who live with at least one of them is 71 percent, but for double orphans it is only 52 percent.

Sub-Saharan Africa had almost as many double orphans in 2003 (7.7 million) as Asia (7.9 million), although Asia has about four times more children than sub-Saharan Africa and twice as many total orphans. These numbers dwarf the number of double orphans in Latin America and the Caribbean (600,000). Of the 7.7 million double orphans in sub-Saharan Africa, just over 60 percent have lost one of their parents due to AIDS (and in many cases both). The number of double orphans is projected to increase in sub-Saharan Africa through 2010 (see figure 7).

4. Increasing proportion of maternal orphans

AIDS is changing the pattern of orphaning in sub-Saharan Africa, where maternal orphans now outnumber paternal orphans in five of the most affected countries. In the absence of HIV/AIDS, children were more likely to become orphans because of a father's death. In the countries of sub-Saharan Africa today, however, women have higher rates of HIV/AIDS than men, and there are now more maternal orphans due to AIDS than paternal orphans due to AIDS. In the most affected countries in southern Africa, 60 percent of orphans have lost their mother, compared with 40 percent in Asia, Latin America, and the Caribbean.

Figure 7. The number of double orphans in sub-Saharan Africa is increasing due to AIDS.



More research is needed to better understand the implications of a child losing his or her mother compared to losing his or her father. Recent household surveys show that in the countries of southern Africa, maternal orphans are especially likely to be 'virtual' double orphans, as it is common for the father to live elsewhere. In Malawi, for

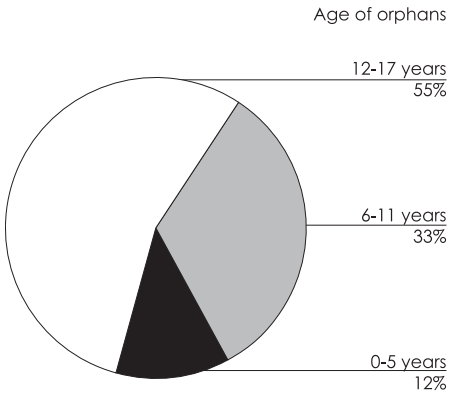
example, only 27 percent of maternal orphans are living with their biological father, while 70 percent of children whose parents are alive live in a household with the father present.

5. Age of orphans

While children can lose their parents at any age, the proportion of children who are orphans generally increases with age, and older orphans greatly outnumber younger orphans. As figure 8 shows, more than half of all orphans are age 12 or older. Of the 143 million orphans in the three regions, 17.5 million (approximately 12 percent) are below age 6; 47 million (33 percent) are ages 6 to 11; and the remaining 79 million (55 percent) are ages 12 to 17.

This age pattern has important implications for the allocation of resources for programs. As the following section describes, there are substantial differences in the needs of children of different ages, the relevant child protection measures for each age group, and how programs should address each group. While programs for very young orphans are important, new needs and different elements of the protective environment must be addressed to protect and provide for the nearly 90 percent of orphans above age 6.

Figure 8. More than half of orphans in sub-Saharan Africa, Asia, and Latin America and the Caribbean are adolescents.



Protecting the Rights and Meeting the Changing Needs of Orphans and Vulnerable Children

The development of a child's full potential – which is every child's right – is seriously threatened if the family environment deteriorates as a result of parental illness and death. It is also threatened when the impacts of HIV/AIDS undermine basic social services and safety nets such as health care and education.

UNICEF/HQ02-0361/Giacomo Pirozzi

The 19-year-old girl on the left cares for herself, her two siblings, and her older sister's three children in Harare, Zimbabwe. Her parents and older sister died of AIDS.

The illness or death of a parent or other family member has differing effects on children, depending in part on a child's age and stage of development. To date, however, most of the policies, programs, information, and literature concerning orphans and other children made vulnerable by HIV/AIDS have tended to regard them as an undifferentiated, homogeneous group. Data and programming recommendations have often failed to make key age-related distinctions, ignoring the physical, cognitive, emotional, and psychosocial differences that characterize children and adolescents in different stages of development. Responses that take these differences into account will be more effective.

To survive and thrive, children and adolescents need to grow up in a family and community environment that provides for their changing needs, thereby promoting their healthy and sound development. Because the overwhelming majority of children and adolescents affected by HIV/AIDS live with a surviving parent or within their extended family, their developmental needs are best met through efforts and interventions that strengthen family care and community support. The age-related needs of infancy and early childhood, middle childhood, and adolescence must inform this programming.

A Developmental Approach

Why take a developmental approach? Children respond very differently to their experiences at different ages, depending on their level of physical, cognitive, emotional, and psychosocial development. For example, the effects of the illness or death of a key caregiver will be different for infants, young children, children in the middle childhood years, and adolescents. The developmental level (including emotional maturity and level of understanding) of a child or adolescent will influence how he or she reacts to the death of a mother or father (or both), to separation from siblings, and to other possible consequences of parental death. A young person's stage of development will also be a factor in determining the kinds of support and protection he or she needs to enhance the prospect of a healthy and productive future.

Infancy and Early Childhood

All children are most vulnerable during the first five years of life. Within this period, a child is at greatest risk of dying in the first year, especially during delivery and the first month after birth. The illness or death of a mother or guardian during a child's first year has life-threatening consequences. While the threat of such a loss to a child's survival gradually diminishes after the first year, it remains significant for several years.

In the first one to two years of life, young children need to feel emotionally close to at least one

consistent and loving caregiver for their healthy development and, in fact, for their survival. In addition to the fulfillment of basic physical needs, the child needs touching, holding, emotional support, and love from this consistent caregiver. When a young child loses such a caregiver, he or she is at risk of losing the ability to make close emotional bonds – to love and be loved – as well as at increased risk of illness and death. Even before the age of 2, children are sensitive to feelings of loss and stress in others and need reassurance.

HIV/AIDS heightens the vulnerability of infant children. While most children born to HIV-positive mothers do not become infected, their chances of survival are diminished if the mother becomes sick with AIDS and dies. Some infants acquire HIV infection from their mother during pregnancy, delivery, or early in life (see box below), greatly reducing their chances of survival.

The diseases of childhood pose the most serious threat to the survival and development of young children in vulnerable households. Boys and girls

Children With HIV/AIDS

Every day, about 1,700 children become infected with HIV. There are an estimated 2.1 million children under age 15 (estimate range, 1.9–2.5 million) living with HIV in the world today. In 2003, about 630,000 children under age 15 (570,000–740,000) became infected.

While adolescents become infected with HIV primarily through unprotected sexual activity, infants are infected during their mother's pregnancy, labor, or delivery, or while breastfeeding. Preventing HIV infection in women of reproductive age is thus the most effective way to decrease the number of young children infected with HIV.

It should be noted that two-thirds of the infants born to HIV-positive mothers do not become infected. In the absence of prophylaxis, estimated rates of mother-to-child HIV transmission in developing countries range from 25 to 45 percent. Approximately two-thirds of these infections occur during pregnancy, labor, or delivery, and the others occur during breastfeeding. Prevention of mother-to-child transmission (PMTCT) programs that provide antiretroviral (ARV) drug prophylaxis to pregnant women and to newborns at birth can reduce the risk of transmission by half. Because of the benefits of exclusive breastfeeding and the risks of replacement or mixed feeding (especially the risk of diarrhea due to unsafe water and poor hygiene), exclusive breastfeeding for six months, or exclusive breastfeeding and early weaning, are the best feeding options in most situations. Current recommendations indicate that replacement feeding should only be considered if it is feasible, safe, affordable, acceptable, and sustainable.

In countries with HIV epidemics concentrated among men having sex with men, men and women who engage in commercial sex, or injecting drug users, risk behavior generally starts during adolescence. Boys are especially affected in these epidemics. Adolescent girls face a disproportionate risk of HIV infection in countries with HIV epidemics in the general population. In some of the most affected countries, the ratio of infected girls to boys is 5 to 1. Girls are more vulnerable to sexually transmitted HIV infection due to a number of biological and social factors, including, among the latter, coerced sex, unsafe sex with older men, and a lack of skills and information about how to protect themselves. Young people living outside family settings – on the streets, for example – are also at increased risk for HIV infection.

Including HIV-positive children in scaled-up care and treatment programs is critical. Brazil has successfully implemented ARV treatment for children and adolescents as part of its national treatment policy. A number of other countries, including Uganda, Zambia, and South Africa, are beginning to enroll large numbers of children living with HIV/AIDS in their programs. Such programs should be comprehensive and include routine child health care, nutrition, and psychosocial care, as well as treatment of HIV/AIDS and related opportunistic infections. Links should be made to existing PMTCT programs and community-based child survival activities such as Integrated Management of Childhood Illness (IMCI) programs. In addition, programs that address HIV/AIDS and its related conditions need to be integrated into routine primary health care services, because the HIV status of most children is unknown, and their health needs, regardless of HIV status, are generally addressed through these services.

under age 5 – especially those whose families live in poverty in developing countries – are vulnerable to potentially fatal measles, diarrhea, and pneumonia. Malnutrition increases the chances of children dying from these diseases. In addition, severe malnutrition during the first few years of life can cause irreversible stunting and impaired cognitive functioning. In settings where immunizations, treatment of childhood illness, and adequate nutrition can not always be assured, programs need to make concerted efforts to ensure that orphans and other vulnerable children under age 5 receive these key child survival interventions, because families with parents or other caregivers affected by HIV/AIDS may find it difficult to do so. Parents and caregivers also need support and training in providing the best care they can for these young children.

Between ages 3 and 6, young children remain vulnerable to disease and malnutrition, but caregivers may neglect their needs because they appear to be more independent. They continue to need a sense of belonging and social and emotional support. They also need opportunities to learn, because this is the critical period for establishing curiosity, exploration, and motor skills.

Children of this age do not understand the finality of death and may expect a person who has died to reappear. They may fear that they have caused a loved one's death. Caregivers need to assure a child that this is not the case and also understand the child's anxiety, sadness, and possible outbursts of anger or regression to earlier forms of behavior. Caregivers need to make the child feel safe and loved, to be willing to talk about loss and the person who died, and to provide clear information about death.

Long-term institutional care is particularly inappropriate for infants and young children, because the healthy emotional, cognitive, and even physical development of children in this age group requires that they have at least one consistent and loving caregiver with whom they can form a bond. There is a pressing need to ensure that family-based care is available for these children, either through support for relatives, foster care, local adoptive placement, or community organizations that are integrally linked to the community. Strategies that can help keep young children in families also include community-based child care and home visits. In response to demand, community-based child care centers are becoming more common in a number of countries. They provide children with food, access to health care, and a place to learn and play. They may also enable older siblings to attend school and provide support for isolated caregivers, including the elderly. Home visits by community volunteers to caregivers who are elderly or children themselves can help them cope and promote good care and healthy practices such as positive discipline, preschool attendance, and adequate nutrition for the children. Home-based care for an ill parent can help families as well as the affected adult.

Middle Childhood

Middle childhood begins around the time a child enters primary school, which varies by country and region based on cultural norms and economic conditions. As children of this age group face new development challenges, the experience of serious parental illness and loss affects them somewhat differently than younger children.

Orphans in middle childhood are able to understand the finality of death and may have intense fears of further abandonment and loss. They may experience anxiety and regress to younger behaviors for a period of time. Others may not appear to react at all until months later. They can benefit from the chance to talk about death and loss, to participate in rituals related to the person they have lost, and to re-establish normal routines.

During middle childhood, school attendance is essential for progress in learning and problem solving. However, the impacts of HIV/AIDS prevent some boys and girls from going to school or affect their ability to study. Orphans are more likely than other children to be excluded from school, with household poverty, age, and relationship with the guardian all affecting school attendance. Studies from Zimbabwe, Tanzania, and Ethiopia have found that orphans of this age are at risk of falling out of family care and, instead of attending school, becoming street children or victims of exploitative labor. Ensuring access to quality education for orphans in middle childhood is an important program priority.

The experiences of a loving family life and group activities with siblings and friends are also important for healthy development during middle childhood. These children need a sense of security and belonging in a family or family-like environment. In addition to this family identity, a growing child

Developmental Risks and Opportunities

In all countries and regions, boys and girls in all stages of development are orphaned or become vulnerable as a result of HIV/AIDS. When responding to the impacts of HIV/AIDS, people need to be aware of the developmental risks of each age group and tailor responses to minimize them. The "tasks" children and adolescents achieve as they develop, the risks they may face if HIV/AIDS compromises their family environment, and the development-related priorities for programs protecting and supporting orphans and vulnerable children are summarized below.

Infancy and early childhood

Tasks: Critical period for establishing survival, growth trajectory, and development of brain function; child establishes a sense of trust and belonging; language acquisition; curiosity and interest in experimentation; developing understanding of cause and effect; readiness to learn in a group setting.

Risks: Illness and death; stunting; lack of attachment; lack of curiosity and interest; emotional withdrawal or instability; fearfulness; reduced learning ability.

Program priorities: Early identification of young children at risk of orphaning; succession planning prior to the death of a parent (especially the mother); ensuring good infant and young child feeding, health care, and growth monitoring and promotion; preserving sibling relationships (particularly when a sibling has been a primary caregiver); supporting consistent and loving caregiving; developing community child daycare and early learning options when needed.

Middle childhood

Tasks: Continued physical growth; developing understanding of rules and responsibility; developing healthy peer relations and family identity; developing skills for numeracy and literacy; increasing ability to express feelings; improving problem-solving skills.

Risks: Inappropriate demanding of attention; withdrawal; destructive and cruel behavior to self or others; lack of sense of morality and rules; difficulty learning.

Program priorities: Ensuring access to school; ensuring adequate nutrition; providing opportunities to participate in community life; supporting family connections and identity; providing opportunities to learn traditional skills and cultural behavior and practices; enabling siblings to remain together; providing opportunities to play with and participate in structured activities with age mates; increasing relationships with caring adults; providing information on death and HIV/AIDS.

Adolescence

Tasks: Physical and sexual maturation; understanding of relationships (negotiation, resisting pressure, intimacy, sense of responsibility for others); challenging rules and testing limits; navigating risk behaviors; developing image of independent self; exploring livelihood opportunities; improved problem solving; understanding of consequences of actions; identity development; cultural learning.

Risks: Lack of capacity for intimacy and responsibility to others; poor peer relations; lack of problem-solving skills; failure to recognize adults who may assist in problem solving; risky behaviors; emotions of anger, resentment, hopelessness, depression; social and cultural marginalization.

Program priorities: Ensuring ongoing access to school or skills training; providing opportunities to connect with adults and observe and learn about adult roles; providing access to youth-friendly health services, including HIV prevention; protecting against abusive labor and sexual exploitation; ensuring adequate nutrition; providing opportunities to develop and maintain close peer relationships; providing adult support in decision-making.

UNICEF/HQ99-0785/Roger Lemoyne

A male social worker discusses HIV/AIDS awareness with a group of children in Ho Chi Minh City, Vietnam.

needs to develop a positive self-identity and self-esteem. Stigma and discrimination related to HIV/AIDS can negatively affect a child's social environment and relationships, however, and damage his or her self-esteem.

Programs that are working with orphans and vulnerable children in middle childhood should focus on ensuring they receive adequate protection and support to live with a surviving parent, with members of the extended family, or in appropriate and well-monitored family-based care in their community. Programs must also ensure that children have access to age-appropriate education, health care, and other basic services.

Adolescence

During adolescence, several key development experiences occur, including physical and sexual maturation, progress toward social and economic independence, and further development of identity. The transition from middle childhood to early adolescence is gradual, and some of the developmental tasks and concerns of middle childhood continue in early adolescence. As the adolescent matures, some issues become increasingly significant, including prevention of sexual abuse and exploitation (and confronting it when it happens), the attainment of life skills[3] (including those for HIV prevention), and the achievement of overall healthy and productive development.

Adolescents understand the nature of loss but may not directly express their worries and anxieties. They may feel resentment and anger at the death of a parent or close family member. They may seem to be coping, but at the same time they can experience depression, hopelessness, and increased vulnerability. This can lead to a sense of alienation, desperation, risk-taking behavior, and

[3] Life skills are a set of abilities for meeting the demands and challenges of everyday life, including psychosocial competencies and interpersonal skills that help people make informed decisions and healthy life choices, build healthy relationships, communicate effectively, solve problems, resist negative pressures, and minimize harmful behaviors.

withdrawal. Adolescents need to have someone assist them with decision-making about future options and opportunities.

In many countries, adolescents have significantly less access to school than younger children. The economic impacts of HIV/AIDS on households jeopardize many adolescents' chances of staying in school, especially if they have to assume new responsibilities for supporting the family. Some become the head of the household if the alternative is for siblings to be separated or if siblings risk losing their inheritance after the death of their parents. Orphaned adolescents may be caught in the dilemma of having to work to support themselves and possibly younger siblings, which prevents them from attending school and receiving the education and training they need to obtain productive work. Economic hardship can also deprive adolescents of much needed recreation and participation in community activities. Depression, hopelessness, and risky behavior can be common reactions to these circumstances that need special attention and strong protection measures.

Even adolescent boys and girls whose families are intact may lack the information, skills, and youth-friendly services to support a positive transition through adolescent sexuality. Because sexual activity (as well as substance abuse and other risky behavior) often begins during adolescence, it is critical to provide comprehensive sexual health education and services to reduce the risks – often heightened for orphans – of unwanted pregnancies, coerced sex, exploitation in commercial sex, and transmission of sexually transmitted infections. Programs must provide information on health behaviors and the life skills that adolescents need to protect themselves.

Orphans may be particularly challenged by the developmental tasks of adolescence. Psychosocial and economic distress can lead to risk-taking behavior linked with unsafe sexual practices and substance abuse. Adolescent orphans in HIV/AIDS-affected communities may be more vulnerable to HIV infection than young children or adults. Young people, especially girls, are becoming infected at younger ages, particularly in communities highly affected by HIV/AIDS.

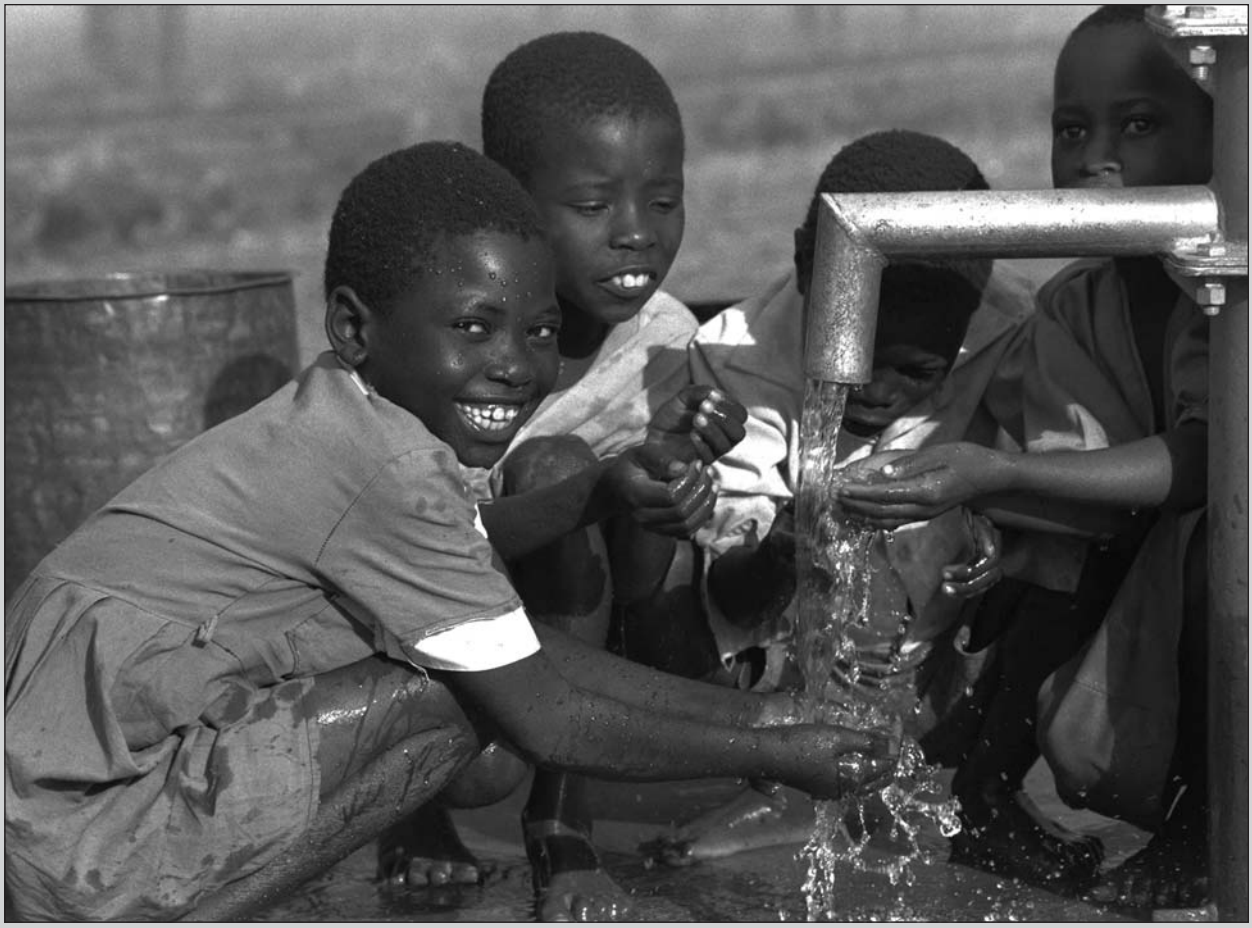
Ensuring that adolescents have access to education, job and life skills training, and health services are essential policy and program priorities. Strengthening the economic capacity of affected households caring for orphaned and vulnerable adolescents will also help keep future opportunities open to them. Connecting adolescents with caring or mentoring adults through participation in school, faith-based, and other community organizations and activities will also promote healthy socialization and a sense of belonging as they approach adulthood.

Supporting Alternatives to Institutional Care

Orphanages, children's villages, or other group residential facilities may seem a logical response to growing orphan populations. In fact, this approach can impede the development of national solutions for orphans and other vulnerable children. Such institutions may be appealing because they can provide food, clothing, and education, but they generally fail to meet young people's emotional and psychological needs. This failure, and its long-term ramifications, support the conclusion of a study in Zimbabwe that countries – and children – are better served by programs that "keep children with the community, surrounded by leaders and peers they know and love."[4]

Traditional residential institutions usually have too few caregivers and are therefore limited in their capacity to provide children the affection, attention, personal identity, and social connections that families and communities can offer. The developmental risks shown in the box on page 16 can thus be substantially heightened in institutional settings.

Institutional care tends to segregate children and adolescents by age and sex and from other young people and adults in their communities. Instead of encouraging independence and creative thinking, institutional life tends to promote dependency and discourage autonomy. For many adolescents, the transition from life in an



UNICEF/HQ96-1223/Giacomo Pirozzi

At a community school in Nthombimbi, Zambia, children gather around a water pump. The school is staffed and maintained by the community for children who cannot afford to attend formal school. Many of the pupils are orphans.

[4] Powell GM, Morreira S, Rudd C, Ngonyama PP. 1994. *Child Welfare Policy and Practice in Zimbabwe* (study of the Department of Pediatrics of the University of Zimbabwe and the Zimbabwe Department of Social Welfare). Zimbabwe: UNICEF.

institution to positive integration and self-support as a young adult in the community is difficult. They lack essential social and cultural skills and a network of connections in the community. In most developing countries, the extended family and community are still the most important social safety nets, and disconnection from these support systems greatly increases an orphan's long-term vulnerability. Poorly prepared to integrate into community life, and with little knowledge of potential risks and how to protect themselves, these young people may feel hopeless and depressed and become involved in harmful activities.

Surveys consistently show that many children in residential institutions have at least one living parent or relative. In many parts of the world, impoverished families sometimes use "orphanages" as an economic-coping mechanism to secure access to services or better material conditions for their children. As a result, institutional care becomes an expensive way to cope with poverty and a growing orphan population. Experience indicates, however, that these children's vital links to local family and clan structures may well decay if institutional care is prolonged. Institutionalized orphans who suffer this loss of family identity and sense of community belonging are at greater risk of losing future support networks than orphans in foster homes or other community settings.

Another drawback to residential care is that its cost per child is substantially higher than the cost of supporting care by a family. The ongoing costs of supporting one child in institutional care could support many times that number of children in family-based care. With the large and growing number of orphans in the countries most affected by HIV/AIDS, it is essential that available resources be used to benefit as many children as effectively as possible.

For children who slip through the extended family safety net, arrangements preferable to traditional institutional care include foster placements, local adoption, surrogate family groups integrated into communities, and smaller-scale group residential care in homelike settings. In some cases, a group of siblings may decide to remain in their home after the death of both parents. With adequate support from members of the extended family or community residents, this can be an acceptable solution because it enables the children to maintain their closest remaining relationships. In rural areas, it may also enable them to retain the use of their parents' land. Lastly, some residential institutions are recognizing their limited capacity to absorb more children and adapting their programs to provide outreach and day support for children in vulnerable households.

To provide alternatives for children who may otherwise end up on the streets or in institutional care, these options for improved care for orphans must become far more widespread than they are at present. Placement in residential institutions is best reserved as a last resort where better care options have not yet been developed or as a temporary measure pending placement in a family.

A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS

In March 2004, the UNAIDS Committee of Cosponsoring Organizations endorsed a *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, a consensus document on how best to respond to the growing number of orphans and other children made vulnerable by HIV/AIDS. The UNAIDS endorsement followed the first Global Partners' Forum convened by UNICEF, with support from UNAIDS, in October 2003. At the Forum, more than 70 practitioners and policymakers from bilateral and multilateral donors, United Nations agencies, foundations, nongovernmental and faith-based organizations, academic and research institutions, and other civil society organizations affirmed the draft framework.

UNICEF/HQ02-0567/Giacomo Pirozzi

A boy hugs his grandmother in Maseru, the capital of Lesotho. He is one of three grandchildren she cares for following the death of their parents from AIDS.

The *Framework* provides a policy and programmatic basis to achieve the goals set for orphans and other children made vulnerable by HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). It brings together global goals, principles, strategies, programming guidance, and key indicators of progress. At the *Framework*'s core are five strategies first presented in the *Children on the Brink* series. The *Framework* also incorporates program guidance based on principles for programming included in *Children on the Brink 2002.*

The *Framework* is based on lessons learned from around the world – not just from Africa – over many years. It considers families and communities the foundation of an effective scaled-up response, recognizes the front-line role of community-based organizations, and includes children and young people as key partners. It calls for action in support of all vulnerable children and the communities in which they reside, and strongly advocates that action in support of orphans and vulnerable children be incorporated into existing policy frameworks and development mechanisms and programs. The *Framework* recognizes that targeting only children affected by HIV/AIDS can exacerbate stigma and discrimination, and advocates that protection, care, and support for orphans and vulnerable children be integrated with other programs designed to reduce poverty, promote children's well-being, and combat HIV/AIDS.

The *Framework* provides a shared basis for developing collaborative action by all groups concerned with the safety and well-being of orphans and vulnerable children. Its implementation will require a broad partnership among many government sectors, donors, and civil society organizations. Individual groups and organizations that apply its guidance to their programs in support of orphans and vulnerable children will find that their activities are strengthened accordingly. Implementation of the *Framework* will also make a significant

contribution toward achieving the goals of such global commitments as the Millennium Development Goals, Education for All, and the Elimination of the Worst Forms of Child Labor.

The five key strategies put forward in the *Framework* are:

1. Strengthen the 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.

When HIV/AIDS begins to affect a household, family relationships provide the most immediate source of support. Recognizing this reality, strengthening the capacity of families to care for and protect orphans and vulnerable children must be at the core of a response strategy. The vast majority of these children continue to live with surviving parents or their extended family, and even most children living on the streets maintain ties with their families. Families are thus the best hope but are in need of support from outside sources to meet immediate survival needs and, in the longer term, to:

- Improve their household economic capacity
- Provide psychosocial support
- Strengthen and support their child care capacity
- Support succession planning
- Enable parents to live longer, better, and in greater dignity
- Strengthen young people's life skills, including how to avoid HIV infection

2. Mobilize and support community-based responses to provide both immediate and long-term support to vulnerable households.

After families, the community is the next safety net. Thousands of grassroots groups are responding to the needs of orphans and vulnerable children in countries affected by HIV/AIDS. Most of their initiatives represent spontaneous efforts of faith-based or other community groups, while some have been mobilized or supported by outside organizations. In some cases, communities are supporting child-headed households that lack support from the extended family.

Reinforcing the capacity of communities to support, protect, and provide care is fundamentally important to building a response that will match the scale of the HIV/AIDS crisis and its long-term impact on children. Actions that communities have taken to protect and support orphans and vulnerable children include:

- Visiting the most vulnerable children to provide emotional and material support
- Alerting authorities to urgent problems
- Developing community gardens to assist vulnerable households
- Planting low-maintenance crops and distributing the produce to vulnerable households
- Organizing cooperative child care programs
- Raising funds for relief assistance to vulnerable individuals
- Organizing youth groups that use drama and music to encourage HIV prevention and compassion for people living with AIDS, their families, and orphans
- Organizing sports and recreation activities to promote the integration of orphans
- Encouraging foster families to send orphans to school
- Encouraging schools to waive fees for orphans and vulnerable children
- Organizing community schools
- Working to prevent the spread of HIV
- Providing skills training

3. Ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration, and others.

The UNGASS Declaration of Commitment calls for parity and increased access to essential services for orphans and vulnerable children. Governments have an obligation to provide services to all children and communities. Partnerships with nongovernmental and civil society organizations are often critical in extending essential services to vulnerable communities. For greater impact and sustainability, there is an urgent need for increased resources, innovative services, and interventions that build the capacity, quality, collaboration, and reach of service delivery programs.

Service delivery priorities and strategies vary by country but usually focus on:

- School enrollment and attendance
- Birth registration for orphans and vulnerable children
- Access to basic health and nutrition services
- Access to safe water and sanitation
- Judicial protections for vulnerable children
- Placement services for children without family care
- Local planning and action

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

While the family has primary responsibility to care for and protect children, national governments have the ultimate responsibility to protect them and ensure their well-being. To meet this obligation, governments must undertake and receive support for a broad range of multisectoral actions. No single ministry has sole jurisdiction over issues affecting orphans and vulnerable children. Governments must find ways to bring together education, finance, health, social welfare, and other ministries to respond in a coordinated and effective way. Key actions include:

- Adopting national policies, strategies, and action plans for protecting orphans and vulnerable children in the context of broader development and poverty reduction plans
- Enhancing government capacity to provide services and protect children and families
- Ensuring that resources reach communities in need
- Developing and enforcing a legislative framework that prohibits discrimination, protects inheritance rights, eliminates the worst forms of child labor, and protects children from abuse
- Providing protection and placement for children without adequate family care
- Establishing mechanisms to ensure ongoing information exchange and collaboration among all stakeholders

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

No single stakeholder has the resources and capacity to mount an effective national response to the impacts of HIV/AIDS. Collaboration is essential at community, district, national, regional, and global levels. Public, private, and civil society groups must develop a sense of shared responsibility for the protection and well-being of orphans and vulnerable children. Fundamental steps in building a supportive environment include increasing awareness of the impacts of HIV/AIDS on children and families among policymakers, community leaders, organizations, and the public; generating a sense of shared responsibility and a vision of how to support and protect those affected; and reducing fear, ignorance, denial, stigma, and discrimination by increasing access to information, challenging myths, and transforming the public perception of HIV/AIDS. Actions to build a more supportive environment can be taken at the national, district, or local levels. They include:

- Conducting a collaborative situation analysis to heighten stakeholders' awareness and to mobilize collective action
- Developing an inclusive national plan of action for orphans and vulnerable children
- Generating a broad sense of responsibility for vulnerable children
- Mobilizing influential leaders to reduce stigma, silence, and discrimination
- Strengthening and supporting social mobilization activities

The challenge of protecting the rights and ensuring the well-being of children affected by HIV/AIDS is unprecedented. There is no quick fix or easy solution, but with a committed partnership to pursue the five strategies outlined above and to continually assess and improve programs, we can relieve massive human suffering and secure a better future for orphans and vulnerable children living in a world with HIV and AIDS.

Child Participation

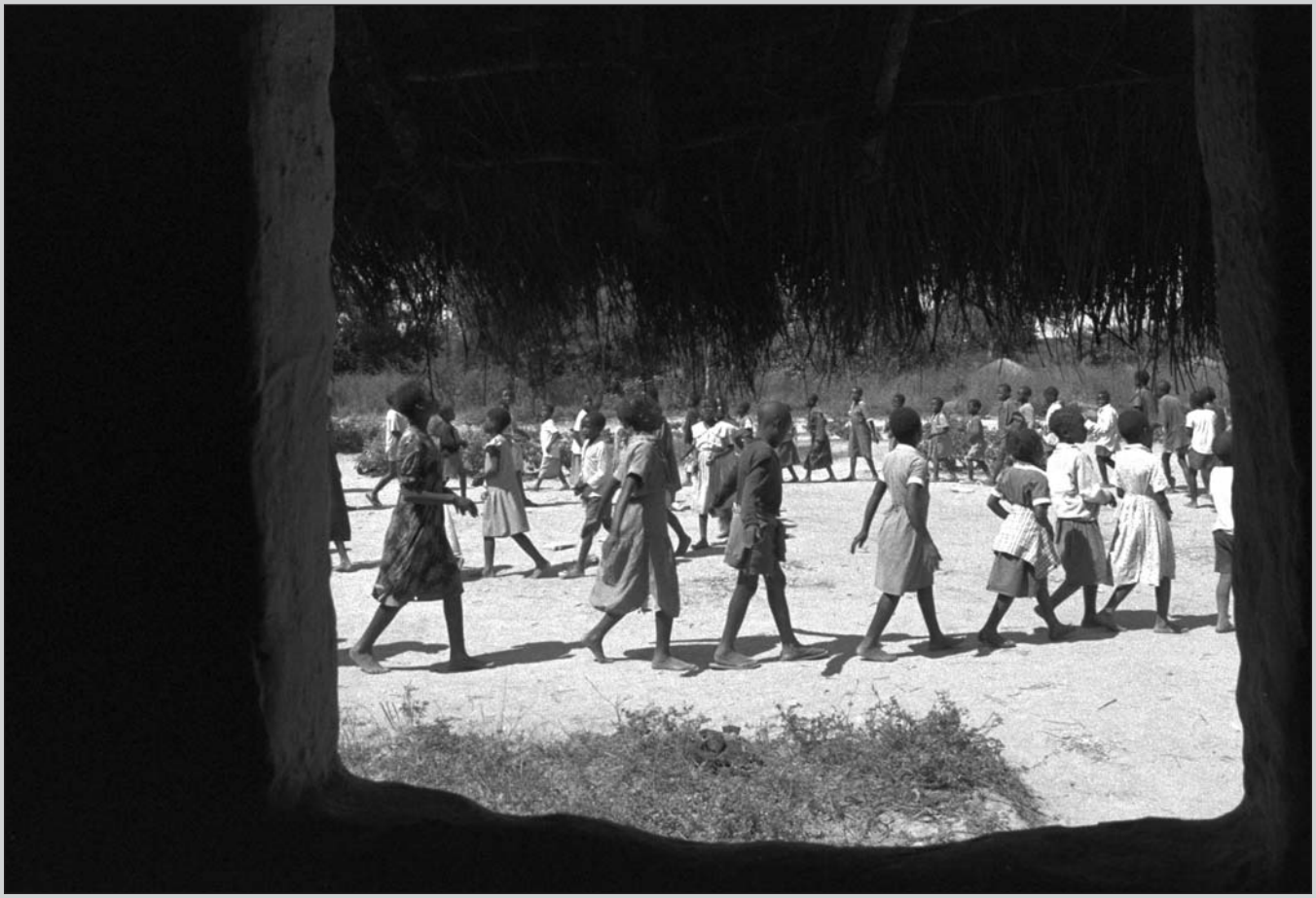
Children and adolescents should be involved in planning and carrying out efforts to mitigate the impact of HIV/AIDS in their communities. They can be a vital part of the solution by providing psychosocial support to peers and younger boys and girls. They can help those who are ill with HIV/AIDS with household tasks. They can participate in dramas, musical activities, youth newspapers, and peer counseling to influence behavior change within the community. They should be seen as important contributors and agents of change, not simply as audiences for HIV/AIDS messages and beneficiaries of HIV/AIDS programming.

Hopelessness and a sense of powerlessness are two of the biggest obstacles to HIV prevention. By actively involving children and adolescents, programs provide them with important information and help them develop essential self-esteem. Efforts to help young people gain control over their destiny and develop hope for the future increase the likelihood they will choose behaviors that will help them avoid HIV infection.

Young people in households with chronically ill parents or caregivers should participate in decision-making processes regarding their future foster care. This is integral to succession planning, which helps HIV-positive parents prepare for the future and give their children the support they will need. Inheritance rights are less likely to be violated when a parent has a known succession plan.

It is up to us all to ensure children's meaningful participation and rights in all matters that concern their safety, well-being, development, and future role in society.

Appendices



UNICEF/HQ98-1029/Giacomo Pirozzi

Children dance and sing in the playground of a community school near Livingstone, Zambia. The local community staffs and maintains the school for children unable to attend formal schools. Many of the students are orphans.

APPENDICES

Table 1: Sub-Saharan Africa: Orphan estimates by type and cause, 2003

Country	All children 0-17 (thousands)	Total orphans as a percent of all children	Total number of orphans	Total number of orphans due to AIDS	Orphans due to AIDS as a percent of all orphans	Maternal orphans			Paternal orphans			Double orphans			Children orphaned in 2003
						AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	
Angola	7,000	15%	1,000,000	110,000	11%	86,000	420,000	510,000	79,000	620,000	700,000	67,000	130,000	200,000	110,000
Benin	4,000	9%	340,000	34,000	10%	22,000	130,000	150,000	21,000	210,000	230,000	11,000	32,000	43,000	39,000
Botswana	800	20%	160,000	120,000	77%	110,000	20,000	130,000	75,000	23,000	99,000	62,000	2,000	64,000	25,000
Burkina Faso	8,000	11%	830,000	260,000	32%	190,000	270,000	450,000	160,000	370,000	530,000	100,000	58,000	160,000	89,000
Burundi	4,000	15%	660,000	200,000	30%	140,000	230,000	370,000	130,000	310,000	430,000	90,000	54,000	140,000	71,000
Cameroon	8,000	12%	930,000	240,000	25%	160,000	310,000	470,000	140,000	470,000	600,000	83,000	66,000	150,000	120,000
Central African Republic	2,000	16%	290,000	110,000	39%	83,000	81,000	160,000	71,000	120,000	190,000	48,000	17,000	65,000	36,000
Chad	4,000	12%	500,000	96,000	19%	65,000	170,000	240,000	59,000	280,000	340,000	35,000	40,000	76,000	61,000
Congo	2,000	13%	260,000	97,000	37%	68,000	70,000	140,000	56,000	110,000	170,000	33,000	14,000	47,000	29,000
Congo, Democratic Rep. of	24,000	17%	4,200,00	770,000	18%	570,000	1,600,000	2,200,000	490,000	2,300,000	2,800,000	370,000	430,000	790,000	480,000
Côte d'Ivoire	7,000	13%	940,000	310,000	32%	230,000	260,000	490,000	180,000	460,000	640,000	120,000	62,000	180,000	110,000
Djibouti	300	11%	33,000	5,000	15%	3,000	12,000	15,000	3,000	19,000	22,000	1,000	2,000	4,000	4,000
Equatorial Guinea*	200	13%	24,000					13,000			16,000			5,000	3,000
Eritrea	2,000	10%	230,000	39,000	17%	24,000	79,000	100,000	21,000	130,000	150,000	9,000	14,000	23,000	26,000
Ethiopia	35,000	11%	3,900,000	720,000	18%	460,000	1,400,000	1,800,000	410,000	2,100,000	2,600,000	190,000	270,000	460,000	470,000
Gabon	500	11%	57,000	14,000	24%	9,000	18,000	27,000	8,000	30,000	38,000	4,000	3,000	7,000	7,000
Gambia	500	9%	45,000	2,000	5%	1,000	17,000	18,000	1,000	30,000	31,000	500	4,000	4,000	5,000
Ghana	10,000	10%	1,000,000	170,000	17%	120,000	370,000	490,000	96,000	540,000	640,000	49,000	75,000	120,000	110,000
Guinea	4,000	10%	420,000	35,000	8%	24,000	180,000	200,000	22,000	250,000	280,000	14,000	45,000	59,000	46,000
Guinea-Bissau*	800	11%	81,000					36,000			56,000			11,000	10,000
Kenya	15,000	11%	1,700,000	650,000	37%	560,000	500,000	1,100,000	380,000	750,000	1,100,000	330,000	110,000	450,000	230,000
Lesotho	1,000	19%	180,000	100,000	56%	79,000	45,000	120,000	64,000	49,000	110,000	49,000	7,000	56,000	28,000
Liberia	2,000	13%	230,000	36,000	15%	27,000	92,000	120,000	24,000	130,000	160,000	17,000	25,000	42,000	28,000
Madagascar	9,000	11%	1,000,000	30,000	3%	17,000	460,000	480,000	17,000	640,000	660,000	7,000	120,000	130,000	110,000
Malawi	7,000	14%	1,000,000	500,000	48%	360,000	260,000	610,000	310,000	350,000	660,000	190,000	47,000	240,000	130,000
Mali	8,000	10%	730,000	75,000	10%	49,000	290,000	330,000	43,000	430,000	470,000	21,000	59,000	80,000	86,000
Mauritania	1,000	9%	140,000	2,000	1%	900	57,000	58,000	900	95,000	96,000	300	14,000	14,000	16,000
Mozambique	10,000	15%	1,500,000	470,000	31%	330,000	480,000	810,000	280,000	690,000	980,000	190,000	110,000	290,000	200,000
Namibia	1,000	12%	120,000	57,000	48%	41,000	30,000	71,000	33,000	40,000	73,000	19,000	5,000	24,000	21,000
Niger	6,000	11%	680,000	24,000	4%	14,000	310,000	320,000	13,000	420,000	430,000	5,000	66,000	71,000	80,000
Nigeria	69,000	10%	7,000,000	1,800,000	26%	1,200,000	2,400,000	3,600,000	1,000,000	3,300,000	4,400,000	490,000	420,000	920,000	870,000
Rwanda	5,000	17%	810,000	160,000	20%	140,000	370,000	510,000	130,000	420,000	550,000	120,000	120,000	240,000	65,000
Senegal	5,000	9%	460,000	17,000	4%	11,000	180,000	190,000	10,000	310,000	320,000	4,000	50,000	54,000	51,000
Sierra Leone*	2,000	14%	350,000					160,000			260,000			68,000	40,000
Somalia*	7,000	11%	770,000					360,000			510,000			96,000	83,000
South Africa	17,000	13%	2,200,000	1,100,000	48%	740,000	440,000	1,200,000	570,000	830,000	1,400,000	290,000	74,000	360,000	370,000
Sudan	16,000	9%	1,300,000	91,000	7%	55,000	520,000	570,000	49,000	840,000	890,000	18,000	99,000	120,000	150,000
Swaziland	600	18%	100,000	65,000	63%	48,000	21,000	69,000	42,000	24,000	66,000	29,000	3,000	32,000	17,000
Tanzania, United Republic of	14,000	14%	2,500,000	980,000	40%	710,000	650,000	1,400,000	580,000	1,000,000	1,600,000	370,000	130,000	500,000	310,000
Togo	2,000	9%	240,000	54,000	23%	37,000	74,000	110,000	32,000	130,000	160,000	18,000	17,000	34,000	31,000
Uganda	18,000	14%	2,000,000	940,000	48%	700,000	450,000	1,100,000	570,000	700,000	1,300,000	380,000	87,000	470,000	190,000
Zambia	6,000	19%	1,100,000	630,000	60%	510,000	200,000	710,000	370,000	290,000	670,000	290,000	33,000	320,000	120,000
Zimbabwe	7,000	19%	1,300,000	980,000	78%	800,000	130,000	940,000	560,000	190,000	760,000	420,000	14,000	440,000	160,000
Total	**350,000**	**12.3%**	**43,400,000**	**12,300,000**	**28%**	**8,900,000**	**14,100,000**	**23,000,000**	**7,300,000**	**20,900,000**	**28,200,000**	**4,600,000**	**3,100,000**	**7,700,000**	**5,200,000**

Note: Due to rounding, totals may not equal sum of column or row figures.
** These countries have insufficient HIV prevalence information to make an estimate of orphans due to AIDS.*

Asia: Orphan estimates by type, 2003

Country	All children 0-17 (thousands)	Total orphans as a percent of all children	Total number of orphans	Maternal orphans	Paternal orphans	Double orphans	Children orphaned in 2003
Afghanistan	14,000	12%	1,600,000	710,000	1,100,000	210,000	180,000
Bangladesh	59,000	9%	5,300,000	2,500,000	3,400,000	650,000	540,000
Bhutan	1,000	7%	90,000	35,000	61,000	7,000	9,000
Brunei Darussalam	100	4%	4,200	1,000	3,000	100	500
Cambodia	7,000	9%	670,000	280,000	480,000	95,000	77,000
China	370,000	6%	20,600,000	5,800,000	15,900,000	1,000,000	2,300,000
Fiji	400	6%	25,000	9,000	18,000	2,000	3,000
India	400,000	9%	35,000,000	15,700,000	23,300,000	4,000,000	3,700,000
Indonesia	76,000	8%	6,100,000	2,300,000	4,400,000	560,000	620,000
Iran (Islamic Republic of)	29,000	7%	2,100,000	790,000	1,400,000	130,000	200,000
Korea, Democratic People's Rep. of	7,000	10%	710,000	200,000	560,000	52,000	90,000
Korea, Republic of	11,000	6%	630,000	130,000	520,000	22,000	71,000
Lao People's Democratic Republic	3,000	10%	290,000	130,000	210,000	42,000	30,000
Malaysia	10,000	5%	480,000	140,000	370,000	23,000	57,000
Mongolia	1,000	8%	78,000	30,000	55,000	6,000	8,000
Myanmar	20,000	9%	1,900,000	710,000	1,400,000	200,000	200,000
Nepal	11,000	9%	1,000,000	480,000	700,000	140,000	110,000
Pakistan	77,000	6%	4,800,000	1,700,000	3,400,000	300,000	540,000
Papua New Guinea	2,000	9%	220,000	94,000	150,000	21,000	23,000
Philippines	37,000	6%	2,100,000	720,000	1,500,000	130,000	230,000
Sri Lanka	6,000	5%	340,000	86,000	270,000	15,000	39,000
Thailand	20,000	7%	1,400,000	400,000	1,100,000	97,000	170,000
Viet Nam	30,000	7%	2,100,000	750,000	1,500,000	160,000	220,000
Total	**1,200,000**	**7.3%**	**87,600,000**	**33,700,000**	**61,800,000**	**7,900,000**	**9,500,000**

Note: Due to rounding, totals may not equal sum of column or row figures.

Latin America and the Caribbean: Orphan estimates by type, 2003

Country	All children 0-17 (thousands)	Total orphans as a percent of all children	Total number of orphans	Maternal orphans	Paternal orphans	Double orphans	Children orphaned in 2003
Argentina	12,000	6%	750,000	140,000	630,000	25,000	87,000
Bahamas	100	7%	7,600	2,000	6,000	500	800
Barbados	65	5%	3,700	800	3,000	<100	400
Belize	100	5%	5,600	2,000	4,000	200	800
Bolivia	4,000	8%	340,000	130,000	230,000	23,000	35,000
Brazil	58,000	7%	4,300,000	1,200,000	3,300,000	210,000	470,000
Chile	5,000	4%	230,000	46,000	190,000	5,000	28,000
Colombia	17,000	5%	910,000	250,000	690,000	31,000	100,000
Costa Rica	1,000	4%	50,000	12,000	39,000	1,000	6,000
Cuba	3,000	4%	130,000	31,000	100,000	3,000	15,000
Dominican Republic	4,000	7%	260,000	85,000	190,000	12,000	30,000
Ecuador	5,000	6%	290,000	91,000	220,000	12,000	33,000
El Salvador	3,000	6%	180,000	53,000	130,000	7,000	19,000
Guatemala	7,000	8%	510,000	190,000	350,000	29,000	57,000
Guyana	400	9%	33,000	12,000	23,000	2,000	4,000
Haiti	4,000	15%	610,000	320,000	390,000	99,000	56,000
Honduras	3,000	5%	180,000	53,000	140,000	15,000	23,000
Jamaica	1,000	4%	45,000	14,000	33,000	1,000	6,000
Mexico	42,000	5%	1,900,000	520,000	1,500,000	57,000	230,000
Nicaragua	3,000	6%	150,000	53,000	100,000	6,000	16,000
Panama	1,000	4%	48,000	12,000	37,000	1,000	6,000
Paraguay	3,000	6%	150,000	48,000	110,000	6,000	18,000
Peru	11,000	6%	720,000	240,000	510,000	34,000	77,000
Suriname	200	6%	13,000	4,000	9,000	600	1,000
Trinidad and Tobago	400	7%	28,000	9,000	21,000	1,000	4,000
Uruguay	1,000	6%	62,000	10,000	53,000	2,000	7,000
Venezuela	10,000	5%	460,000	120,000	350,000	14,000	56,000
Total	**200,000**	**6.2%**	**12,400,000**	**3,700,000**	**9,300,000**	**600,000**	**1,400,000**
Total all regions	**1,700,000**	**8.4%**	**143,000,000**	**60,300,000**	**99,300,000**	**16,200,000**	**16,100,000**

Note: Due to rounding, totals may not equal sum of column or row figures.

Table 2: Orphans by type, cause, and year for sub-Saharan Africa, Asia, and Latin America and the Caribbean

Region	Year	All children 0-17 (thousands)	Total orphans as a percent of all children	Total number of orphans	Total number of orphans due to AIDS	Orphans due to AIDS as a percent of all orphans	Maternal orphans	Paternal orphans	Double orphans	Children orphaned during year
Sub-Saharan Africa	1990	260,000	10.9%	28,400,000	550,000	1.9%	12,800,000	19,100,000	3,500,000	3,200,000
	1995	290,000	11.2%	32,500,000	3,000,000	9.2%	15,200,000	21,700,000	4,300,000	4,000,000
	2000	330,000	11.9%	39,200,000	8,500,000	21.7%	19,800,000	25,800,000	6,400,000	4,900,000
	2003	350,000	12.3%	43,400,000	12,300,000	28.3%	23,000,000	28,200,000	7,700,000	5,200,000
	2010	400,000	12.5%	50,000,000	18,400,000	36.8%	27,600,000	32,000,000	9,600,000	5,300,000
Asia*	1990	1,100,000	8.8%	96,600,000	–	–	41,200,000	67,200,000	11,800,000	10,300,000
	1995	1,100,000	8.6%	94,500,000	–	–	39,100,000	65,900,000	10,500,000	10,000,000
	2000	1,200,000	7.5%	90,200,000	–	–	35,700,000	63,200,000	8,700,000	9,700,000
	2003	1,200,000	7.3%	87,600,000	–	–	33,700,000	61,800,000	7,900,000	9,500,000
	2010	1,200,000	6.7%	80,100,000	–	–	28,400,000	57,700,000	6,100,000	8,700,000
Latin America and the Caribbean*	1990	190,000	7.1%	13,400,000	–	–	4,400,000	9,600,000	800,000	1,400,000
	1995	190,000	7.0%	13,300,000	–	–	4,300,000	9,700,000	700,000	1,400,000
	2000	200,000	6.4%	12,800,000	–	–	3,900,000	9,500,000	700,000	1,400,000
	2003	200,000	6.2%	12,400,000	–	–	3,700,000	9,300,000	600,000	1,400,000
	2010	200,000	6.0%	12,000,000	–	–	3,300,000	9,100,000	500,000	1,400,000
All Regions	1990	1,600,000	8.7%	138,400,000	–	–	58,400,000	95,900,000	16,100,000	14,900,000
	1995	1,600,000	8.8%	140,300,000	–	–	58,600,000	97,300,000	15,500,000	15,400,000
	2000	1,700,000	8.4%	142,200,000	–	–	59,400,000	98,500,000	15,800,000	16,000,000
	2003	1,700,000	8.4%	143,400,000	–	–	60,300,000	99,300,000	16,200,000	16,100,000
	2010	1,800,000	7.9%	142,100,000	–	–	59,300,000	98,800,000	16,200,000	15,400,000

Note: Due to rounding, totals may not equal sum of column or row figures.
** These regions have insufficient HIV prevalence information to make an estimate of orphans due to AIDS.*

Table 3: Sub-Saharan Africa: Number of orphans by year, country, and region

Country	1990	1995	2000	2003	2010	Orphans as a percent of all children: 1990	1995	2000	2003	2010
Angola	690,000	790,000	920,000	1,000,000	1,200,000	14%	14%	15%	15%	14%
Benin	250,000	280,000	320,000	340,000	370,000	10%	9%	9%	9%	9%
Botswana	50,000	58,000	120,000	160,000	190,000	7%	7%	15%	20%	24%
Burkina Faso	510,000	630,000	780,000	830,000	910,000	10%	10%	11%	11%	10%
Burundi	360,000	460,000	600,000	660,000	750,000	12%	13%	15%	15%	14%
Cameroon	670,000	710,000	820,000	930,000	1,100,000	11%	11%	11%	12%	14%
Central African Republic	180,000	200,000	260,000	290,000	350,000	13%	13%	15%	16%	18%
Chad	340,000	380,000	440,000	500,000	600,000	12%	11%	12%	12%	12%
Congo	130,000	170,000	230,000	260,000	300,000	10%	11%	13%	13%	12%
Congo, Democratic Republic of	2,400,000	2,900,000	3,700,000	4,200,000	4,900,000	14%	15%	17%	17%	17%
Côte d'Ivoire	610,000	740,000	880,000	940,000	1,000,000	10%	11%	12%	13%	13%
Djibouti	25,000	27,000	31,000	33,000	36,000	11%	11%	11%	11%	10%
Equatorial Guinea	18,000	19,000	22,000	24,000	31,000	14%	13%	13%	13%	15%
Eritrea	170,000	190,000	210,000	230,000	250,000	11%	11%	10%	10%	10%
Ethiopia	2,800,000	3,200,000	3,700,000	3,900,000	4,700,000	12%	11%	11%	11%	11%
Gabon	45,000	48,000	53,000	57,000	68,000	10%	10%	10%	11%	12%
Gambia	48,000	47,000	45,000	45,000	45,000	12%	10%	9%	9%	8%
Ghana	880,000	930,000	980,000	1,000,000	1,000,000	11%	10%	10%	10%	10%
Guinea	360,000	380,000	400,000	420,000	470,000	12%	11%	10%	10%	10%
Guinea-Bissau	65,000	69,000	75,000	81,000	100,000	13%	12%	11%	11%	11%
Kenya	1,300,000	1,300,000	1,600,000	1,700,000	1,900,000	11%	10%	11%	11%	11%
Lesotho	99,000	98,000	140,000	180,000	210,000	12%	11%	14%	19%	23%
Liberia	140,000	170,000	210,000	230,000	290,000	11%	11%	12%	13%	13%
Madagascar	790,000	870,000	960,000	1,000,000	1,100,000	13%	12%	12%	11%	11%
Malawi	560,000	660,000	880,000	1,000,000	1,300,000	11%	11%	13%	14%	15%
Mali	520,000	580,000	660,000	730,000	870,000	10%	10%	10%	10%	9%
Mauritania	110,000	120,000	130,000	140,000	160,000	11%	10%	10%	9%	9%
Mozambique	930,000	1,000,000	1,300,000	1,500,000	1,900,000	12%	12%	14%	15%	17%
Namibia	74,000	74,000	90,000	120,000	180,000	10%	9%	10%	12%	18%
Niger	490,000	560,000	630,000	680,000	820,000	12%	11%	11%	11%	10%
Nigeria	5,000,000	5,500,000	6,300,000	7,000,000	8,200,000	10%	10%	10%	10%	10%
Rwanda	550,000	750,000	830,000	810,000	800,000	14%	18%	19%	17%	14%
Senegal	400,000	420,000	450,000	460,000	480,000	10%	10%	10%	9%	9%
Sierra Leone	260,000	290,000	330,000	350,000	400,000	14%	14%	14%	14%	14%
Somalia	520,000	610,000	720,000	770,000	850,000	11%	12%	12%	11%	10%
South Africa	1,500,000	1,500,000	1,800,000	2,200,000	3,100,000	10%	9%	10%	13%	19%
Sudan	1,200,000	1,300,000	1,300,000	1,300,000	1,500,000	10%	9%	9%	9%	9%
Swaziland	50,000	53,000	76,000	100,000	130,000	11%	10%	14%	18%	24%
Tanzania, United Republic of	1,300,000	1,500,000	2,100,000	2,500,000	2,900,000	9%	10%	12%	14%	15%
Togo	170,000	180,000	210,000	240,000	280,000	9%	9%	9%	9%	10%
Uganda	950,000	1,400,000	1,800,000	2,000,000	1,900,000	10%	13%	15%	14%	11%
Zambia	420,000	640,000	930,000	1,100,000	1,200,000	10%	13%	18%	19%	19%
Zimbabwe	370,000	570,000	1,000,000	1,300,000	1,400,000	7%	9%	16%	19%	21%
Total	**28,400,000**	**32,500,000**	**39,200,000**	**43,400,000**	**50,000,000**	**11%**	**11%**	**12%**	**12%**	**12%**

Note: Due to rounding, totals may not equal sum of column or row figures.

Table 3: Asia: Number of orphans by year, country, and region

Country	1990	1995	2000	2003	2010	Orphans as a percent of all children: 1990	1995	2000	2003	2010
Afghanistan	1,300,000	1,400,000	1,500,000	1,600,000	1,800,000	13%	12%	12%	12%	11%
Bangladesh	5,400,000	5,500,000	5,400,000	5,300,000	4,900,000	11%	10%	10%	9%	8%
Bhutan	95,000	93,000	91,000	90,000	87,000	11%	10%	8%	7%	6%
Brunei Darussalam	4,500	4,500	4,300	4,200	4,000	4%	4%	4%	4%	4%
Cambodia	560,000	580,000	650,000	670,000	690,000	10%	9%	10%	9%	9%
China	24,700,000	23,500,000	21,500,000	20,600,000	18,000,000	6%	6%	6%	6%	5%
Fiji	24,000	25,000	25,000	25,000	25,000	7%	7%	6%	6%	6%
India	37,900,000	37,100,000	35,800,000	35,000,000	32,300,000	11%	10%	9%	9%	8%
Indonesia	7,600,000	7,300,000	6,500,000	6,100,000	5,200,000	10%	9%	9%	8%	7%
Iran (Islamic Republic of)	2,400,000	2,400,000	2,300,000	2,100,000	1,600,000	9%	8%	8%	7%	6%
Korea, Dem. People's Rep. of	440,000	500,000	650,000	710,000	740,000	7%	7%	9%	10%	12%
Korea, Republic of	850,000	780,000	680,000	630,000	590,000	6%	6%	6%	6%	6%
Lao People's Dem. Republic	280,000	290,000	300,000	290,000	280,000	13%	12%	11%	10%	9%
Malaysia	460,000	480,000	490,000	480,000	470,000	6%	5%	5%	5%	5%
Mongolia	110,000	100,000	88,000	78,000	60,000	10%	9%	8%	8%	6%
Myanmar	2,100,000	2,000,000	1,900,000	1,900,000	1,700,000	11%	10%	10%	9%	9%
Nepal	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	12%	11%	10%	9%	8%
Pakistan	4,400,000	4,600,000	4,700,000	4,800,000	4,800,000	8%	7%	7%	6%	5%
Papua New Guinea	210,000	220,000	220,000	220,000	220,000	12%	11%	10%	9%	8%
Philippines	2,200,000	2,200,000	2,200,000	2,100,000	2,000,000	7%	7%	6%	6%	5%
Sri Lanka	420,000	400,000	370,000	340,000	310,000	6%	6%	6%	5%	5%
Thailand	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	7%	7%	7%	7%	7%
Viet Nam	2,700,000	2,600,000	2,300,000	2,100,000	1,800,000	9%	8%	7%	7%	6%
Total	**96,600,000**	**94,500,000**	**90,200,000**	**87,600,000**	**80,100,000**	**9%**	**8%**	**8%**	**7%**	**7%**

Note: Due to rounding, totals may not equal sum of column or row figures.

Table 3: Latin America and the Caribbean: Number of orphans by year, country, and region

Country	1990	1995	2000	2003	2010	Orphans as a percent of all children: 1990	1995	2000	2003	2010
Argentina	820,000	800,000	770,000	750,000	720,000	7%	7%	7%	6%	6%
Bahamas	5,600	6,700	8,000	7,600	7,200	6%	7%	8%	7%	7%
Barbados	3,600	3,400	3,600	3,700	3,700	4%	4%	5%	5%	6%
Belize	4,100	4,500	5,100	5,600	7,100	4%	4%	4%	5%	6%
Bolivia	380,000	360,000	350,000	340,000	320,000	11%	10%	9%	8%	7%
Brazil	4,900,000	4,900,000	4,600,000	4,300,000	4,000,000	8%	8%	8%	7%	7%
Chile	240,000	230,000	230,000	230,000	230,000	5%	5%	4%	4%	5%
Colombia	930,000	950,000	920,000	910,000	940,000	6%	6%	6%	5%	5%
Costa Rica	46,000	47,000	49,000	50,000	50,000	4%	4%	4%	4%	4%
Cuba	130,000	130,000	130,000	130,000	120,000	4%	5%	4%	4%	5%
Dominican Republic	230,000	240,000	250,000	260,000	260,000	7%	7%	7%	7%	7%
Ecuador	340,000	320,000	300,000	290,000	280,000	7%	7%	6%	6%	5%
El Salvador	230,000	210,000	190,000	180,000	170,000	9%	8%	6%	6%	5%
Guatemala	460,000	480,000	500,000	510,000	520,000	9%	9%	8%	8%	7%
Guyana	28,000	29,000	31,000	33,000	35,000	8%	8%	8%	9%	9%
Haiti	490,000	590,000	630,000	610,000	560,000	13%	15%	15%	15%	13%
Honduras	150,000	160,000	170,000	180,000	200,000	6%	6%	5%	5%	5%
Jamaica	46,000	46,000	45,000	45,000	53,000	4%	4%	4%	4%	5%
Mexico	2,200,000	2,100,000	2,000,000	1,900,000	1,900,000	6%	5%	5%	5%	4%
Nicaragua	170,000	170,000	160,000	150,000	140,000	8%	7%	6%	6%	5%
Panama	48,000	48,000	48,000	48,000	52,000	5%	5%	4%	4%	4%
Paraguay	120,000	130,000	140,000	150,000	160,000	6%	6%	6%	6%	5%
Peru	850,000	800,000	740,000	720,000	680,000	8%	7%	7%	6%	6%
Suriname	11,000	12,000	13,000	13,000	14,000	6%	7%	6%	6%	7%
Trinidad & Tobago	28,000	28,000	29,000	28,000	27,000	6%	6%	6%	7%	7%
Uruguay	69,000	66,000	63,000	62,000	57,000	7%	7%	6%	6%	6%
Venezuela	440,000	450,000	450,000	460,000	490,000	5%	5%	5%	5%	5%
Total	**13,400,000**	**13,300,000**	**12,800,000**	**12,400,000**	**12,000,000**	**7%**	**7%**	**6%**	**6%**	**6%**
Total all regions	**138,000,000**	**140,000,000**	**142,000,000**	**143,000,000**	**142,000,000**	**9%**	**9%**	**8%**	**8%**	**8%**

Note: Due to rounding, totals may not equal sum of column or row figures.

Appendix 2

Methods to Estimate and Project the Impact of HIV/AIDS on the Number of Orphaned Children

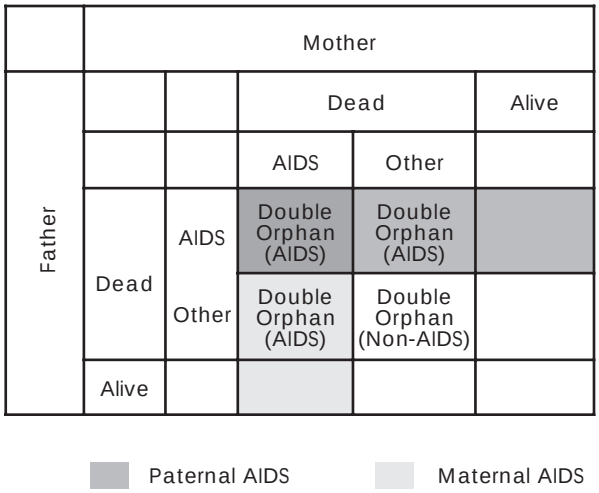
HIV/AIDS has an impact on adult mortality, fertility, and child survival, the main factors in estimating numbers of orphans. To respond to the need for standardized, widely accepted methods for estimates and projections of orphan numbers (including maternal, paternal, and double orphans), representatives from UNAIDS, UNICEF, the U.S. Bureau of the Census, and USAID met in 2001 and 2002 under the auspices of the UNAIDS Reference Group on Estimates, Modelling, and Projections. An important part of these estimates are the new 2003 estimates on HIV prevalence and mortality prepared by the UNAIDS/WHO Working Group on Global HIV/AIDS & STD Surveillance.

Methods of estimating orphans due to AIDS and other causes in countries with generalized epidemics derived by Grassly and Timæus were adopted by the Reference Group in 2002 and subsequently used to produce the estimates in this report. The methods are reported in detail elsewhere (Grassly and Timæus submitted; UNAIDS Reference Group 2002).

A key change in the procedures for the estimates of orphans in this document is the exclusion of estimates of orphans due to AIDS in countries with low levels of HIV prevalence. The *Children on the Brink 2002* report included estimates of orphans due to AIDS for countries outside sub-Saharan Africa with epidemics mainly among high-risk groups. In these countries, a large percentage of people living with HIV/AIDS are from populations such as injecting drug users or men who have sex with men, whose fertility rates are unknown. Therefore it was felt that insufficient information was available to prepare estimates of equal quality of children orphaned due to AIDS in these countries. Also, as adult prevalence is lower in these countries, it is unlikely that AIDS can have a large impact at the national level on the number of children who are orphaned.

This report uses the definition of an orphan due to AIDS that was agreed upon at the Reference Group meeting as "a child who has at least one parent dead from AIDS," and the definition of a double orphan due to AIDS as "a child whose mother and father have both died, at least one due to AIDS" (see figure 9).

Figure 9. The relationship between maternal, paternal, and double orphans and parental status (modified from UNAIDS Reference Group, 2002.)



Maternal Orphans

Maternal orphans are those children whose mother has died, and where the survival status of the father is unknown (alive, dead from AIDS, or dead from other causes). Maternal orphans due to AIDS are estimated using a similar method to that previously described (Gregson et al. 1994). The number of children born to women who have died from AIDS over the preceding 17 years is estimated using country- and age-specific fertility rates, and the number of these who are still alive and under 18 years old is calculated using a country-specific life table. These calculations take account of the impact of HIV infection on fertility, as well as the probability of the virus being transmitted from mother to child, resulting in a reduction in survival of the child. The HIV status of the mother in the years prior to death from AIDS must be back-calculated, using estimates of the rate of disease progression. The calculations also account for the impact of maternal death on child survival in the year before and after birth, which occurs

irrespective of the HIV status of the child (Crampin et al. 2003; Nakiyingi et al 2003: Ng'weshemi et al 2003).

Maternal orphans due to causes other than AIDS are estimated in a similar way. However, it is assumed that HIV prevalence (and hence vertical transmission) among women dying from causes other than AIDS is zero, since the majority tend to be women over the age of 35 years old where HIV prevalence is low. This assumption is necessary because of the absence of data on prevalence among these women, as opposed to women attending antenatal clinics (ANC). At worst, it may overestimate maternal orphans due to causes other than AIDS by 5 percent (Grassly and Timæus submitted).

Paternal Orphans

The population projections based on female fertility schedules imply a total fertility rate for men that, together with standard male fertility schedules, can be used to estimate age-specific fertility for men. Male fertility can then be used to estimate the number of children whose father died from AIDS in the preceding 17 years in the same way as for estimates of maternal orphans due to AIDS. To account for the impact of HIV on the fertility of a man's partner, and the impact of mother-to-child HIV transmission on child survival, additional information on concordance of parents' HIV status is required. This is based on data on the prevalence of HIV among the partners of HIV-positive men from 23 studies. Logistic regression of concordance of HIV positivity on HIV prevalence in the adult population (from ANC data) reveals a significant positive correlation, both because of the increased probability of pre-existing infection in the female partner and because high HIV prevalence is a marker for risk factors for transmission, such as high prevalence of bacterial sexually transmitted infections or low condom use.

Paternal orphans due to causes other than AIDS are estimated in a similar way, with the assumption that female partners of men dying from AIDS have a prevalence of HIV equivalent to that for women attending ANC.

Double Orphans

Numbers of double orphans due to AIDS as defined can be estimated by calculating the total number of children whose parents have both died from any cause and subtracting those children where both deaths were not due to AIDS (see figure 9). Deaths of parents are not independent due to shared risk factors, such as socioeconomic status and environment, and also due to the transmission of disease. The number of double orphans is therefore higher than would be expected if deaths were independent. This excess risk of being a double orphan was estimated by fitting a multilevel Poisson regression model to data on maternal, paternal, and double orphan numbers from Demographic and Health Surveys (DHS) carried out in 31 countries. These analyses reveal that the excess risk, and hence the ratio of double to maternal and paternal orphan numbers, is dependent on a child's age, HIV prevalence five years before the survey, and marriage patterns in the population (proportion of 15- to 19-year-old women unmarried and prevalence of polygamy). If maternal and paternal orphan numbers are known precisely, this regression predicts orphan numbers within 5 percent for the DHS data fitted. Care should be taken in applying these regression results for projections of double orphan numbers into the future, where projected HIV prevalence (lagged by 5 years) may be higher than the range fitted in the DHS (0 to 15 percent, with only Zimbabwe 1999 having a higher lagged prevalence of 23.6 percent).

Validation

Estimates of orphan numbers published in *Children on the Brink 2002*, based on the methods described above, were compared to estimates of orphans in countries in sub-Saharan Africa that were derived from household surveys (Grassly et al. in press). Estimates of total orphans ages 0 to14 from the DHS and MICS surveys were found to be in fairly close agreement with estimates derived from the demographic models, after accounting for an overestimate of adult mortality due to causes other than AIDS.

Of course, estimates of orphan numbers will only be as accurate as the demographic and epidemiological data on which they are based. Differences in demographic and epidemiological assumptions in the past have led to differing estimates of numbers of orphans due to AIDS by different organizations (United Nations 1995; Hunter and Williamson 2000; UNAIDS 2000). As the data and assumptions improve, and consensus is reached on appropriate

methods, global estimates of orphan numbers and the impact of HIV/AIDS will likewise improve.

Country Selection

Children on the Brink 2004 includes orphan estimates for 93 countries. This includes 43 countries in Africa, 23 in Asia, and 27 in Latin America and the Caribbean. They are:

Sub-Saharan Africa: All countries were included, except the island nations of Cape Verde, Comoros, Mauritius, Sao Tome & Principe, Seychelles, and Reunion. These countries were excluded because either insufficient information was available to prepare estimates or they have populations under 1 million and no significant AIDS epidemics.

Latin America and the Caribbean: All countries were included, except for countries where insufficient information was available to prepare estimates (Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent/Grenadines).

Asia: For the purpose of this report, Asia includes all countries in the region outside the former Soviet Union, Japan, and Singapore. All countries were included except the Maldives, which had insufficient information with which to prepare estimates.

References

Crampin AC, Floyd S, Glynn JR, et al. 2003. The long-term impact of HIV and orphanhood on the mortality and physical well-being of children in rural Malawi. *AIDS* **17**:389-397.

Grassly NC, Timæus IM. Orphan numbers in populations with generalised AIDS epidemics. *AIDS* (submitted).

Grassly NC, Lewis JJC, Mahy M, Walker N, and Timæus IM. 2004. Comparison of survey estimates with UNAIDS/WHO projections of mortality and orphan numbers in sub-Saharan Africa. *Population Studies* **58** (in press).

Gregson S, Garnett GP, et al. 1994. Assessing the potential impact of the HIV-1 epidemic on orphanhood and the demographic structure of populations in sub-Saharan Africa. *Population Studies* **48**(3):435-458.

Hunter S and Williamson J. 2000. *Children on the Brink 2000.* Executive Summary, Updated Estimates and Recommendations for Intervention. USAID. Available at www.usaid.gov.

Nakiyingi JS, Bracher M, Whitworth JA, et al. 2003. Child survival in relation to mother's HIV infection and survival: Evidence from a Ugandan cohort study. *AIDS* **17**:1827-1834.

Ng'weshemi J, Urassa M, Isingo R, et al. 2003. HIV impact on mother and child mortality in rural Tanzania. *AIDS* **33**:393-404.

United Nations. 2003. *World population prospects: The 2002 revision*. New York: United Nations Population Division.

UNAIDS. 2004. *Report on the global HIV/AIDS epidemic – July 2004*. Geneva: UNAIDS. Available at www.unaids.org.

UNAIDS Reference Group on Estimates, Modelling and Projections. 2002. Improved methods and assumptions for estimation of the HIV/AIDS epidemic and its impact: Recommendations of the UNAIDS Reference Group on Estimates, Modelling and Projections. *AIDS* **16**:W1-W16.

UNAIDS, UNICEF, USAID. 2002. *Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies*. Washington, D.C.: USAID. Available at www.unaids.org, www.unicef.org, and www.usaid.gov.

Appendix 3

Monitoring and Evaluation Indicators

A key challenge in developing effective action for orphans and vulnerable children is the lack of monitoring and evaluation data. Reliable information that is consistent within and across countries is essential for policy planning, program monitoring, decision-making, and national and global advocacy, as well as for providing a focus for the different sectors and groups involved in supporting vulnerable children, families, and communities.

To monitor progress toward the goals outlined in the Declaration of Commitment on HIV/AIDS of the June 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS), a core set of indicators was developed.[5] One indicator (orphan school attendance) was related specifically to orphans, but this alone is insufficient to guide countries, organizations, and agencies involved in protecting and supporting children and families affected by HIV/AIDS.

UNICEF/HQ96-1399/Giacomo Pirozzi

A girl stands by the doorway of her classroom at a daycare center in Kibera, the largest shantytown in Nairobi, Kenya. The center provides basic education and meals for orphaned children.

Accordingly, in April 2003, UNICEF convened the Inter-Agency Task Team on Orphans and Other Vulnerable Children,[6] which brought together a broad coalition of stakeholders to reach a consensus on a set of core indicators to measure national progress in improving the welfare of orphans and vulnerable children[7]. Working from the UNGASS Declaration of Commitment, the team distilled 37 specific activities for improving the welfare of orphans and vulnerable children into 10 key domains (policies and strategies, education, health, nutrition, psychosocial support, family capacity, community capacity, resources, protection, and institutional care and shelter) that need to be addressed and monitored at the national level. As outlined below, the indicators reflect the strategies defined within the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*.

In addition to monitoring national indicators, systematic monitoring of program effectiveness and quality is critical. Identifying best practices and disseminating lessons learned will contribute to program improvement and the expansion of responses that work. Both national and program-level monitoring will help ensure the quality of interventions, validate response strategies, and ensure accountability for attaining global goals.

[5]UNAIDS. August 2002. *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators*. Geneva: UNAIDS. Available at www.unaids.org.

[6]This UNAIDS Inter-Agency Task Team on Orphans and Other Vulnerable Children, which is convened by UNICEF, includes all UNAIDS cosponsors, USAID, the Displaced Children and Orphans Fund/USAID, the International Federation of Red Cross and Red Crescent Societies, Save the Children Fund/UK, the Hope for African Children Initiative, and the International HIV/AIDS Alliance.

[7]UNAIDS and UNICEF. April 2003. *Report on the Technical Consultation on Indicators Development for Children Orphaned and Made Vulnerable by HIV/AIDS, Gaborone, Botswana, 2-4 April 2003*. New York: UNICEF. Available at www.unicef.org.

Proposed Indicators for Monitoring the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS

	Strategic Approach	Domains
1	**Strengthen the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS**	
	Core Indicators	
	1: Basic material needs: Proportion of children that have three locally defined basic material needs	Family capacity
	2: Malnutrition: Ratio of orphans to non-orphans of underweight prevalence	Nutrition
	3: Sex before age 15: Ratio of orphans to non-orphans who had sex before age 15	Health
	Additional indicators:	
	A1: Food security: Proportion of households that are food insecure	Nutrition
	A2: Psychosocial well-being: Ratio of orphans to non-orphans with an adequate score for psychological health	Psychosocial support
	A3: Connectedness to an adult caregiver: The proportion of orphans who have a positive connection with primary caregiver	Psychosocial support
	A4: Succession planning: The proportion of children for whom a caregiver has been appointed in case of premature death of current caregiver	Protection
2	**Mobilize and strengthen community-based responses**	
	Core Indicators	
	4: Children outside of family care: Proportion of all children living outside of family care	Institutional care and shelter
	5: External support for households with orphans and vulnerable children: Percent of orphans living in households that receive external support	Community capacity
	Additional indicators:	
	A5: Orphans living with siblings: Percent of double orphans who have siblings living in other households	Community/family capacity
3	**Ensure access to essential services for orphans and vulnerable children**	
	Core Indicators	
	6: Orphan school attendance ratio: ratio of school attendance for double orphans to non-orphans for children ages 10-14	Education
	7: Proportion of orphans who receive psychosocial support	Psychosocial support
	8: Birth registration: Proportion of children ages 0-4 whose births are reported registered	Protection
4	**Ensure that governments protect the most vulnerable children**	
	Core Indicators	
	9: Orphans and Vulnerable Children Program Effort Index	Policies and strategies/Resources
	Additional indicators:	
	A6: Property transfer: Percentage of women who have experienced property dispossession	Protection
	A7: Quality of institutional care (based on international standards)	Institutional care and shelter
5	**Raise awareness to create a supportive environment for children affected by HIV/AIDS**	
	Core Indicators	
	10: Percent of children under age 18 who are orphans	Key indicator
	Additional indicators:	
	A8: Stigma and discrimination: Percent of adults expressing accepting attitudes toward people with HIV	Protection

See www.childinfo.org for detailed guide on these indicators.

Appendix 4

Programming Guidance

Valuable lessons have been learned through the many community programs for orphans and vulnerable children around the world. To reflect progress and lessons learned, this edition of *Children on the Brink* features a slight modification of a widely recognized set of programming principles provided in *Children on the Brink 2002*. The new *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (see pages 21 to 24 of this report) brings together the common elements and key themes of these principles in a way that complements the five basic strategies for action. It provides the following programming guidance for both governments and civil society groups at the community, district, and national levels.

UNICEF/HQ99-0789/Roger Lemoyne

A baby in a crib holds a man's hand at a center for children who have HIV/AIDS and other illnesses in Ho Chi Minh City, Vietnam.

Focus on the most vulnerable children and communities, not only children orphaned by AIDS. Programs should not single out children orphaned by HIV/AIDS. Targeting specific categories of children can increase stigmatization, discrimination, and harm to those children while denying support to other children and adolescents in the community who may also have profound needs. Orphans are not the only children made vulnerable by AIDS. All children living in communities hit by the epidemic are affected. Services and community mobilization efforts should be directed toward communities where the disease is increasing the vulnerability of children and adolescents.

Define community-specific problems and vulnerabilities at the outset and pursue locally determined intervention strategies. Each community is unique in terms of its problems, priorities, and available resources. It is necessary to identify orphans and vulnerable children and collect baseline information about them, including the households in which they live, before support activities can be designed. Giving a community a central role in this process will increase its sense of ownership of, and responsibility for, new interventions that emerge. An essential aspect of programming for children is to engage community members in the assessment of their needs and priorities so that locally tailored interventions can be developed.

Involve children and young people as active participants in the response. Children and adolescents are not simply a passive, powerless group to receive assistance. They are part of the solution to the problems presented by the HIV/AIDS epidemic and can play a vital role in mitigating its impact. Young people can help communities identify and understand the most critical problems faced by orphans and vulnerable children. They can visit with children, include them in recreation and other social activities, and promote their social integration and sense of connection to the greater community. Involving youth in addressing community-wide problems can increase their self-esteem and a sense of control over their lives while contributing to responsible and compassionate behavior.

Give particular attention to the roles of children, men, and women, and address gender discrimination. Much of the burden of caring for people with HIV or AIDS and for orphans and

vulnerable children falls on women and girls. Particular attention needs to be given to protecting and supporting girls in these circumstances. Due to their lower social status, girls and women in many circumstances are more vulnerable to sexual abuse and exploitation than boys and men. Orphans and children living in HIV-affected households are especially vulnerable, and program interventions to protect them from abuse and possible HIV infection are needed. The "demand" side of child abuse and prostitution, and the issues of male sexual norms, gender inequity, and sexual exploitation of children and adolescents, must also be addressed. It is important that men assume greater responsibility for raising children, for providing care for those who are ill, and for daily household tasks. In many countries, women are discriminated against by statutory or traditional laws or policies that forbid them from owning land or that prohibit widows from inheriting land or property. Such laws and policies – along with judicial administrative systems – must be changed to protect the basic rights of women and children.

Strengthen partnerships and mobilize collaborative action. The impact of HIV/AIDS on children, their families, and their communities cannot be addressed without collaboration and coordination among stakeholders. This requires the active involvement of government structures; international agencies; nongovernmental, faith-based, and community organizations; donors; businesses; the media; and others. Many grassroots groups in impoverished communities have come together to use their own resources to support orphans, vulnerable children, and people living with HIV/AIDS. These local groups provide good examples of assessment, planning, and collaborative action for groups at other levels.

Link HIV/AIDS prevention activities and care and support activities for people living with HIV/AIDS with support for vulnerable children. The HIV/AIDS-related problems of children and families are complex and interlinked. They demand holistic, multisectoral, mutually reinforcing program strategies. Providing care for children and adults affected by HIV/AIDS can be especially effective for HIV prevention. Caring for people with HIV/AIDS keeps awareness levels about the epidemic high. It informs both children and adults about how people get infected, how the illness progresses, and the consequences it can have on them and their families. Both adults and young people are more likely to adopt safer and more caring behaviors if they are looking after those affected. Many caregivers have begun to promote prevention because of their familiarity with the disease and their recognition of the urgent need to prevent more sickness, death, and orphaning of children.

Use external support to strengthen community initiative and motivation. Governments, donors, and nongovernmental, faith-based, and community organizations must focus on strengthening and supporting the ongoing efforts of communities themselves. While outside funding and material assistance are needed, it is important to ensure that the amount of assistance and its timing and continuity do not have a detrimental effect on government incentive, community solidarity, or local initiative. To prevent dependency on external assistance or donor-driven conditions and priorities, local and national mechanisms must be in place to reinforce and expand upon efforts already in place.

Appendix 5

National Actions

The *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* provides guidance to leaders and other decision-makers who can rally support for orphans and vulnerable children. Governments in affected countries can use the *Framework* to review major lines of action and strengthen their responses. Donor governments will be better able to assess their policy commitments and plan increased resource allocations. Implementing agencies at all levels will find direction to help them plan, manage, and evaluate their programs. Finally, the *Framework* is an important tool for advocacy to attract new partners and to position orphans and vulnerable children high on global, national, and local agendas.

At the core of the *Framework* is a consensus about the urgent need to increase resources and action for orphans and vulnerable children. To this end, the *Framework* makes the following recommendations:

- National governments should be encouraged and supported in giving priority to orphans and vulnerable children in national policies, plans, budgets, and legislation; in collaborating with nongovernmental and community organizations to ensure efforts are well-coordinated; and in monitoring progress toward national and global goals.

- All stakeholders should advocate to end the stigma, discrimination, and silence surrounding HIV/AIDS and affected children. They should also mobilize to put orphans and vulnerable children high on the development agenda.

- National governments, in partnership with international agencies and other stakeholders, must measure progress over time in closing the gap between what is being done and what must be done to fulfill the rights and ensure the well-being of orphans and vulnerable children.

- *All* governments should assess their resource commitments to urgently increase and sustain financial support for an adequate response over the long term.

Policy Achievements

At the June 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS), world leaders created and endorsed the Declaration of Commitment on HIV/AIDS. This Declaration included a commitment to ensure that children orphaned or made vulnerable by HIV/AIDS have the same access as other boys and girls to social support services, including schooling, shelter, nutrition, and health services. It also makes a commitment to the protection of orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking, and loss of inheritance. The UNGASS Declaration called upon countries to develop strategies to achieve these goals by 2003 and to implement these strategies by 2005.

Many countries – Honduras, Jamaica, Malawi, Namibia, Thailand, Uganda, and Zimbabwe among them – are now putting sound policies into place to provide a more protective environment for orphans and children made vulnerable by HIV/AIDS. The government of Uganda, for example, finalized its National Strategic Program *Plan of Interventions for Orphans and Other Vulnerable Children* in December 2003. The *Plan* provides a framework for strategic direction and resource allocation for protecting and supporting vulnerable children and families. It promotes a multisectoral, integrated, gender-sensitive, and rights-based approach to planning and implementing interventions for orphans, other vulnerable children, and the families with whom they may live. It provides overall guidance, recommendations for interventions, and a framework for implementing programs in government, the private sector, civil society, and other development sectors where partners are working to mitigate the impacts of HIV/AIDS on orphans and vulnerable children.

The achievements of Uganda and other countries are examples of the commitment required to ensure that the rights of vulnerable children and their families are protected and their essential needs are met.

Appendix 6

Selected Resources

Discussion Forums

Children Affected by AIDS Electronic Discussion Forum (hosted by USAID and the Synergy Project)
This forum facilitates vital discussion and information exchange on efforts to mitigate the impact of HIV/AIDS on children, families, and communities worldwide.
See:
http://www.synergyaids.com/caba/cabaindex.asp

The Regional Psychosocial Support Initiative PSS Forum (made possible by the Regional Psychosocial Support Initiative, or REPSSI, in Buluwayo, Zimbabwe, with funding from the Swiss Agency for Development and Cooperation, the Swedish International Development Agency, and the Novartis Foundation for Sustainable Development).
This interactive forum about psychosocial support for children affected by HIV/AIDS provides opportunities for practitioners, academics, donors, and others in the field to contribute, learn, stay informed, and share opinions.
See: http://www.repssi.org

Publications

A Family Is for a Lifetime: Part I. A Discussion of the Need for Family Care for Children Impacted by HIV/AIDS; Part II. An Annotated Bibliography (Jan Williamson, author, March 2004)
This document, prepared for the USAID Office of HIV/AIDS by the Synergy Project of TvT Global Health and Development Strategies, includes an overview of the available literature on providing for the care of children outside family care.
See:
http://www.synergyaids.com/resources.asp?id=5088

A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (July 2004)
This document published by UNICEF outlines interventions and actions for governmental agencies, faith-based and nongovernmental organizations, academic institutions, the private sector, and civil society to protect, care, and support all vulnerable children.
See: http://www.unicef.org

Africa's Orphaned Generations (November 2003)
This 52-page UNAIDS and UNICEF report provides new data and analysis on caring practices, coping mechanisms, and the impact of orphaning on children, families, households, and communities based on analysis of over 60 national representative household surveys from 40 countries in the region.
See:
http://www.unicef.org/media/files/orphans.pdf

Conducting a Situation Analysis of Orphans & Vulnerable Children Affected by HIV/AIDS: A Framework and Resource Guide (John Williamson, Adrienne Cox, and Beverly Johnston, authors, February 2004)
This framework and resource guide from USAID's Bureau for Africa, Office of Sustainable Development, includes material to guide programmers in the field in planning and conducting a situation analysis of orphans and vulnerable children affected by HIV/AIDS.
See: http://www.dec.org

Family and Community Interventions for Children Affected by AIDS (Linda Richter, Julie Manegold, and Riashnee Patther, authors, 2004)
This publication from the Health Sciences Research Council in South Africa reviews the available scientific and programmatic information on interventions aimed at children, families, households, and communities.
It can be ordered from: http://www.hsrcpublishers.co.za/index.html?e-lib.html~content

Roofs and Roots: The Care of Separated Children in the Developing World (David Tolfree, author, 1995)
This publication from Save the Children examines issues concerning the care of children separated from their families in the context of the developing

world. The publication is no longer in print but a limited number of copies are available from Save the Children UK. Inquiries should be addressed to Hanny Abuzaid at H.Abuzaid@scfuk.org.uk.

Sub-National Distribution and Situation of Orphans: An Analysis of the President's Emergency Plan for AIDS Relief Focus Countries. (Florence Nyangara, author, March 2004)
Prepared for USAID's Bureau for Africa, Office of Sustainable Development, this analysis provides information about the communities where orphaned children reside within countries and these children's living situations.
See: http://www.dec.org

USAID Project Profiles: Children Affected by HIV/AIDS (3rd edition, September 2003)
This report highlights nearly 100 USAID-supported projects assisting children and youth affected by HIV/AIDS.
See:
http://www.usaid.gov/our_work/global_health/aids/Publications/index.html

Whose Children? Separated Children's Protection and Participation in Emergencies (David Tolfree, author, 2003)
This publication from Rädda Barnen (Save the Children, Sweden) analyzes issues of fostering, group care, and other types of care arrangements for separated children and adolescents in large-scale emergencies. It can be ordered from:
http://www1.rb.se/Shop/Products/Product.aspx?ItemId=352

Toolkits

Changing Minds, Policies and Lives Project: Toolkits for Child Welfare Services
The Changing Minds, Policies and Lives Project is a joint World Bank and UNICEF project supporting national programs to reduce the institutionalization of vulnerable children in transition countries through reform of child welfare systems. Three toolkits have been developed supporting the efforts for systemic reform of child protection system.
See:
http://wbln0018.worldbank.org/HDNet/hddocs.nsf/0/189EF6304D3FEC9E85256D1800626941?OpenDocument

Orphans and Other Vulnerable Children Support Toolkit: A CD-Rom and Web Site for NGOs and CBOs
This toolkit from Family Health International and the International HIV/AIDS Alliance offers a Web site and CD-Rom with over 300 downloadable resources and supporting information on how to assist orphans and other vulnerable children. It is expected to be available in mid-2004.
See: http://www.ovcsupport.net

Web Sites

UNAIDS: http://www.unaids.org
UNICEF: http://www.unicef.org/aids
USAID: http://www.usaid.gov
U.S. Bureau of the Census:
http://www.census.gov/ipc/www/hivaidsn.html

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