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National plans of action for orphans and vulnerable children in sub-Saharan Africa

Where are the youngest children?

By Patrice Engle

Bernard van Leer *Foundation*

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About the author

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Executive Summary

In 2005, an estimated 48 million children aged 0–18 years – 12 percent of all children in sub-Saharan Africa – were orphans, and that number is expected to rise to 53 million by 2010. One quarter of all orphans are orphaned because of AIDS, and about 2.6 million children are currently infected with HIV. Untreated, most children born with HIV will die before their fourth birthday, most likely in the first two years of life. UNICEF concludes that, although they represent a smaller percentage of all orphans, the youngest orphans are the least resilient and have the greatest need for physical care and emotional nurturing.

Although it is recognised that the focus of support must be on all children made vulnerable by HIV/AIDS, including those living with sick parents or in extreme poverty, the youngest are often invisible to programme planners, despite their vulnerability.

In response to the general awareness of the increasing number of these children, a global initiative to develop national plans of action (NPAs) for these orphans and vulnerable children (OVCs), or children affected by HIV and AIDS, has been launched. Between 2003 and 2007, a number of countries did a rapid assessment of the living conditions of children affected by HIV/AIDS and developed plans and costing estimates for appropriate interventions. The plans of 17 countries in sub-Saharan Africa

were reviewed, comprising all of the high prevalence countries whose NPAs were finalised.

The review found that there is a wide range in the developmental appropriateness of the plans within the 17 countries. The most common interventions are health and nutrition and birth registration. Slightly less than half of the plans have components that include childcare centres (8) or community-based centre programmes (7). Some NPAs incorporated concerns for psychosocial support for younger children (4), a holistic approach to the treatment of HIV-infected children (6) and incorporating young children's concerns into home-based care (3). Only two programmes mentioned capacity building for working with young children and three plans had age categories in their monitoring and evaluation plans. Some NPAs included programmes for young children but did not include funding.

The evidence suggests that there is a clear and significant trend over time for increased incorporation of developmentally informed perspectives into plans, with the more recent plans having many more components. This change has been influenced by a series of advocacy efforts by the early childhood development (ECD) community and the HIV/AIDS community. However, these plans remain vague and not well defined. More efforts are needed to ensure that they will in fact be

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implemented, and that there will be sufficient quality in the responses.

A number of assumptions were noted in the plans, such as the belief that funds allocated to a family in general will go equally to all members of the family. As a result, the author makes the following recommendations:

Evaluate assumptions. This paper reviews a number of assumptions made in NPAs that are not well supported by evidence. When there is a lack of experience or evidence, judgements must be made without data; however, over time assumptions need to be evaluated for accuracy or they will lead to ineffective programmes.

Provide adequate funding for the NPAs to include ECD measures. The critical actors in preparing and implementing each country's NPA face many challenges. They must have sufficient funds to be able to move beyond the most basic needs of food, immunisations, and primary school attendance in order to include ECD interventions that can have long-term impacts on children's well-being.

Build the case with evidence. Good evidence for the importance of early interventions for children with HIV is needed for good NPAs, including clear directions on the most effective measures. Simple indictors of child outcomes, such as those developed by 'Speak for the Child' (Lusk 2005) or the Human Sciences Research Council (Rochart and Richter 2007) will help communities decide what works for them. Assessments of existing programmes are

beginning to highlight important characteristics in particular contexts, but they are too few (Engle et al. 2007; Potterton 2007).

Develop capacity in ECD at the country level. In order for these measures to be successful, a concerted effort is needed to develop capacity for ECD, including examples of programmes that work, guidelines for programmes, and trained workers. These should build on existing child-rearing practices. South Africa is beginning this effort with the establishment of new roles, such as the ECD Community Development Worker.

Strengthen the role of the health sector for young children's development and develop new platforms for care. Linking ECD with other interventions such as Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS or home-based approaches should be a key component of NPAs, as they provide an excellent foundation for improving the well-being of both caregivers and children (Michaels et al. 2005). Incorporating mental health issues for the primary caregiver into these efforts is key to success.

Strengthen structures at local, regional, and national levels for an integrated approach. As has been mentioned many times, an adequate response to the multiple needs of young children requires a coordination of approaches across sectors. This has begun to evolve through the process of developing NPAs, but it must continue and be supported in the implementation phase.

Support women's rights. In the AIDS pandemic, the heaviest burden both of the disease and of care for orphaned and/or vulnerable children is being borne by women. Because children's well-being and rights, particularly young children's well-being, is so closely linked to the status and rights of women, this should be a central component of many plans. However, it is rarely included in the NPAs. Linkages with efforts to improve women' rights, both for themselves and for children, need to be made in all plans.

Link the NPAs with other plans in order to effectively implement them. Many of these plans are still far from being clear enough to be implemented and are missing key components. However, these components may exist in other government documents, as in the case of South Africa and Kenya's ECD policy. Linking the NPAs with other efforts within countries is essential for their adequate implementation.

As the NPAs evolve and become more closely linked with other policy documents within the country, the specific needs of young children should be a top priority, along with those of school-aged children and adolescents.

"To be fully effective, responses must take into consideration the whole experience of the child and the caregiver at every stage of development and engage targeted, evidence-based efforts at the household, community and national levels" (UNICEF 2006a p. 19).

Introduction

Every 30 seconds a child in Africa loses a parent to HIV/AIDS. In 2005, an estimated 48 million children aged 0–18 years – 12 percent of all children in sub-Saharan Africa – were orphans, and that number is expected to rise to 53 million by 2010 (UNICEF 2006a). One quarter of all orphans are orphaned because of AIDS, and between 2.1 and 2.9 million children are currently infected with HIV. Untreated, most children born with HIV will die before their fourth birthday, most likely in the first two years of life (Richter and Foster 2006). Over half of these orphans are under age 12, and 7 million (16 percent) of the orphans in Africa are under 6 years of age (UNICEF 2006a). Moreover, it is estimated that 25 percent of the orphans in sub-Saharan Africa experienced a parents' death before the age of 5 (UNICEF 2006a).

UNICEF (2006a) concludes that, although they represent a smaller percentage of all orphans, the youngest orphans are the least resilient and have the greatest need for physical care and emotional nurturing (p. 6). "The age of orphans and the age when they were orphaned have significant implications for planning a response that meets children's needs at varying developmental stages" (UNICEF 2006a, p. 6).

It is now well known that the early years are the most important years for a child's survival, growth and development. Many of the conditions that threaten the survival of infants and young children also leave those who do survive at risk, often with physical, cognitive and emotional impairments from which they will never fully recover. Thus the early childhood years offer an unparalleled window of opportunity to impact the future well-being of these vulnerable children.

There is a growing awareness that the focus must go beyond orphans to include all children made vulnerable by HIV/AIDS, including those living with sick parents or in extreme poverty (UNICEF 2006). Richter and Foster (2006) paint this picture for South Africa: "The impact of HIV/AIDS goes beyond orphaning. Very large numbers of children are affected by the AIDS epidemic – greatly in excess of estimates of the numbers of children orphaned. For example, in South Africa in 2001, just over 600,000 children were recorded in the census as having lost both parents. However, given fertility and HIV prevalence rates at the time, it can be estimated that more than 2.5 million South African children had a mother who was alive but infected with HIV. Without effective treatment, these children are at risk, in years to come, of a deteriorating quality of life as an increasing share of household resources, including emotional and social support, are directed to assisting one or more sick adults and eventually burying them, mostly at the expense of children's nutrition, health and schooling." (Richter and Foster 2006, p. 6)

Given the number of young children who are currently orphans in sub-Saharan Africa and

the much greater number who are vulnerable because a parent is sick or the child is living in extreme poverty, specific programme efforts must be made to meet the needs of this most vulnerable group. However, as Fonseca and co-authors (2007) show, the youngest are often invisible to programme planners, despite their vulnerability.

In the last five years, many of the countries that have the highest numbers and percentages of children who are vulnerable to the impacts of HIV and AIDS have developed NPAs to address the problems that HIV/AIDS and poverty have brought to children. Between 2003 and 2007, a number of countries performed a rapid assessment of the living conditions of children affected by HIV/AIDS and developed plans and cost estimates for appropriate interventions.

Have young children been visible in these plans? Has particular attention been paid to their requirements, compared to other children affected by HIV/AIDS? And if so, what sorts of programmes are recommended? The national plans provide an indication of the extent to which the situation of young children is being recognised and reflected in the country's plans and policies. The analysis of the plans and of factors associated with a country's degree of attention to age-appropriate programmes and policies reflect the impact of recent advocacy; it also indicates the gaps that need to be filled if younger children – as well as older OVCs – are receiving support that is their basic right and that is appropriate to their needs.

While support for OVCs has grown in recent years, most effort has been allocated to primary-school-aged children, and, other than health, much less attention has been given to the holistic needs of younger children, as indicated by an assessment in 2004 (Monasch et al. 2007). Yet many studies document the greater risks in early childhood (e.g., Walker et al. 2007), their long-term consequences (Grantham-McGregor et al. 2007) and the effectiveness of interventions in this age group (Engle et al. 2007b).

There are three reasons for wanting young children to be included in the NPAs. First, as the numbers indicate, there are a substantial number of young children who are orphans and/or vulnerable, but they tend to escape notice. Second, they have specific rights and requirements for care that differ from those of older children. For example, because young children require more caregiving and are less able to help with family chores and other work than older children, they may be perceived as a greater burden to overworked caregivers. Rearing a young child requires knowledge about nutrition, health, sanitation, stimulation, and psychosocial support that may not be available to grandmothers or other alternate caregivers who may not have received the newest information provided to pregnant women and young mothers though health systems. Young children are less able than older children to protect themselves from poor treatment, stigma, or loss of rights such as inheritance. Third, because of the growth potential of young children, the possibilities for effective

interventions to prevent long-term negative consequences are greater than at older ages.

Although there are now plans of action for OVCs in many other parts of the world, this paper focuses on the countries with the highest prevalence because of the difficulty young children face as the normal safety nets for caring for young children are strained. At this point, all of these countries are in sub-Saharan Africa, and many are in Eastern and Southern Africa.

The purpose of this paper is to examine 17 NPAs for orphans and vulnerable children prepared in the hardest-hit areas in sub-Saharan Africa in order to evaluate their response to the specific needs of young children (generally defined as children under age eight), including the transition to primary school) These 17 were selected because they have the highest rates of HIV infection and their plans were the most developed. Botswana and Central Africa Republic met these criteria but were not included because their plans were not yet well enough developed for analysis.

The paper summarises each country's responses to younger children: its definition of vulnerability, whether it includes language supporting young children's rights, and finally, whether the programming the country advocates is appropriate for ensuring the rights of young children. This might include programmes unique to young children (e.g., free healthcare for young children, or early child development centres) or adaptations of comprehensive programmes for younger

children (e.g., how to address psychosocial support programmes to young children). Chapter 2 contains a list of criteria.

This analysis does not evaluate the quality of the plans, their implementation, or the adequacy of the amount of funds being requested. Rather, it assesses whether the plans use an age-appropriate lens and a rights perspective. The initial justification and the recommended activities are analysed for their inclusion of young children. The rights perspective is based on the General Comment 7 to the Convention on the Rights of the Child (CRC) (UNCRC et al. 2006). The report is based on papers available to the author as of the end of 2007; some have been approved by governments and others are still in draft form. Thus, the analysis must be considered as a guideline and the recommendations made for a constantly changing landscape.

These plans are important because, as the Tanzanian Plan of Action argues: "A conducive policy and service delivery environment is fundamental for a scaled-up response to the Most Vulnerable Children [MVC]. This can only be realised through formulation and implementation of functional policies, creation of a legal framework and establishment of MVC response coordination structures and systems to prevent and mitigate vulnerability of the OVC/MVC to HIV/AIDS and poverty." (United Republic of Tanzania 2005).

This section introduces the purpose and plan of the paper. Chapter 2 outlines what should

be in a NPA for OVCs that is age-appropriate or developmentally informed, as well as the questions that were asked of each plan based in part on the General Comment 7 to the CRC and the emerging concept of 'vulnerability'. (UNCRC et al. 2006). Chapter 3 briefly outlines the process of developing the NPAs in sub-Saharan Africa for OVCs, and other analyses that have been made of these plans. Chapter 4 outlines the efforts that have been made to bring to public attention the situation of young children as well as older children, including their particular vulnerabilities. Chapter 5 describes the basis for selecting the 17 countries' plans for review and the criteria for judging their attention to young children, and also reviews this attention. Finally, Chapter 6 examines assumptions in the current plans, makes recommendations for the future development of plans for young children affected by HIV/AIDS and recommends future actions. Annex 1 describes recommended interventions for young children affected by HIV and AIDS. Annex 2 summarises the role of ECD in a sample of seven NPAs.

Chapter 1: Defining an age-appropriate response: Ensuring the rights of young children who are orphans and/or vulnerable in sub-Saharan Africa

1.1. Characteristics of young children in vulnerable circumstances

1.1.1. The importance of early child development

Defining early child development (ECD). Child development refers to the ordered emergence of interdependent skills of sensorimotor, cognitive–language, and social–emotional functioning. Children's development is strongly affected by their health and nutritional status, as well as by learning opportunities in their environment. A child continues to develop to adulthood, and every stage is important, but the early phase (prenatal through age eight) is particularly critical for later development. This is the period of time during which the brain develops most rapidly, cognitive and language skills develop, social and emotional patterns are formed, and both risk and opportunity for change are largest. It is also a period of time during which there are often relatively few government investments (e.g., school) other than in maternal and child health care and immunisations. Therefore, variations in family well-being and economic levels have played a larger role in children's well-being than when services provide a kind of safety net. Because the factors influencing a child's early development are biological, psychological, and social, supporting a child's right to development requires a holistic and inter-sectoral approach to the early years.

What risks interfere with ECD? Over 200 million young children in the developing world do not fulfil their potential for development, resulting in a loss of 20 percent of GDP per year. Because of this lost potential, many countries are beginning to look at ECD (Grantham-McGregor et al. 2007). Poverty and the socio-cultural context increase young children's exposure to biological and psychosocial risks that affect development through changes in brain structure and function and behavioural changes. Major well-documented risks include stunting (often associated with low birth weight and lack of exclusive breastfeeding), iron deficiency anaemia, iodine deficiency, and lack of stimulation in the environment. Additional potential risk factors include exposure to violence, maternal depression, parental loss, and environmental toxins (Walker et al. 2007). Multiple risks, which are very common, have a much greater impact on child development than single risks.

Why is ECD important? Some argue that improving ECD may be the most effective strategy for human capital development for poverty reduction (Heckman 2006). Increased productivity is an important component of most poverty reduction strategies, but primary

schooling often does not help to reduce disparities and break the cycle of poverty. Poorer children enter school later, are more likely to repeat or drop out, and their performance remains below that of children who are better off. Early childhood is widely recognised as a unique period of time in which to help children initiate schooling on a more equal level and to begin to move forward.

1.1.2. Relevance for young children affected by HIV and AIDS

There are two pathways by which chronic parental illness or death may affect young children. The first is through increasing poverty, often associated with the loss of income due to HIV infection and death of primary caregivers, as well as the costs of medical care, funerals, etc. These effects tend to result in food insecurity, reduction in the use of fee-based services, and shortages of other material goods like blankets and shelter. The

second is through decreased caregiving capacity when the primary caregiver is chronically ill or there is a new caregiver. Multiple possible effects include depression, stress and isolation for the primary caregiver, reduced childcare time, and reduced skills in caregiving. Both the direct effects of each of these factors, and the indirect effects of the factors on one another increase young children's vulnerability. For example, in the 'Speak for the Child' project in western Kenya, young children were less likely to receive several meals a day, to be shown a book, or receive positive support from caregivers before an intervention than after one. Some of these patterns were outlined by Stein et al. (2005).

The kinds of effects that might be seen for young children who are coping with parental illness, depression, or death have been outlined in several intervention studies. In the 'Speak for the Child' project in western Kenya, young

Figure 1. Two pathways to child outcomes
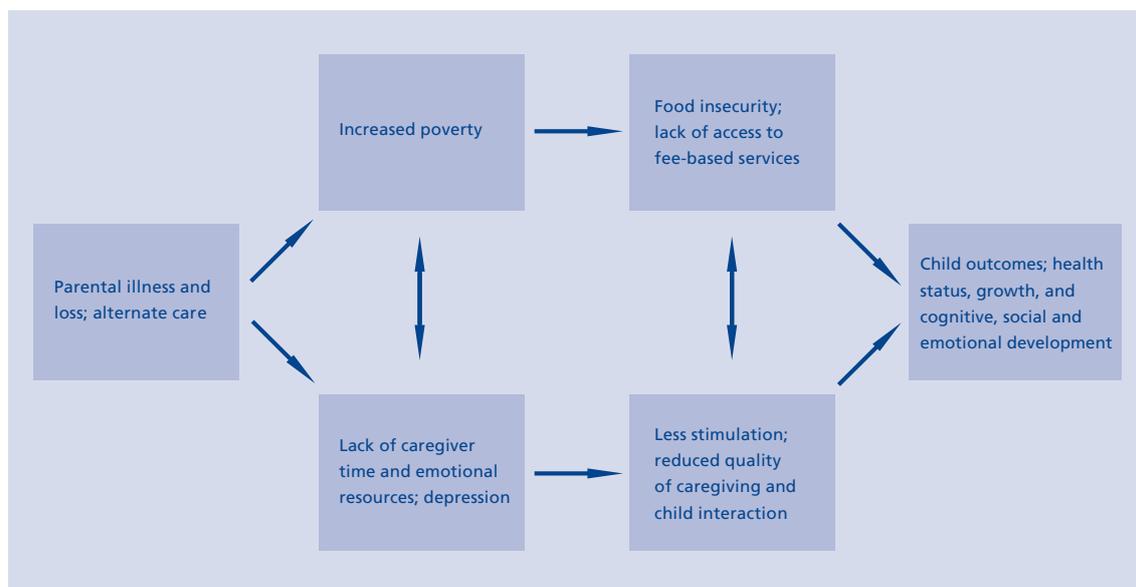
children prior to an intervention were more likely to be withdrawn and passive – acting out, disobedient, or unable to pay attention to learning activities (Lusk 2005). With older children, orphaning due to HIV/AIDS was associated with higher rates of depression and suicidal ideation among 10–17-year-olds (Cluver et al. 2007).

On the other hand, there is no clear evidence that these children are more likely to be malnourished (Stewart 2007), Because poverty was found to be the greater risk factor for malnutrition in five countries in Eastern and Southern Africa the author concluded that identification of vulnerable children should be based on indicators of household poverty, rather than on orphan status. Yet there may be

exceptions. A recent evaluation in Zimbabwe (Watts et al. 2007) found that stunting and being underweight were most common in double and maternal orphans compared to other children. Differences in poverty did not explain the greater exposure to chronic malnutrition, and, after further adjustment for exposure to extreme poverty, OVCs were still more likely to have diarrhoeal disease and acute respiratory infections. Maternal and double orphans were also less likely to have health cards than other children, and OVCs with acute respiratory infections were significantly more likely not to have received treatment than non-OVCs.

Subbarao and Coury outline the major risks by age level of child affected by HIV and AIDS in a World Bank publication (2004).

Table 1. Risks due to HIV and AIDS by age group of child

Infants	Pre-school-age children	School-age children	Adolescents
Exposure to HIV/AIDS (mother-child transmission through breastfeeding and birth) • frequent infections; • poor nutrition; • poor growth; • emotional deprivation; • developmental delays; • attachment disorders.	Loss of social contact and stimulation • begin to experience and respond to the trauma of loss (parents, siblings, home); • poor nutrition and growth; • exposure to abusive; environments • decreasing role of frequent infections.	Becoming caretakers for parents and siblings • losing access to education; • increasing awareness of stigma; • sexual abuse; • physical and verbal abuse; • depression; • increasing workload (child labour).	Further increase in responsibilities as they assume role of provider and caretaker • exclusion from education; • poor self-esteem; • depression; • sexual abuse/teen pregnancy; • sexually transmitted illnesses, including HIV; • exclusion from formal employment.

Sources: Subbarao and Coury (2004).

Given the importance of early stimulation on cognitive development, one might suspect that children who are raised by caregivers struggling with illness or loss might have lower cognitive levels. There is some evidence that children of infected mothers "also manifest disturbances in their development" (Stein et al. 2005, p. 116). Supporting this hypothesis, a recent experiment in Uganda by CARE showed significant improvements in the cognitive functioning and development of OVCs enrolled in childcare programmes compared with OVCs who were not enrolled (CARE 2007).

Children who have been infected with HIV have been shown to have neurodevelopmental delays in language, motor and mental development in some but not all studies (Stein et al. 2005; Potterton 2007). They were reported to be the subjects of sexual and other kinds of abuse, but these children were not compared with equivalent non-orphans (Rochat and Richter 2007).

Some programmes and policies are unique to young children, such as daycare centres, whereas in other cases interventions need to be adapted to the age group (for example, teaching a 2-year-old to use a sanitation system is very different from teaching a 12-year-old, a memory book will be different for a 4-year-old from that for a 12-year-old and psychosocial counselling is very different for these two age groups).

Most of the NPAs are organised into the following major categories: strengthening families and communities, access to services, policy and legislation, social mobilisation and awareness of stigma, monitoring and evaluation, and capacity building, following the *Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF and the Expert Working Group of the Global Partners Forum for Orphans and Vulnerable Children 2004). The recommendations in each area come from the *Operational Guidelines for Supporting Early Child Development (ECD) in Multi-sectoral HIV/AIDS Programs in Africa* (World Bank, UNICEF and UNAIDS 2004). This document includes a long list of potential interventions, some appropriate for all children (e.g., water and sanitation), and some that are specifically appropriate for young children made vulnerable by HIV/AIDS. These are shown in Annex 1. From this list, key additional programme components for young children should include:

Strengthening families and communities:
- developing ECD centres in communities that can provide young children with food, care and support as well as release older girls for school;
- providing parenting skills and support visits for caregivers focusing particularly on the skills needed for younger children, and assisting alternate caregivers;
- supporting caregivers' own well-being and their ability to form bonds with young children;
- supporting childcare so that families can focus on income-generating activities or, in the case of child-headed households, so that the head child can attend school.

Access to services:

- increasing the accessibility and quality of healthcare for young children;
- providing nutritional food supplements for young children;
- providing pre-schools and ECD programmes to help prepare children for school;
- providing psychosocial support programmes that include age-appropriate counselling. For example, disclosure techniques regarding how children should be told about their own death or the death of a parent should be adapted to the child's age.

Policy and legislation:

- ensuring birth registration to ensure children access to services;
- establishing legislation to ensure women's rights to divorce, inheritance, etc.;

For each of these interventions, an overarching concern is one of funding and the capacity to provide a quality programme as well as the ability to monitor outcomes.

1.2. Defining young children's rights: General Comment 7 from the Convention on the Rights of the Child

A rights perspective adds several additional components to the criteria for judging the age appropriateness of the NPAs. In addition to the basic principles of child rights in the CRC – to ensure the best interests of the child, non-discrimination, the child's right to survival, well-being and development, and respect for the views of the child – the CRC underlines the holistic approach to rights: all criteria must be met (UNCRC et al. 2006).

These principles are generic to all children. The United Nations Committee on the Rights of the Child (UNCRC) recently decided that it is not sufficiently clear for young children, and published General Comment 7 to clarify the ways in which the CRC should be applied to this age group (UNCRC et al. 2006). This document highlighted such issues as the importance of a child's ability to express his or her views even at a young age, the importance of protection for young children, the need to increase resources for ECD services and programmes, and the responsibility of the state to support families in their child-rearing roles.

Based on the premises of the CRC and General Comment 7, we first examined whether there were holistic approaches in some key interventions, such as treatment for children living with AIDS or home-based care. Second, we looked for examples of specific awareness of the unique stigmas facing young children. Third, we examined whether there was a concern for the young child's right to express his or her views and have them taken into account according to his or her emerging capabilities. Overall, was there a concern for child rights?

Children have the right to be heard

A 2002 report by Gillian Mann for Save the Children/Malawi illustrated the differences between adults'
and children's opinions of extended family care for OVCs. On page 3 of she writes:

"In Malawi and globally, the vast majority of children rendered parentless by AIDS are living within
the extended family. This study examines reasons why such children are, or are not, taken in by
their relatives. A remarkable discrepancy was found in the views of adults and children: while adults
tended to believe that children should play no part in the decision-making for their care, children
themselves expressed clear and well-considered opinions on the characteristics of the most suitable care
arrangements. … While adults emphasised the material capacity of a family to care for an orphaned
child, children were much more concerned about being cared for by adults who would love them and
respect the honour of their deceased parents. This led to a strong preference for care by grandparents,
even if this meant living in extremely poor material and economic circumstances."

Adult guardians articulated a strong belief that orphans exhibit behavioural problems, rendering
caretaking difficult. These same adults, according to Mann, were very critical of OVCs who complained
of discrimination and felt that they should appreciate the financial challenges posed by their arrival
in new families. On the other hand, interviews with OVCs revealed a startling pattern of abuse and
discrimination at the household level.

1.3. Vulnerability in sub-Saharan Africa: More than orphans

As noted earlier, a major change in policy has been to move from a focus on orphaned children to a focus on those made vulnerable by HIV/AIDS through parental illness and associated poverty (UNICEF 2006a). In 2006, the focus was expanded to include children aged 0–18 years who are infected with HIV, children who have lost one or both parents, and children whose survival, well-being or development is impacted by HIV or AIDS (UNICEF 2006a).

In 2005, UNICEF, along with partners from UNAIDS, the World Bank, USAID, Save the Children, and others defined vulnerability for the definitive monitoring and evaluation guide:

An **orphan** is a child below the age of 18 who has lost one or both parents.
A **child** made vulnerable by HIV/AIDS who is below the age of 18 and meets one or more of the following criteria:
1. has lost one or both parents, or
2. has a chronically ill parent (regardless

of whether the parent lives in the same household as the child), or

3. lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or

4. lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or

5. lives outside of family care (i.e., lives in an institution or on the streets).

They noted that "countries can add or exclude categories based on their country context. It is, however, recommended to use the above definition where possible in order to monitor changes over time and compare and learn from different countries." (UNICEF et al. 2005 p. 18).

Further, they examined pilot-study data and concluded that "analyses of the pilot surveys of these indicators showed that children who were categorised as vulnerable had much worse outcomes than children who were orphaned. This is probably because children who are orphaned could have lost their parent many years prior to the survey, while children who are vulnerable, by definition, were made vulnerable in the past year. Disaggregating the data by vulnerable status will provide useful information for directing a national response for children affected by HIV/AIDS" (p. 21).

A review of the NPAs reveals many different definitions of vulnerability. All of the plans focus on a wider group of children than just children orphaned by HIV and AIDS. The numbers are remarkably different. For example, in Kenya, approximately 13% are orphaned of which 46% (6% total) are due to AIDS, but fully 40% of all children are considered to be vulnerable according to the NPA. In Zambia, 16% are orphans, but 67% of all children live below the poverty line. Therefore, a general consensus is that plans need to target more children than those who are specifically single or double orphans. Thus, the definitions of orphans and vulnerable children begin with orphans, but expand far beyond these definitions.

In some cases, the definition of 'vulnerable' is so broad, it is difficult to measure or construct a harmonised, national, user-friendly system for identifying who should receive services.

One example of a definition of vulnerability was proposed, very rightly, by Nigeria. They argue: "According to the World Bank's Thematic Group for the OVC Toolkit[1], vulnerability, defined within a Social Risk Management (SRM) framework, is 'the likelihood of being harmed by unforeseen events or as susceptibility to exogenous shocks'" (Federal Republic of Nigeria, 2006). A vulnerable household is one with a poor ability to prevent the likelihood of crises, to reduce the likelihood of a negative impact in the case of a crisis and to cope with the negative impacts of a crisis. In the perspective of SRM, vulnerable children are those who face a higher risk than their local peers of experiencing:

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[1] *World Bank OVC Thematic Group and Kielland, A. (2004) "Orphans and vulnerable children (OVCs)". Presentation.*

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- infant, child and adolescent mortality;
- low immunisation, low access to health services, high malnutrition, and high burden of disease;
- low school enrolment rates, high repetition rates, poor school performance, and/or high drop out rates;
- intra-household neglect vis-à-vis other children in the household (reduced access to attention, food, care);

- family and community abuse and maltreatment (harassment and violence);
- economic and sexual exploitation, due to lack of care and protection.

Nigeria concluded that "not all orphans could be classified as vulnerable", thus recognising that the category of 'orphan' would not capture all the dimensions needed.

Chapter 2: Development of the national plans of action for orphans and vulnerable children

2.1. UNGASS: A global commitment

This chapter provides a very brief history of policy development for children affected by AIDS and the guiding principles for action. In September 2000, the largest ever gathering of world leaders adopted the United Nations Millennium Declaration. Key among them is the fight against HIV/AIDS. In June 2001, nearly 50 countries signed the United Nations General Assembly Special Session (UNGASS) *Declaration of Commitment on HIV/AIDS* to have time-bound plans for *OVCs*. This commitment was repeated in May 2002 at the UN General Assembly Special Session on Children – 'A World Fit for Children' reaffirmed the Millennium Development Goals and the 2001 Special Session goals for children affected by HIV/AIDS. This effort was not developmentally informed; the only age-related recommendations are toward HIV prevention among young people.

In 2004, the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* was developed to lead actions on OVCs (UNICEF and the Expert Working Group of the Global Partners Forum for Orphans and Vulnerable Children 2004). The *Framework*, endorsed by many agencies, describes five broad strategies to structure countries' responses for children affected by HIV/AIDS and these formed the basis for the NPAs. These include: strengthening family capacity, increasing access to services, creating awareness of the need for a supportive environment for children, mobilising community-based response and government actions. It does not include age-appropriate responses.

2.2. From UNGASS to RAAAP

In October 2003, funding partners reached an agreement for greater collaboration to rapidly scale up and improve the quality of the response to OVCs. USAID, UNICEF, UNAIDS and the World Food Programme (WFP) proposed a Rapid Assessment Analysis and Action Planning (RAAAP) exercise. The process involved a participatory situation analysis, a costed national plan, a monitoring and evaluation framework, and definitions of the terms 'vulnerable' and 'orphan'.

Seventeen countries in Africa (Botswana, Central African Republic, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) were selected to take part based on their high HIV prevalence rates, high numbers of orphans and inclusion in the US Presidential Initiative on HIV/AIDS (PEPFAR) selected countries (Phiri and Webb 2004).

NPAs were designed to be two-year 'emergency' plans to put services into the hands of children, and thus did not address more complex issues. They were prepared with the following seven general goals:

1. Strengthen the capacity of families to protect and care for OVCs.

2. Mobilise and support community-based responses.

3. Ensure access for OVCs to essential services including, but not limited to, education, healthcare and birth registration.

4. Ensure that improved policy and legislation are put in place to protect the most vulnerable children.

Table 2. Indicators by strategic approach and age of target group

Strengthening the capacity of families to protect and care for children	*Core indicators* **1:** Basic material needs **2:** Malnutrition/underweight prevalence **3:** Sex before age 15	5–17 years 0–4 15–17
	Additional indicators **A1:** Food security not appropriate **A2:** Psychological health **A3:** Connection with an adult caregiver **A4:** Succession planning protection	NA 12–17 12–17 NA
Mobilising and strengthening community-based responses	*Core indicators* **4:** Children outside of family care **5:** External support for OVCs	0–17 0–17
	Additional indicator **A5:** Orphans living with siblings	0–17
Ensuring access to essential services	*Core indicators* **6:** Orphan school attendance ratio **7:** Birth registration	10–14 0–4
	Additional indicator **A6:** Property dispossession	15–49
Ensuring that governments protect the most vulnerable children	*Core indicator* **8:** Orphaned and Vulnerable Children Policy and Planning Effort Index	NA
	Additional indicator **A6:** Property dispossession	15–49
Raising awareness to create a supportive environment	*Core indicators* **9:** Percentage of children who are orphans **10:** Percentage of children who are vulnerable	0–17 0–17
	Additional indicator **A7:** Stigma and discrimination	15–49

Source: UNICEF, UNAIDS, USAID, DHS, Family Health International, World Bank, Save the Children and AIDS Alliance (2005)

5. With the aim of creating a supportive environment for children and families affected by HIV/AIDS, implement awareness-raising campaigns at selected levels through advocacy and social mobilisation.

6. Strengthen national capacity to monitor and evaluate programme effectiveness and quality.

7. Strengthen and support national coordination and institutional structures.

Sets of indicators were to be used in all plans (Table 2). All referred to children overall – none of these refer to any developmentally informed variables, not even the health and nutrition indicators.

Following these initial plans, most of which were prepared for the years 2004–2006, a number of countries have extended the time frame of their plans to five years or have adapted and adjusted them so that they are more closely linked to other government initiatives rather than simply an emergency response. Table 3 shows the status of the plans of the 17 countries used in this analysis, including when the most recent plan was prepared and the years covered by the plan.

2.3. Other evaluations of the national plans of action

The effort analysis
In 2004, the World Bank and UNICEF conducted an 'effort analysis' in which they tried to determine how much countries had progressed

in developing their plans. Monasch et al. (2007) report an analysis of how well the plans were developed in 2004. Seven experts who ranked 10 of the 17 countries[2] concluded that the plans were strong in areas such as consultation and planning but weak in the areas of gender analysis and age analysis: "Analysis of the specific needs of OVCs by the various age groups was again weak across all countries (average score 1.7 out of 4)" (Phiri and Webb 2004). The reports, on the whole, did not indicate in detail either the absence or presence of any disparities by age or any thinking around issues of ECD or specific needs of adolescents. The reviewers speculate that "time constraints may have prevented gender and ECD specialists being brought into the process, but their technical input and analysis is necessary" (Phiri and Webb 2004).

The report also reviewed the completeness of the plans in five priority thematic areas:
1. Access to education.
2. Nutrition and healthcare.
3. Care and treatment for children living with HIV and AIDS;
4. Psychosocial support for children affected by HIV and AIDS.
5. Legislative reform/legal protection.

There was much country variability, but in general the rankings were highest for education (primary school) and health and nutrition, and lowest for age-appropriate programming and for adequacy of costing (Fig. 3).

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[2] *Ethiopia, Kenya, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe*

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Figure 2. Specific needs of various age groups

Summary score for specific needs of various age groups by country
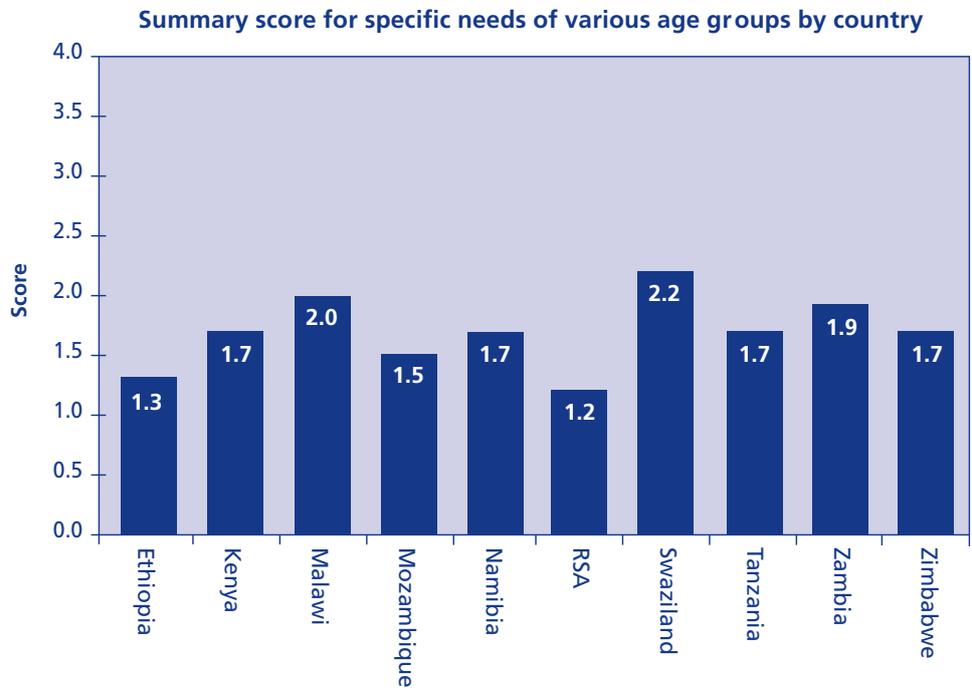
Figure 3. Median adequacy ranking of 10 plans in each thematic area
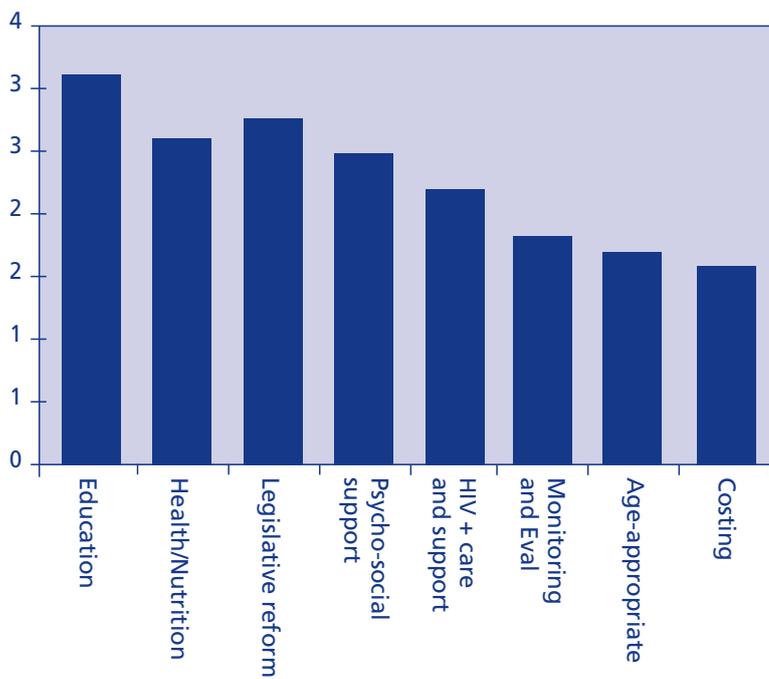
Webb et al. (2006) evaluated the process of developing plans using the RAAAP methods in 16 countries. Webb et al. (2006) concluded that there had been progress, but suggests several steps that are critical for improving next steps. Based on a review of 16 countries' process of developing NPAs through the RAAAP process, they conclude:

"This review of experiences to date with the RAAAP process highlights some key areas of learning, including: (a) fund mobilisation has been slow and has reached approximately only one-third of what is required; (b) ownership and integration into development planning of the issue of orphans and vulnerable children at country level has been undermined by the perception that the response is an 'emergency' and externally (donor) driven exercise; (c) centralised planning has failed to appreciate the complexity of context and responses at the meso- and micro-levels within countries, entailing the need to support a comprehensive decentralisation process of planning and implementation; (d) comprehensive multisectoral and interagency collaboration, involving civil society, is an important but overlooked element of the planning process; and (e) definitional variation between countries has led to large variations in budgets and coverage targets. While the RAAAP process has undoubtedly raised awareness at state level of the nature and extent of the 'orphan crisis'

and raised vital resources, only full integration of the new planning process for orphans and vulnerable children within the range of macro and national development tools will allow the response to be sustainable in the longer term" (Webb et al. 2006, p. 170).

Social protection evaluation
In 2006, 14 of the plans were evaluated for how well they handled issues of social protection (Sabates-Wheeler and Pelham 2006). The authors recognised that the plans were originally designed to meet emergency needs and that often there was a level of sophistication in the drafts and deliberations not reflected in the final paper. They noted that some of the plans were vague, suggesting that they may be hard to implement, were not very evidence-based, or lacked contextual specificity or empirical grounding. They pointed out certain assumptions – such as the reliance on the family as the centre of support – that failed to take into account the very lack of family support created in situations of vulnerability such as HIV/AIDS. They questioned whether funds given to the family as a whole would be allocated in a fair manner to orphans. As well, taking into account that the number of orphans will grow, they questioned the lack of focus on prevention and the absence of a monitoring plan. Finally, they commented that there was little focus placed on any other characteristics of vulnerability such as gender, ethnicity, disability or poverty status.

Chapter 3: Advocacy steps to make young children more visible

Recognising that the issues for young children were not well represented in national plans for children made vulnerable by HIV/AIDS, the ECD community began to highlight concerns specific to young children. This effort began in 2002 and has resulted in increased awareness of young children's concerns. The campaign has been short but intense.

3.1. Publications, projects and meetings from 2002 to present

The Consultative Group's 2002 publication on ECD and HIV/AIDS first highlighted the unique concerns of young children affected by HIV and AIDS (Lusk and O'Gara 2002). Under O'Gara's leadership, the Academy for Educational Development conducted a ground-breaking study and interventions to improve the well-being of young children affected by HIV in Kisumu, Kenya (Lusk and O'Gara 2002). This ongoing project clearly documented the risks that young orphans face, as well as the benefits of a home-visiting programme and pre-school for these children and their caregivers, compared to a control group (Lusk et al. 2003; Lusk 2005).

The UNICEF Innocenti Research Centre prepared a report on OVCs in 2003, in which Peter Laugharn introduced the concept of a 'developmentally informed' approach to OVCs. This concept, used in this paper, suggests that children's development must be considered in programming and planning.

In 2003 and 2004, the World Bank also wanted to increase the visibility of young children in their funding programs for children affected by AIDS. The operational guidelines for supporting early child development in multi-sectoral HIV/AIDS programmes in Africa (2004) were jointly published by the World Bank, UNICEF and UNAIDS. The document was translated into French and Portuguese in order to assist countries in planning for young children. To assist in this planning, the World Bank had developed a *Child Needs Assessment Toolkit* (Task Force on Child Survival and Development and Early Child Development Team, World Bank 2002) that could be used to evaluate the circumstances and characteristics of children below the age of eight.

In *Children on the brink 2002: A joint report on orphan estimates and program strategies,* published by UNAIDS, UNICEF and USAID, numbers of orphans were not disaggregated by age, the definition of 'child' referred to ages 0–14 years and no specific reference was made to younger children. However, the next issue of *Children on the brink* (UNAIDS et al. 2004) included age breakdowns and discussed why it might be important to take a developmentally informed approach in dealing with children affected by AIDS. At the same time, a concern was

raised that the age definition for a 'child' should go to 18 years. Therefore, in the 2004 report, data on children from 0–18 years old were reported for the first time. This obviously resulted in a drop in the percentage, but not the actual number, of children who were in the youngest age group. When the data were disaggregated by age using the 0–18-year cut-off, in 2004 in sub-Saharan Africa there were 7 million children under the age of 6 who were orphans (16 percent of the total number of orphans in that region). Other age breakdowns suggested that in some countries the number was even higher. Most of the children who were HIV-positive were also under age eight, a fact that also emphasises the specific needs of younger children.

In *Children on the brink 2004,* the section on age-appropriate responses describes the different developmental phases a child goes through in early childhood, middle childhood, and adolescence, and argued that these major differences in capability and concern required different kinds of responses. For example, children think about death differently along the age span. Although there is a belief in a number of countries that it is better to not talk to children about death and dying until they have the 'brain' for it (for example, age 14), there are age-appropriate ways to discuss death. Evidence suggests that being honest with children in ways that they can understand will reduce their worry, concern and sense of culpability. For example, in western Kenya, children used to wait by the side of the road for their deceased parents to return. However, after mentors with the 'Speak for the Child' project encouraged family

members to explain the truth to young orphans, they no longer waited and began to adapt to their new life (Lusk et al. 2003).

A series of publications by the Bernard van Leer Foundation on young children and HIV/ AIDS (Sherr 2005a; Sherr 2005b; Dunn 2005) highlighted the unique issues faced by children affected by HIV and AIDS. These papers focused on the concept of 'young children' as having unique needs and perspectives, rather than the intervention of 'early child development'. The Road to Toronto initiative, to highlight psychosocial issues, lead to the publication of the landmark volume *Where the Heart Is,* which summarised a number of key observations about the process of child development in highly stressed circumstances (Richter et al. 2006).

The greater understanding of development in early childhood in sub-Saharan Africa was fostered by two major international conferences on ECD, the first in Eritrea in 2002 and the second in Ghana in 2005, co-hosted by the World Bank, ADEA, and UNICEF. In the second conference, a whole series of presentations focused specifically on how young children are affected by HIV/AIDS.

Finally, the efforts of a number of organisations – including the Bernard van Leer Foundation, Firelight Foundation, UNICEF and others – to increase attention to all children and particularly to younger children at the major AIDS conferences has resulted in a new awareness of these issues. A satellite session was held at the Bangkok AIDS meeting on this topic,

another was held at the AIDS Impact Seminar in 2005, and a two-day seminar was held before the Toronto Global AIDS meeting in 2006. Age-appropriate responses were also discussed at the AIDS Impact Seminar in Marseilles in 2007.

Have these efforts made a difference? Unquestionably they have. The national plans in some countries reflect these publications and analyses. But for others, the response, as one can see from the analysis of the NPAs, is still very slow.

3.2. World Bank/UNICEF collaboration on ECD and HIV/AIDS

In an effort to increase the amount of funding allocated to young children, the World Bank and UNICEF, along with other partners, targeted five sub-Saharan African countries for special support in developing programmes for ECD and HIV/AIDS. Ghana, Malawi, Rwanda, Tanzania, and Zambia were selected because (a) the World Bank had an active fund in the country that could be tapped to support these activities, (b) interest and capacity by government was deemed adequate and (c) UNICEF staff had interest and capacity on the ground to support the effort.

An orientation conference in Tanzania in April of 2004 brought these countries together to share their ideas about how to better adapt their policies and programmes to the needs of young children. Subsequently, a civil society organisation in each country received funding from 2005 to 2006 to develop the tools necessary to improve their programming and build policies for ECD and HIV. They were to map out ECD-related programmes that addressed young OVCs, to find or develop tools needed for ECD approaches and to assist civil society organisations to apply for the World Bank funds. This information was intended to influence the national plans for OVCs.

Three of the five countries reported high interest by their governments (Ghana, Tanzania, and Zambia), one felt that the level of interest was medium and one reported low interest. However, the effects of the project can be seen in the increased awareness of young children in the NPAs even in countries, such as Rwanda, that reported low interest ((Engle et al. 2007a). Although it was a good start, a more sustained effort was needed.

Chapter 4: Assessment of the national plans of action

4.1. Country selection

This analysis of countries was intended to cover the original 17 RAAAP countries in Africa (Botswana, Central African Republic, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe) since they had been selected for the RAAAP based on high HIV prevalence rates, a high orphan population and selection as one of PEPFAR countries (Phiri and Webb 2004). Two of these countries were not included in the final list (Botswana and the Central Africa Republic) because their plans were not sufficiently clear. Two were added: Angola and Mali, who had subsequently completed their NPAs and were introduced to the RAAAP later, maintaining a total of 17 countries studied.

As of November 2007, 31 countries in sub-Saharan Africa had begun a national action plan. In Eastern and Southern Africa, 14 of the 17 countries were used in the analysis. Botswana and Burundi were not used, as the plans were not complete, and Somalia did not have a plan. Representation was much lower for West Africa. Of the 14 countries with some form of plan, only Côte d'Ivoire, Mali, and Nigeria were used, as these were the most complete. The other 11 had incomplete drafts and were not operationalised or costed. Although this is not a representative sample of all NPAs, it is representative of the countries with a high

prevalence of OVCs, where the set of issues facing young children is likely to be greater.

In 2005, 11 more countries initiated their NPAs. These were Angola, Botswana, Burkina Faso, Burundi, Democratic Republic of the Congo, Djibouti, Eritrea, Ghana, Madagascar, Somalia, and the Southern Sudan. Of these countries, Angola had a completed plan and Mali has just approved its own, so they were both included. All relevant information is shown in Table 3.

Of these 17 countries, some had additional inputs that might have resulted in improved attention to young children's issues. Four were involved in the World Bank/UNICEF/UNAIDS initiative on ECD and HIV/AIDS (Malawi, Rwanda, Tanzania, and Zambia) and five were Bernard van Leer target countries (Kenya, South Africa, Tanzania, Uganda, and Zimbabwe). Of course, other countries may have also benefited from national and international non-governmental organisations (NGOs). The status of the NPAs is shown in Table 3.

4.2. Methodology

The analysis was conducted in three parts: Status of the plans, the standard for evaluating the plans, and the system for scoring them.

4.2.1. Status of the NPAs (Table 3)
Table 3 summarises the status of each of the 17 national plans: the year introduced, the

years covered, whether the situation analysis presents numbers of children disaggregated by age, whether there is an ECD policy in place, whether the country was involved in two specific ECD-focused approaches (World Bank efforts and Bernard van Leer leadership), and finally a total ranking from 1 to 5 on the overall developmental adequacy of the plan.

The overall summary score for the degree to which the NPA was developmentally appropriate was calculated from the sum of the points received for each item listed below, with scores ranging from '1 = not at all adequate' to '5 = adequately developmental'. It should be noted that even if a plan is rated as 'adequate', this does not necessarily imply that the implementation is adequate.

Points were awarded for:
- a discussion of the situation of young children, including numbers and percentages of OVCs by age group or discussion of the special needs or circumstances of OVCs by age group (1 point);
- inclusion of programme(s) that would apply to young children, either catering specifically to young children or adapting an existing programme (1 point each);
- detailed description(s) of such programme(s), including funding allocation (1 additional point);
- a monitoring and evaluation plan that includes an assessment by age group (1 point).

4.2.2. Standards for evaluating the developmental adequacy of the NPAs

This section identifies the criteria used in evaluating the individual components of the plans. It should be noted that the ECD approach should never entail the development of separate HIV/AIDS programmes for young children but rather an extension and adaptation of existing programmes that provide care and support for children affected and/or infected by HIV. Nor should the NPA focus only on young children; ideally a policy for OVCs will be 'developmentally informed', so that there are somewhat different recommendations for different age groups.

In some cases, a programme is evaluated as to whether it is 'holistic', i.e., based on the rights perspective and General Comment 7. A holistic programme focuses not only a child's health but also the child's well-being, which is considered to be the perspective of an ECD approach.

Questions are organised according to generic categories in the plan:

4.2.2.1. Strengthening families and communities
- Are there any community programmes that provide information and support to caregivers of young children through home visiting, etc?
- Are there (usually informal) community-based childcare centres?
- Do psychosocial support programmes

address the specific needs of younger children?

- Do care and support programmes for people living with AIDS (PLWAs) include a component of attention to young children?

4.2.2.2. Access to services

- Are there health and nutrition programmes directed toward young children?
- Are there programmes for HIV-positive young children that incorporate social and emotional well-being and parenting as well as medical treatment?
- Are there early child development and education programmes to improve school readiness?

4.2.2.3. Policy and legislation

- Is there a system of birth registration in place to facilitate service delivery to all children?

4.2.2.4. Monitoring and evaluation

- Are monitoring analyses planned by age group?

4.2.2.5. National response and capacity development

- Are there activities for capacity building that focus on working with young children?
- Is there a planned national-level inter-sectoral organising structure?

4.2.2.6. Support for child rights

Additional questions, included in the annex summaries, related to the plan's awareness of young children's rights, including the recognition of the importance of a holistic approach and particular attention to young children in capacity building and monitoring and evaluation, areas that could enhance and support programming.

The evaluations in Table 4 indicate whether an age-appropriate programme was included or if a programme had an ECD focus (that is, supporting young children's well-being rather than viewing all children in a single group). If an activity that could apply to younger children (e.g., psychosocial support) did not mention adaptations to the child's age, they were not considered to be age-appropriate. All rankings were made by the author.

4.3. Results of the analysis

Only the NPA in each country was used, even though there could have been relevant information in other documents. All versions evaluated were from 2007.

4.3.1. Timing of plans and situation analysis

Table 3 shows that the date of introduction ranges from 2003 to 2007. Only six of the plans mention age groups in the situation analysis, and only three present age breakdowns in the data. One of the most notable changes is Kenya, which in 2005 did not have any age breakdown, but in 2006 issued a revision in which all interventions were categorised according to age breakdowns.

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Table 3. Summary of national plans of action with respect to young children

Country	Year completed	Years covered	Does situation analysis include age breakdown?	Young children in programme? 1–5 (1=none; 5=high)	Was there an ECD policy as of 2005? Y= yes N=no UD= under development	Participation in Bernard van Leer, (BvLF) UNICEF and World Bank (ECD and HIV/AIDS)
Angola	June 2006	2006–2008	No	3	Y	
Côte d'Ivoire	2004	2004–2006	No	1	N	
Ethiopia	2003	2004–2006	No	1	Y	
Kenya	July 2006	2005–2009	No but mentions % in ECD centres and discusses importance of age differences	4	UD	BvLF
Lesotho	2005	3 years (end date not specified)	No	1	UD	
Malawi	2005	2005–2009	0–4: 11% 5–9: 36% 10–14: 55%	5	Y	ECD and HIV/AIDS
Mali	2004	2006–2010	No	1	Y	
Mozambique	0ct 2005	2005–2006	Importance of age groups, no data	3	UD	
Namibia	Oct 2007	2006–2010	No	3	UD	
Nigeria	Jan 2006	2006–2010	No	3	UD	
Rwanda	July 2006	2006–2011	Presented and discussed	5	N	ECD and HIV/AIDS
South Africa	Oct 2005	2006–2008	No	2	Y	BvLF
Swaziland	2005	2006–2010	No	2	UD	
Tanzania	Oct 2005 Guiding document as of May 2007	2006–2010	No	3	N; Child development policy 1996	BvL; ECD and HIV/AIDS
Uganda	Oct 2004	2004–2009	Presented, not discussed	2	UD	BvLF
Zambia	Sept 2005	2007–2011	0–4: 12% 5–9: 35% 10–14: 52%	3	N	ECD and HIV/AIDS
Zimbabwe	July 2004	2004–2008	Over half are 10–14 otherwise none	1	UD	BvLF

4.3.2. Total ECD-appropriateness score

The total scores for developmental-appropriateness are also shown in Table 3. For five countries the score was 1 (no mention of young children) and for five others it was either 4 or 5, reflecting considerable focus on meeting the developmental needs of young children. Overall, there was a wide range of responses. Five countries included no particular attention to young children in their plans (Côte d'Ivoire, Ethiopia, Lesotho, Mali, and Zimbabwe) and four countries received a 4 or 5 (Kenya, Malawi, Namibia, and Rwanda).

Which factors were associated with getting a higher or lower score? A critical factor appears to be the time at which the most recent draft of the plan was prepared. Figure 4 shows changes in the scores according to the year in which the plan was prepared. The two are significantly related (r(15)=0.58, *P*<0.05), showing that the later plans were far more likely to have a higher score. Four of the five NPAs that received a score of 1 were prepared in 2003 or 2004, and four of the five highest-scored plans (4 or 5) were prepared in 2005 or 2006. All five programmes prepared in 2006 had scores of 3 or above.

Figure 4 shows the relationship between the year of finalisation and the mean rating score for that group, plus the number of countries included in the year's mean. All years had more than one country plan prepared, and seven were prepared in 2005.

Figure 4. Mean rating scale for age appropriateness of NPAs by year of the plan's finalisation (n=17) (r (15)= 0.66, P<0.01)
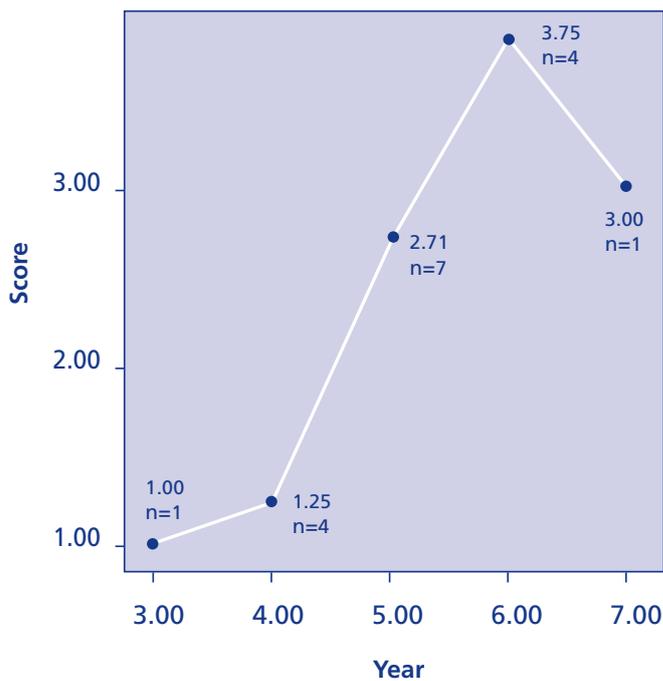
There was a trend towards higher scores in countries with an exposure to specific initiatives. Of the ECD and HIV/AIDS Bank/UNICEF initiative countries, two scored 5 and two scored 3. But the causality is not clear, since countries became involved in the ECD and HIV/AIDS initiative because of their existing interest in ECD. Of the countries with an ECD focus supported by the Bernard van Leer Foundation, scores ranged from 1 to 4. However it is possible that Zimbabwe, which scored 1 in this category, could have many good initiatives that are not reflected in its national policy.

Countries that had an ECD policy did not necessarily include programming for young children in their NPA. Five countries had a policy on ECD in 2005, four did not, and eight had a policy in progress. In each category, the scores spanned the total range from 1 to 5. In many cases, the presence of an ECD policy was not mentioned in the document, as in the case of Namibia. The lack of mention of the ECD policy may indicate that there is still a lack of coordination between the ECD planners and the HIV/AIDS planners.

4.4. Evaluation of programme components

Table 4 shows the types of programmes initiated by the 17 countries that included an age-appropriate response. Figure 5 shows the number of countries that included age-appropriate elements in their programme(s).

Figure 5. Number of countries that included ECD-focused elements in their national plans of action
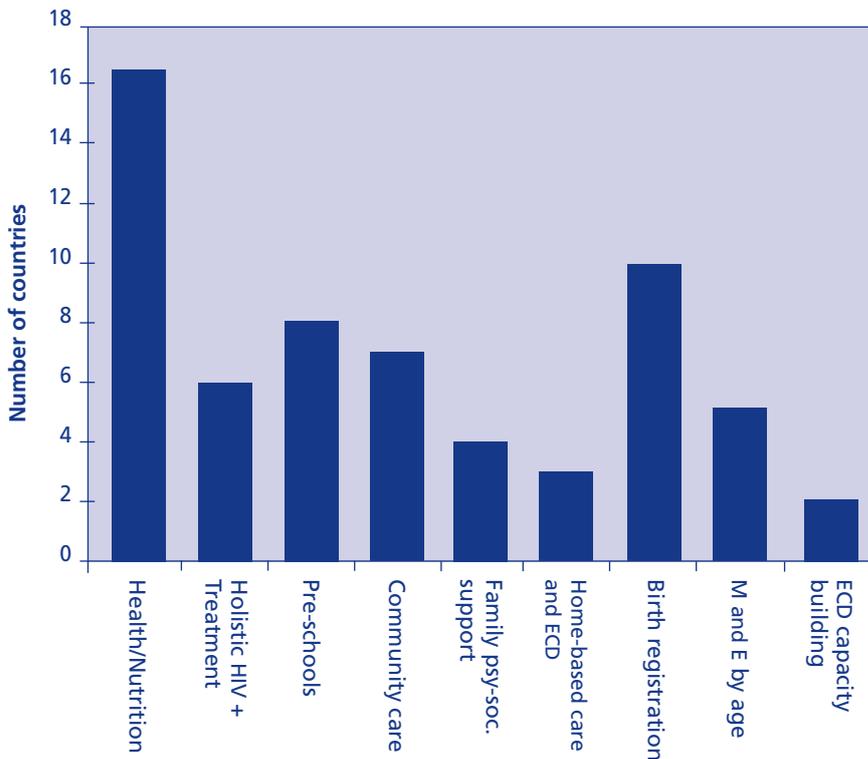
Table 4. Programming responses to the needs of OVCs: Programme components that respond to the developmental needs of young children and have a holistic approach

Country	Year	Access to services: health and nutrition specifically aimed at young children	Access to services: holistic treatment for HIV+ children	Access to services: supports for transition to school; early childhood education	Community-based responses: targeted community childcare centres	Strengthen family care and caregivers: psychosocial support	Home-based healthcare includes young children	Policy and legislation: improve birth registration systems
Angola	June 2006	Yes – access to health services; feeding for vulnerable 0–2-yr-olds	Plan is pending	No	Yes – reactivate community childcare programmes for most vulnerable communities; based on mapping needs; specifies number of centres and training of care providers	Support for families in health, nutrition, emotional development, to vulnerable families, but not age-specific	No mention of home-based care	No
Côte d'Ivoire	2004	Yes	No	No	No	No	No	Yes
Ethiopia	2003	Increase access and referral; not age-specific	Yes but not holistic	No	No	Support for families but not age-appropriate	Not mentioned	Yes
Kenya	2005/ 2006*	Increase access for all; schedule for immunisations micronutrients	Not mentioned in NPA	Nothing on transition to school; mention of support to ECD and monitoring	Recommended for child-headed households only; also recommended for protection of vulnerable children as future priority	One session per year for caregivers on how to deal with young children	Not mentioned	Yes, high priority
Lesotho	2005	Yes	Yes but not holistic	No	No	Has play therapy but not age-based psychosocial support	Not mentioned	Not mentioned
Malawi	2005	Yes	Yes	No	Many community-based child centres exist that serve orphans and vulnerable children	community-based childcare teacher will also be trained to do home visits	Has to involve psychosocial support	
Mali	2004	Yes	Services but not holistic	No	No	Yes but across ages	Not age-specific	Not mentioned
Mozambique	2005	Yes	Services but not holistic	Pre-school strategy for 3–6-yr-olds	Expand daycare centres for young OVCs, particularly in rural area	Broad and multi-sectoral; does not vary by age	Holistic approach, including spiritual; not age-specific	Yes to strengthen

*The Kenya plan of action differed very much from the 2005 version, which did not consider developmental issues at all, to the 2006 version, in which the Government defined three separate basic packages based on three age groups, and incorporated a number of elements related to young children. Both are described in Annex 2, but the second one is reviewed here.

Table 4. (continued)

Namibia	2007	Yes, free access for 0–3-yr-olds for elderly caregivers; feeding in ECD centres, water in ECD centres	Medical, not holistic	Expand ECD programmes expand to more OVC	Expand ECD programmes and give community support for vulnerable groups	Generic family support	Holistic approach, not age specific;	Yes
Nigeria	2006	Yes	Services but not holistic	Institute free pre-primary education and specific counselling for OVC	Not age-specific	Broad	Incorporates improving care for children	Yes
Rwanda	2006	Yes	Yes – holistic approach	ECD centres established, model programmes	Community based childcare programmes established and facilitators trained	Holistic childcare – age-based minimum package of interventions	Family-based intervention, but not developmental	Yes
South Africa	2005	Not specific	Yes	No	Listed price in budget; otherwise not there	Not age-specific – comprehensive and integrated services	No	
Swaziland	2005	Yes – feeding at NCP, improved access to minimum services	Limited; ARVs, adding feeding at clinics	Some focus on ECD in Neighbour-hood Care Points (community organisations)	NCPs centre of community support; volunteers serve orphans, many are young, some after-school, non-formal education; range of services through NCPs	Some training for caregivers on health and nutrition issues; Income-generating activities and food production but no reference to care situation	Not mentioned	Yes, planned to improve
Tanzania	2005	Free health services, strong nutrition focus	Very holistic, but not age specific	Included pre-school in plans but no funds	Strengthen psychosocial support, community support; not age-specific	Not age-specific	Training HBC workers on ECD but no funds allocated	Not mentioned
Uganda	2003	Yes	Yes	No	Mentioned once as a process indicator, otherwise no	Not age-specific	Not mentioned	Yes
Zambia	2005	Yes	Yes	Incorporates IECD into school system; not clear nor costed	Provision of cash transfers; not childcare	Information and support to caregivers on childcare information	Not mentioned	Yes
Zimbabwe	2004	Access to services	Medical care only	No	None	Not age-specific	No	

4.4.1. Health and nutrition services

The most common intervention for young children was improved access to health services. All country plans included an improvement in health and nutrition services, such as free access to healthcare for all children, free access for OVCs or for children with elderly caregivers (Republic of Namibia 2004). Some limited the healthcare to a specific package of free services, usually including immunisations and micronutrients and perhaps healthcare. Some (e.g., Tanzania) focused on monitoring growth and improving nutritional status.

No countries incorporated a concern for the HIV-affected child's development and psychosocial care into their health services, although this has been strongly recommended to the WHO by Richter and Foster (2005). They make the following recommendations:

Give strong guidance to Ministries of Health to lead a holistic response to children in communities affected by AIDS.

- Promote integrated responses to children based on knowledge and experience gained within the health sector and its partners.
- Promote health centres as nodes of support, working together with community initiatives on the common agenda articulated by the
- *Framework (*Subbarao and Coury 2004) to support children and families.
- Strengthen the community component of IMCI and ensure that it used to organise and coordinate health sector responses to children in communities affected by HIV/AIDS.

4.4.1.1. Services for HIV-positive children

Of the 17 countries, six incorporated other elements into their plans for treating children living with HIV, who are usually younger children: Malawi, Rwanda, South Africa, Tanzania, Uganda and Zambia. Tanzania's programme was very holistic but not age-specific. For the rest, the medical model and provision of ARVs was the major intervention, if one was mentioned at all. There is a great need for more information on children's course of development, the possible effects of the virus on their functioning, and psychosocial as well as medical guidance. These issues are only now beginning to be addressed.

4.4.1.2. ECD centres (pre-schools) and community-based centres

All plans focused on strategies for helping orphaned and vulnerable children to stay in school, although there was less attention to facilitating the transition to school. Eleven countries proposed some form of organised early childcare services. Some focused primarily on school readiness: Nigeria proposed free pre-primary education in the schools for all and specific counselling for OVCs. Mozambique suggested developing a pre-school strategy. Zambia proposed incorporating ECD into a school support system, but the description was not clear, and no funds were allocated in the first year.

The more common approach was a community-based childcare system, which was well-developed in Malawi, Namibia, and Swaziland. Namibia proposed to enrol more OVCs into

existing centres, and Angola, Mozambique, and Rwanda proposed to expand childcare centres for the most vulnerable. Some countries mentioned provision for early childcare but did not include it in the budgeting process (Tanzania), or they mentioned it only in one place, within a specific plan (South Africa). Kenya recommended that centres be available only for children being cared for in child-headed households to enable the older caregiver to attend school, and this was viewed as an 'extended' (that is, additional, dependent on funding) rather than a minimal service. In the budget it was proposed as a support for all vulnerable young children if funds were available.

Unfortunately, it appears that many of the benefits of ECD centres for the child and the family are not recognised. Few countries mentioned that community-based childcare could serve the purpose of supporting families by providing access to services like food and healthcare, psychosocial support for children, a respite for families, and a source of protection for girls. Although the idea is growing, it lacks complete support. In fact, few countries included any capacity building for workers in this realm, suggesting that they are not yet well aware of what these community based centres might require.

A number of countries proposed increasing agricultural productivity, but additional food was incorporated with community-based systems or childcare for only three countries: Swaziland, Namibia, and Angola. The need for alternate childcare when the primary caregiver is working must also be considered. Finally, working as a childcare provider could be a good source of income generation that would benefit both the care provider and the children.

4.4.1.3. Psychosocial support
Although all of the programmes included some form of psychosocial support, almost none recognised the unique needs of young children. Kenya's plan did so: they suggested one session per year for caregivers in how to deal with young children. Zambia also recognised the importance of helping caregivers deal with young children, but the activities were broad and not well defined. In Malawi, Rwanda, and Swaziland, the Community Child Care Teachers (volunteers) will be used for this purpose, although there was no special training or capacity building included.

4.4.1.4. Birth registration
Most countries advocated improved birth registration.

4.4.1.5. Rights perspective
Most of the countries expressed their plans in terms of children's rights, but very few mentioned young children's rights. One country clearly noted the importance of young children's expression of their wishes, and only one acknowledged young children's rights to play.

4.4.1.6. Monitoring and evaluation and capacity building
In order to implement a programme that takes a developmentally appropriate approach, it is necessary to monitor the results using age

disaggregation. Even though six countries showed an awareness of age differences in their situation analyses, less than five included disaggregation of impacts by age, which is a great loss. Further, only two countries specifically argued for capacity building in ECD. Unless there is stronger institutional support, the ECD interventions will remain at the level of theory and will neither be implemented nor evaluated.

Chapter 5: Conclusions, assumptions, and recommendations

This chapter reviews the extent to which age appropriate programming was included in the plans. The comments should be seen in the context of the evaluation of these plans generally. In a recent review, Webb et al. (2006) concluded that there had been progress, but suggests several steps that are critical for improving next steps in general. Based on a review of 16 countries' process of developing NPAs through the RAAAP process. In general, there is a need for integrating the response for orphans and vulnerable children into a comprehensive and multi-sectoral collaboration. They also recommend the use of a single definition of orphan as proposed in 2005 in the *Monitoring and Evaluation Guide* rather than the multiple definitions. Finally they recommend that "full integration of the new planning process" for orphans and vulnerable children will result in a sustainable response.

5.1. Conclusions from the analysis and assessment of the NPAs

Many countries' plans did not incorporate **developmental concerns** at all into their thinking. Uganda's NPA was very carefully and thoroughly prepared and even included age-based data, but did not incorporate this into its programming. On the other hand, some countries, such as Kenya, Malawi, and Rwanda seemed to include a strong commitment to young children in their plans.

Some NPAs have **changed over time.** The most dramatic change was in Kenya's plan of action. The July 2005 version essentially had no reference to young children. However, the July 2006 version recognised the importance of a developmental approach and was clearly influenced by *Children on the brink 2004,* which was quoted extensively (UNAIDS, UNICEF and USAID 2004). In this version, three age groups are defined, each with somewhat different 'minimum packages', including variations in psychosocial support by age, and in educational opportunities. The recommendation for a community-based childcare programme is limited to child-headed households, potentially missing the value of a pre-school experience for reasons other than alternate childcare. The approach tends to be holistic, linking across sectors.

The other countries with strong ECD plans all **participated in the 2004 workshop** and this may have influenced their thinking (Kenya, South Africa, Uganda, and Zimbabwe did not). However, we must recognise that they were invited because they were already interested.

Despite a growing recognition of young children affected by HIV and AIDS, there is still a **low level of funds** that are actually allocated. In many cases, programmes existed that had no allocated funding, suggesting that they will not be part of the implementation plan.

ECD centres are often seen only as educational institutions, not as **sources of psychosocial support,** respite for caregivers, and means to free up older girls' time. It is surprising that none of the NPAs appeared to consider that a childcare centre could be a source of psychosocial support and joy for children, as well as facilitating the delivery of healthcare services and food. It was seen in Kenya as a way to help a children who are the heads of their households attend school. The increasing demands of childcare on older children were recognised only in Zambia.

Income-generating projects seemed to be recommended without any consideration of who would take care of **unattended children.** This is a particular concern for young children.

In general, the interventions to improve **psychosocial support** for young children were very weak, such as the one session per year recommended in Kenya.

Some children are **abandoned** at birth but the number is not known, and they were not included in the NPAs.

The focus has shifted strongly to **helping children with vulnerability** in general, rather than targeting children who are orphans due to AIDS. Similarly, there is a recognition that the burden on children may be greater when a parent is ill than when the parent has died and the child has made the initial adjustment. However, because these definitions are still vague, one sometimes sees the narrow

definition of 'orphan' still being used. The recommendation of the newest *Monitoring and Evaluation Guide* ((UNICEF et al. 2004).) has contributed to more consistency across countries. An orphan is defined as a child aged under 18 years who has lost one or both parents. A child made vulnerable by HIV/AIDS has a chronically ill parent, lives in a household with a chronically ill adult, lives in a household with adult death in the past year and/ or lives outside family care (i.e., lives in an institution or on the streets; (UNICEF, UNAIDS, USAID, DHS, Family Health International, World Bank, Save the Children and AIDS Alliance 2005) The complexities of the definitions in Annex 1 are rich but do not permit cross-country comparisons.

Very little attention has been paid to **capacity building** in working with young children, nor to standards of quality for some of these programmes. These need to be incorporated into plans in the future, including new roles for workers to be trained in new kinds of services.

5.2. Assumptions made in the NPAs

There seems to be an assumption **that if the family's well-being is increased, benefits will flow to all children.** This is the rationale behind the new interest in cash transfer mechanisms. However, under certain circumstances this may not happen, and the youngest children are the most vulnerable to both stigma and lack of care. The issues of intra-household allocation of resources, stigma and discrimination within the household are often very important in

determining what children will receive. This issue will grow with the increased use of cash transfers. For non-biological caregivers, the discrimination is more obvious. "Regardless of their age, all children cared for by adults who are not the biological parent may be at risk of discrimination due to differential care provided to non-biological children when compared to biological children" (Case et al. 2004 cited in Fonseca et al. 2007). There is some evidence that adults who are not as closely related to the children provide less positive care than more closely related adults. Namibian children recognised this in their interviews at age 5, as many reported a preference to live with e.g., a grandmother than with other, possibly wealthier relatives (Hayden 2006).

Counselling young children isn't necessary or possible. In Michaels et al.'s study (2005) of the treatment of children living with HIV in South Africa, many of the healthcare workers reported feeling uncomfortable in dealing with issues surrounding HIV/AIDS. There are materials to help: an NGO developed a book about how children understand death and UNICEF South Africa prepared two books on young children with HIV (UNICEF South Africa and Early Learning Resource Unit 2007).

No special skills are needed to work with young children. Many countries appear to assume that no training is needed, as only two countries' NPAs mentioned training. However, as noted above, special training is very necessary. South Africa is developing new positions (e.g.,

ECD Community Worker) with job definitions and educational criteria to build this market.

All early childcare centres need is a physical space and a community volunteer. Although the number of countries that are beginning to consider early childcare centres as ways of meeting multiple needs of children are increasing, there is a concern that the quality is very poor and that the long-term consequences will be negative. Guidelines for staff training and for basic factors such as child/teacher ratios must be developed for each country and incorporated into the plans. Otherwise, the situation as described by Cox et al. (2006) of one teacher for every 75 children will occur in some centres, with no hope of a quality programme.

One size fits all. Hardly any plans discuss variability within and between countries. Yet we know from past experience that each intervention must be specific to the context.

HIV positive children need only medical solutions. Only a few countries recognise the multiple needs and difficulties of caring for these children.

We don't know or don't have time to find the most effective approach. There is an absence of consistent, systematic information about what works in what places. Interventions with participatory outcomes are beginning to demonstrate what can be done to improve the well-being of young children.

Stigma is the same for older as for younger children. Young children of HIV-positive mothers are often assumed to be seropositive as well. Specific awareness campaigns are required to change this view.

One can address children's rights without addressing women's rights. Women's rights to inheritance, to divorce or to control over sexual behaviour are ignored in most policies.

5.3. Recommendations and future directions in policy and programming for young children made vulnerable by HIV and AIDS

Have issues facing young children affected by AIDS and otherwise vulnerable children made it into the NPAs and onto the global agenda? There are some signs that this is happening. In a paper prepared for PEPFAR (CARE 2008) in 2005, ECD was listed as one of the key interventions that should receive funding. In testimony to the US Congress, and in a subsequent publication the head of CARE, Helene Gayle, specifically named ECD as a key intervention for a comprehensive approach (CARE 2008). The World Bank and UNICEF continue to support interventions for young children, and the Bernard van Leer Foundation is continuing active advocacy for children made vulnerable by HIV and AIDS.

5.3.1. Recommendations
Evaluate assumptions. The previous chapter reviewed a number of assumptions made in NPAs that are not well supported by evidence. These assumptions were made when the programs were first prepared, in the absence of evidence, but over time they need to be re-evaluated for to see if they are consistent with new evidence or they will lead to ineffective programmes.

Provide adequate funding for the NPAs to include ECD measures. The critical actors in preparing and implementing each country's NPA face many challenges. They must have sufficient funds to be able to move beyond the most basic needs of food, immunisations, and primary school attendance in order to include ECD interventions that can have long-term impacts on children's well-being.

Build the case with evidence. Good evidence for the importance of early interventions for children with HIV is needed for good NPAs, including clear directions on the most effective measures. Simple indictors of child outcomes, such as those developed by 'Speak for the Child' (Lusk 2005) or the Human Sciences Research Council (Rochart and Richter 2007) will help communities decide what works for them. Assessments of existing programmes are beginning to highlight important characteristics in particular contexts, but they are too few (Engle et al. 2007a; Potterton 2007).

Develop capacity in ECD at the country level. In order for these measures to be successful, a concerted effort is needed to develop capacity for ECD, including examples of programmes that work, guidelines for programmes and trained workers. These should build on existing child-rearing practices. South Africa is beginning this effort with the establishment

of new roles, such as the ECD Community Development Worker.

Strengthen the role of the health sector for young children's development and develop new platforms for care. Linking ECD with other interventions such as PMTCT or home-based approaches should be a key component of NPAs, as they provide an excellent foundation for improving the well-being of both caregivers and children (Michaels et al. 2005). Incorporating mental health issues for the primary caregiver into these efforts is key to success.

Strengthen structures at local, regional, and national levels for an integrated approach. As has been mentioned many times, an adequate response to the multiple needs of young children requires a coordination of approaches across sectors. This has begun to evolve through the process of developing NPAs, but it must continue and be supported in the implementation phase.

Support women's rights. In the AIDS pandemic, the heaviest burden both of the disease and of care for orphaned and/or vulnerable children is being borne by women. Because children's well-being and rights, particularly young children's well-being, is so closely linked to the status and rights of women, this should be a central component of many plans. However, it is rarely included in the NPAs. Linkages with efforts to improve women' rights, both for themselves and for children, need to be made in all plans. Link the NPAs with other plans in order to effectively implement them. Many of these plans are still far from being clear enough to be implemented and are missing key components. However, these components may exist in other government documents, as in the case of South Africa's and Kenya's ECD policies. Linking the plan with other efforts within countries is essential for an adequate implementation of these plans.

As the NPAs evolve and become more closely linked with other policies within the country, the specific needs of young children should be a top priority, along with those of school-aged children and adolescents.

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Annex 1: Recommended actions for young children from *Operational Guidelines for Supporting Early Child Development* (World Bank, UNICEF and UNAIDS 2004) categorised into the major categories listed in the *Framework* (UNICEF and the Expert Working Group of the Global Partners Forum for Orphans and Vulnerable Children 2004)

1. Strengthening family capacity:
- Sensitise family members in special needs of young children such as grieving, counselling for emotional stability, positive discipline techniques, stimulation and play, and the importance of consistent care.
- Support family-based care, foster care, local adoptive placements, home visits, or community- and faith-based organisations that are integrally linked to community and family preservation and support child-headed and elderly-headed households with information, resources, and social support, particularly for the more complex needs of younger children.
- Help parents to plan for the future of their child, including discussing the future in developmentally appropriate ways.
- Train caregivers in special health, nutrition, and stimulation needs of young children and in child feeding practices. Young children are vulnerable to measles, diarrhoea, and pneumonia, and lacking nutrition these diseases could be potentially fatal. Support kitchen gardens.
- Improve hygiene and sanitation in the home, with a special focus on how young children

use these systems.
- Ensure parental health (including ART), and appropriate infant (breastfeeding and complementary feeding) practices, including building a relationship with the child.
- Support families through income-generating activities and treatment options that allow time for young children.
- Provide home visiting for isolated caregivers (rural).
- Use home visitors for palliative care to support caregivers and give more attention to children at home, particularly younger (and more isolated) children.
- Help link families with basic services and access to funds; sponsor income-generating activities when there are alternative childcare services so that older children do not need to leave school.

2. Mobilising community-based responses:
- Provide community monitoring of the situation of young children orphaned by HIV/AIDS as well as additional support when necessary.
- Develop and/or strengthen community-based childcare centres, small group

community homes, or external play areas; and use them as a place for children to learn, play, socialise with peers, and have access to nutritious food and health services.

- Incorporate caring practices such as play and stimulation into community facilities.
- Provide emotional support and social networks for caregivers, perhaps through childcare centres.
- Provide income-earning activities for caregivers, within their community.

3. Enabling children's access to essential services:

- Ensure child's access to free basic services: immunisation and treatment of childhood diseases, including paediatric ART.
- Organise cooperative childcare programmes.
- Use childcare centres as health posts.
- Ensure family's access to safe water and sanitation.

4. Ensuring government action to protect the most vulnerable children:

- Support access to birth registration.
- Count younger as well as older children in national data; disaggregate by age.
- Provide judicial protection specifically for young children. Develop a national policy for OVCs or include the issues of young OVCs in other policies (e.g., health policy).
- Legally protect young children against stigma and gender discrimination, including in receipt of services.
- Review and establish legislation to protect inheritance rights of young children.
- Cover all pre-school costs and abolish pre-school fees for young orphans and vulnerable children.

- Strengthen social welfare sector and services.

5. Enhancing awareness for creating supportive environments for children:

- Conduct a mass campaign on parenting and young children's need for a consistent caregiver.
- Conduct a collaborative situation analysis of young children with all stakeholders.
- Raise awareness on potential developmental consequences for young children in institutional care. Strongly encourage family-based care or family type environments.
- Provide community education. Organise community schools and outreach campaigns.
- Support community mobilisation to create change in community's attitude towards HIV-positive adults and children and erroneous beliefs about mother-to-child transmission.

6. Training care providers/capacity building

- Train care providers, frontline workers, and community volunteers in childcare, in health, nutrition, hygiene, and universal precaution practices, psychosocial care, outreach activities, and in counselling skills in a developmentally appropriate way.
- Increase the capacity for health, nutrition, sanitation, and education workers to understand the risks of HIV/AIDS, keys to prevention, and the special needs of young children infected by HIV/AIDS.
- Train pre-school/childcare workers on HIV/AIDS awareness, including issues of discrimination and transmission and universal precaution practices.

Annex 2: Examples of national plans of action that have age-appropriate components

This Annex summarises the role of ECD in a representative group of seven national plans of action from different regions as of October 2007.

Kenya

Republic of Kenya, Office of the Vice President and Ministry of Home Affairs and National Heritage (2005). Republic of Kenya, Office of the Vice President and Ministry of Home Affairs (2006)

Status of the plan and definition of vulnerabilities

In July 2006, Kenya revised the National Action Plan (Republic of Kenya 2006) prepared in July 2005, which was a three-year plan. The current revision changes the plan to a five-year plan. It is costed in broad terms for 2005/2006 through 2007/2008. The NPA has an extensive introduction, linking it to the previous NPA, a discussion of links with many other initiatives for social welfare in Kenya, and includes a careful assessment of costing assumptions and estimates, including a discussion of regional variations. It also includes a monitoring and evaluation plan.

Unlike any other plan reviewed here, the Kenyan plan includes an in-depth discussion of the importance of having a developmentally appropriate response to OVCs. This discussion appeared between the 2005 and the 2006 version. It appears that one of the influences was the discussion of developmental changes described in *Children on the brink* (USAID, UNAIDS and UNICEF 2004).

a. Definition of vulnerability

The definition of the target group extends beyond orphans (children who have lost one or both parents to AIDS). Approximately 11 percent of children under 18 years are orphans, about 50 to 60 percent due to AIDS. However, the NPA paper argues that up to 6 million Kenyan children require special care and protection; this amounts to 40 percent of the country's total child population – far more than the number of orphans.

In fact, the NPA suggests that children are vulnerable long before their parents die.

"Girls, in particular, assume caring responsibilities for ailing parents and parenting responsibilities for their siblings. With agricultural productivity negatively affected by HIV/AIDS, food security is increasingly threatened, adversely affecting the nutritional status of children. Children from affected families may drop out of school and the education of all children is affected by the impact of the epidemic on teachers and the resulting quality impact. Generalised poverty and disintegrating family circumstances expose children to exploitation and abuse. Evidence suggests that among the possible consequences

of increasing numbers of OVCs could be escalating crime and social disorganisation."

The NPA argues that the extent of vulnerability depends on whether the child is infected, whether there are relatives willing and able to take care of them, whether they are allowed to go to school, and how they are treated in the community. Other significant factors are the degree of psychosocial trauma they suffered as a result of losing their parents and the responsibilities they are left with.

Specifically, the paper defines vulnerable children as falling into the following categories, with girls in each category usually needing to be prioritised:

● orphaned children;
● children who are abandoned;
● child offenders;
● children infected or affected by HIV/AIDS;
● children living in child-headed households;
● children living with elderly guardians;
● children whose lives and circumstances render them especially vulnerable to the impact of HIV/AIDS;
● children engaged in the worst forms of child labour as defined by by the International Labour Organization.

b. Situation analysis: Does it incorporate age breakdowns?
The situation analysis does not present data by age groups, although it does note that "[a]ccess to early childhood development (ECD) and education remains low, with 65 percent of children aged 3 to 6 years currently not accessing ECD services."

As noted above, the 2006 NPA recognises the distinct vulnerabilities of children at different ages. The plan states:

"Children respond very differently to their experiences at different ages, depending on their level of physical, cognitive, emotional and psychosocial development. 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. 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.

We must not regard OVCs as a homogeneous and undifferentiated group. Our policies, programmes, information, and literature concerning orphans and other children made vulnerable by HIV/AIDS may be informed by a developmental, life cycle, approach. Data and programming recommendations have often failed to make key distinctions, ignoring the physical, cognitive, emotional, and psychosocial differences that characterise children and adolescents in different stages of development. As shown in this chapter, responses that take

these differences into account will be more relevant to the child.

The age-related needs of infancy and early childhood, middle childhood, and adolescence must inform this programming."

The plan discusses each age group and the recommendations for programming for each. The discussion for infancy and early childhood (0–5-year-olds) follows.

"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 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 fulfilment of basic physical needs, the child needs touching, holding, emotional support, and love from the 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. Children at this stage of life 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, 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 under age 5 – especially those whose families live in poverty in developing countries – are vulnerable to potentially fatal measles, diarrhoea, 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 immunisations, treatment of childhood illness, and adequate nutrition can not always be assured, programmes 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 behaviour. 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 organisations that are integrally linked to the community. Strategies that can help keep young children in families also include community-based childcare and home visits. In response to demand, community-based childcare centres are becoming more common in a number of countries. They provide children with food, access to healthcare, 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, pre-school attendance, and adequate nutrition for the children. Home-based care for an ill parent can help families as well as the affected adult."

This discussion outlines eloquently the many challenges and risks for young children in vulnerable conditions. A number of responses are suggested in the section: keeping children with families through increased support to families, community-based childcare, special attention to social and emotional support for young children, sensitive and simple explanations, and increased health and nutrition care. However, in the following section, the plan outlines a specific set of recommendations for this age group. The list is limited to meeting basic needs, health services, basic nutrition, and one session per year with caregivers to discuss young children's needs and concerns. In only one case is community-based childcare recommended: when the household is headed by another child, and this is an intervention "only if there are additional funds". Thus, although the introduction discussed many critical factors in an age-related response, the plan makes only a few of these recommendations.

Recommended minimum package for children 0–5 years old:

Based on the above discussion and the major health threats as defined by the Ministry of Health, a minimum package for this age group may be defined as follows:

- Ensure appropriate family-based care is available to the child.
- Ensure the family and child have proper housing or shelter.
- Ensure the child has received all required immunisations aas defined by the Ministry of Health (MOH) in the OVC plan. Annex 13 presents the MOH 806 form, which is also referred to as the Health Card and which provides the details of the immunisation schedule as approved by the Ministry of Health. It is important that the caregiver retains this card and presents it on every visit to health facilities.
- If a primary health facility is within reasonable distance, ensure that child and caregiver visit the facility that will provide growth monitoring support and provision of vitamin A to the child as indicated in Annex 13, MOH 806 form; also ensure that the caregiver attends health promotion sensitisation sessions provided by health workers in health facilities.
- Ensure the child receives proper nutrition, including iodised salt.
- Ensure that the child has obtained her/his official birth registration papers.
- Ensure the child has proper clothing.
- Ensure child's caregiver attends one awareness-raising session per year that includes:
  - the basic psychosocial support needed by children 0–6 years old. As part of the psychosocial needs of the child, their rights include being listened to and participation in decisions that affect them;

however, the child-participation component at this stage of life cycle will be very limited and tailored with respect to the capacity of the child.
  - basic hygiene and health education;
  - basic protection issues, including advocating against female genital mutilation (FGM);
  - how to prevent malaria;
  - how to prevent diarrhoea and pneumonia.

Recommended extended package for children 0–5 years old:

- If resources permit, additional support interventions that define an extended package may include the following: provision of anti-retroviral (ARV) drugs and theraphy for opportunistic infections for HIV-positive children. Please note that after initial assessment of HIV status, drugs are provided free of cost by Ministry of Health to HIV-positive individuals.
- home visits by social workers;
- community-based daycare centres for children whose head of household attends school;
- provision of insecticide-treated bed-nets; if a reasonably priced early childhood development and education centre (ECDE) is available within a reasonable distance, ensure children that who are 4 or 5 years of age are enrolled and attend;
- provide additional awareness-raising session(s) for the child's caregiver that may include [Please note this is a non-comprehensive list of suggestions]:

- importance of ECD activities;
- interaction with child regarding death of a loved one;
- protection issues tailored to the local setting;
- advanced psychosocial support.

Despite the strong advocacy for needs of young children, the response is still limited. It is possible that this NPA draws on other funding sources. For example, the NPA refers to the "MoE Kenya Education Sector Support Programme (KESSP)" for more discussion on ECD centres.

c. Is there an ECD policy in place?
It was under development in 2005.

d. Status of NPA
- *National action plan for OVCs exists or is in planning?* Yes.
- *National action plan has been adopted by government?* Draft.
- *National action plan exists with and specifies estimated costs and sources specified?* Yes.
- *Monitoring and evaluation plan exists?* Yes.
- *Resources defined and roles of ministries defined?* Yes.

Does the plan reflect the general principles as applied to young children?
As with most plans, there is a generic support for the best interests of the child, non-discrimination, and strengthening families and communities to perform their role, but there is no mention of an age-appropriate response. However, this plan is unusual in that it phrases the interventions in terms of rights.

It recognises the value of a developmental and holistic approach, at least at the outset. And it is most unusual in suggesting in the introductory session that even young children have the right to express an opinion and have it taken into account. In the list of interventions for children 0–5 years old, one of the interventions listed in the 'minimum package' is to "ensure that the child's caregiver attends one awareness-raising session per year that includes basic psychosocial support needed by children 0–6 years old. As part of the psychosocial needs of the child, their right to being listened to and participation in decisions affecting them is explored, but the child participation component at this stage of life cycle will be very limited and tailored with respect to the capacity of the child." The right to play is not mentioned.

Programming for young children
A minimum package of health interventions is required and these are age-specific, but otherwise none of the interventions vary by age. Examples of services include vaccinations, micronutrients, supplementary feeding for vulnerable families, water and sanitation interventions, birth registration, psychosocial support, and home visiting by the health team for the most vulnerable children.

The approach to children who are HIV-positive is primarily in terms of the supply of ARVs, but it is not holistic. Programmes to support families cover the age span, including increasing income, school support, and social mobilisation. ECDE programmes that are designed to meet the needs of children made vulnerable by HIV

and AIDS do appear, but they are not always well defined, and the costing is not shown for each item. A current activity under education services is "support to early child development". Under the heading of "extended services if funds permit" for all three age groups, community-based daycare centres are to accept children 4 and 5 years of age in child-headed households in order to enable the head child to attend school. However, for other vulnerable children 0–5 years old, there appears to be no provision for enrolment in ECD centres.

On the other hand, under the heading of protection for vulnerable children, the following activity is highlighted as highest priority for future action:

"Protection and care of vulnerable children enhanced through: supporting the establishment of daycare centres for OVCs at community level."

Resources for young children in the NPA Resources are not designated by age; in the costing model, the young child is assumed to require only 0.24 of a Kenyan shilling compared to an adolescent, who uses 1.0. No specific capacity building for young children is included.

Evaluation
In the 2006 version, great strides were made in recognising the importance of a developmental perspective on young children, compared to the 2005 version. Although not reflected strongly in programming, it shows an increasing awareness of the importance of age disaggregation. One can hope that this attitude continues to be reflected in subsequent versions of the plan. The costing picture is broad, so that it is not clear how much will be spent on each item. But this NPA is sophisticated and shows promise.

The country was given a score of 4 out of 5 because two or more examples of age-appropriate programming were mentioned, and there was an analysis of age appropriateness.[3] However, it did not receive a 5 because it was not clearly costed or well defined.

Mali
Secrétariat exécutif du haut conseil national de lutte contre le SIDA (SE/HCNLS), en partenariat avec le Ministère de la promotion de la femme, de l'enfant et de la famille, UNICEF et l'onusidales (2004); Secrétariat exécutif, Présidence de la république de Mali, Haut conseil national de lutte contre le sida (2004)

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[3] *The overall summary score for the degree to which the NPA was developmentally appropriate was calculated from the sum of the points received for each item listed below, with scores ranging from '1 = not at all adequate' to '5 = adequately developmental'. It should be noted that even if a plan is rated as "adequate", this does not necessarily imply that the implementation is adequate.*

Points were awarded for:
- *a discussion of the situation of young children, including numbers and percentages of OVCs by age group or discussion of the special needs or circumstances of OVCs by age group (1 point);*
- *inclusion of programme(s) that would apply to young children, either catering specifically to young children or adapting an existing programme (1 point each);*
- *detailed description(s) of such programme(s), including funding allocation (1 additional point);*
- *a monitoring and evaluation plan that includes an assessment by age group (1 point).*

See also Chapters 4.2 and 4.3 above.

Status of the plan and definition of vulnerabilities

a. Definition of vulnerability
Not included.

b. Situation analysis
No breakdown by age.

c. Is there an ECD policy in place?
Yes.

d. Status of the NPA
- *National action plan for OVCs exists or is planned?* Yes (2006–2010).
- *National action plan adopted by government signed in 2004?* Plan underway.
- *National action plan with estimated costs and sources specified?* No.
- *Monitoring and evaluation plan?* Yes.
- *Resources defined and roles of ministries defined?* Yes, for ministries.

Does the plan reflect the general principles as applied to young children?
There are no comments on age differences in support for children's rights.

Programming for young children
Health and nutrition services are appropriate to age level, with specific health system and medical aids for affected young children. For example, there is a programme to feed children of seropositive mothers, but the perspective is medical rather than holistic. No mention of birth registration is included.

The only mention of ECD programmes is a mention of the importance of training workers in daycare centres for children. Otherwise all programming approaches are generic or for older children.

Resources for young children in the NPA
a. There are capacity-building activities that at one point include training for infant daycare workers.
b. The monitoring and evaluation is unrelated to age grouping.

Evaluation
Except for one small mention, there is no discussion of age appropriateness or unique vulnerabilities of any age group. For this reason, the score is 1.

Mozambique
Republic of Mozambique, Ministry for Women and Social Action (2005)

Status of the plan and definition of vulnerabilities

a. Definition of vulnerability
Orphan: A child who has lost one or both parents. No distinction is made between children orphaned by AIDS and those orphaned by other causes.
Vulnerable children: Children who fit into the following categories:
- children in households below the poverty line;
- children in households headed by children,

youth, the elderly or women;

- children in households where an adult is chronically ill;
- children affected or infected by HIV/AIDS; street children;
- children living in institutions (e.g., orphanages, prisons, mental health facilities);
- children in conflict with the law (e.g., children wanted for petty crimes);
- children with disabilities;
- child victims of violence;
- child victims of sexual abuse and exploitation;
- child victims of trafficking;
- child victims of the worst forms of child labour;
- children who are married before the legally defined age;
- child refugees and displaced children.

Target group of the plan for OVCs

The purpose of the NPA for OVCs is to meet the pressing needs of orphans and other children made vulnerable by HIV/AIDS. Recognising the need to establish priority areas for intervention, this plan considers its priority to be target groups children who are below the **poverty line** in one of the following categories:

a. orphans (maternal, paternal and of both parents);
b. children infected and affected by HIV/AIDS;
c. children living in households headed by children, women and the elderly;

d. children living in households with a chronically ill adult.[4]

This plan is not intended to duplicate or replace sector policies, but to present guidelines for government action and create the institutional mechanisms to facilitate coordination of the activities to benefit children. In this context, the National Action Plan for OVCs is guided by the strategy set out in PNAC (National Plan of Action for Children), and puts into operation the interventions required to meet the specific needs and to deal with the precarious conditions of orphans and other vulnerable children.

b. Situation analysis: Does it incorporate age groups?

OVC programmes must not all be applied to a single age group. The needs of different age groups vary, and a life-cycle approach should therefore be taken with age-specific interventions focusing on the following age groups: 0–5, 6–12, and 13–17 years. (However, no data are presented.) Births are not registered.

c. Is there an ECD policy in place?

2005 – under development.

d. Status of NPA

- *National action plan for OVCs exists or is planned?* Yes, budgeted for 2005–2006, but plan is for until 2010.
- *National action plan adopted by government?* No.

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[4] *For budgeting purposes, a proxy of the number of such children was taken to be those who, it was estimated, would lose one of their parents within a year.*

- *National action plan with estimated costs and sources specified?* Yes.
- *Monitoring and evaluation plan?* Yes.
- *Resources defined and roles of ministries defined?* Yes.

Does the plan reflect the general principles as applied to young children?

- *Does the plan have an option for holistic programming for young children?* No.
- *Does the plan protect young children from discrimination as individuals or as a group?* FBOs are key providers of home-based care and provide basic needs to children in the communities as well as spiritual and psychosocial support. They have created an atmosphere of acceptance in communities that contributes to eliminating stigmatisation and discrimination of OVCs and people living with HIV/AIDS (PLWHAs)
- *Does the plan reflect a concern for the best interests of the young child?* Community support is stressed.
- *Does the plan have a concern with the child's right to express his or her views and have them taken into account?* No.
- *Are there provisions to support parents in order to assist them in avoiding separation from their children? This could include financial, etc.* Not specific.

Programming for young children (see Table 3)

1. *Are there health and nutrition programmes directed toward young children*? Free healthcare (in principle) to orphans and other vulnerable children by the Ministry of Health; improved access to health services by vulnerable families, through programmes to accelerate HIV prevention, better access to ARV drugs (including paediatric treatment), extended immunisation programmes (targeting measles and polio), mosquito nets, and services for prevention of mother-to-child transmission.

2. *Programmes for HIV-positive young children that are holistic?* Exist, but are not holistic.

3. *Are there parenting education programmes to help families deal with child-rearing?* Training is available for family members/caregivers and peer groups in protecting and caring for OVCs – medical, psychosocial support, home-based care, HIV prevention and counselling (no age specified).

4. *Are there early child development and education programmes that are designed to meet the needs of children made vulnerable by HIV and AIDS?* and 5. Care and support programmes? Support the development of a strong pre-school strategy for children between 3 and 6 years old (from summary); Support pre-schools for younger children (2–5 years old) in communities (from NAP). Expand daycare centres for pre-school age OVCs, particularly in rural areas.

5. *Is there a system of birth registration in place to facilitate every child receiving services?* Accelerate the birth registration process for all children at national level with full participation of the communities; accelerate the implementation of the NPA on birth registration in all provinces to increase access of orphans to birth certificates.

6. *Is there a programme in place to prevent the transmission of HIV to young children that*

incorporates care of young children? Support the prevention of HIV/AIDS through home-based care and PMTCT plus programmes.

7. *Are there systems for adequate alternate care for young children without families?* Not by age group.

8. *Are there supports for a child's right to play?* No.

Resources for young children in the NPA

Resources are not designated by age; in the costing model, the young child is assumed to require only 0.24 of a Kenyan shilling compared to an adolescent, who uses 1.0. No specific capacity building for young children is included.

Evaluation

Although there is not a situation analysis that discusses age-appropriate responses or age breakdowns, some age-appropriate responses are mentioned: daycare centres for orphans, a pre-school strategy, and a holistic approach to PMTCT is suggested. Although is it not clear if funding is adequate for the goals, there is at least some recognition of the unique needs of younger children.

Score: 4 out of 5; one programmatic line is mentioned and costed. The unique situation of young children is recognised.

Namibia (Plan for 2004–2007)

Government of Namibia, Ministry of Gender Equality and Child Welfare (2007)

In 2007 a revision of the 2004–2006 plan was presented. The section below describes the

new plan. Several changes were made between the initial plan, and the new one related to ECD. Initially the plan at least mentioned age-differentiated programs. The 2007 programme focuses almost entirely on either children 10–14 and 15–17, or on children in general. Many of the specific comments about young children made in 2004 are no longer present. The only exceptions are the focus on health and nutrition for young children, the support for feeding in ECD centres, and an increase in numbers of children attending the centres.

Status of the plan and definition of vulnerabilities

a. Definition of vulnerability
Orphan: A child under the age of 18 whose mother, father, both parents, or primary caregiver has died and/or is in need of care and protection
Vulnerable child is:

- a child living with a chronically ill caregiver, defined as a caregiver who was too ill to carry out daily chores during 3 of the last 12 months;
- a child living with a caregiver with a disability who is not able to complete household chores;
- a child of school-going age who is unable to attend a regular school due to disability;
- a child living in a household headed by an elderly caregiver (60 years or older with no one in the household between the ages of 18–59 years);
- a child living in a poor household, defined as a household that spends over 60% of total household income on food;
- a child living in a child-headed household

(meaning a household headed by a child under the age of 18);

● a child who has experienced a death of an adult (18–59 years) in the household during the last 12 months.

b. Situation analysis: Does it incorporate age groups?

No; no numbers, and the only age group mentioned is for children 10–14. The earlier statement, "Opportunities to meet young children's needs are greatly reduced in HIV/AIDS affected communities and HIV/AIDS programmes tend to ignore the 0–8 age group" has been dropped.

c. Is there an ECD policy in place?

Yes, but not mentioned in the document.

d. Status of the NPA

● *National action plan for OVCs exists or is planned?* The first version is dated July 2004; the revision is dated October of 2007;

● *National action plan adopted by government?* 2006–2010;

● *National action plan with estimated costs and sources specified?* Yes.

● *Monitoring and evaluation plan?* Yes.

● *Resources defined and roles of ministries defined?* Yes.

Does the plan reflect the general principles as applied to young children?

● *Does the plan have an option for holistic programming for young children?* At least discussed a few options for young children –

describes a holistic approach for all children.

● *Does the plan protect young children from discrimination as individuals or as a group?* Not specifically.

● *Does the plan reflect a concern for the best interests of the young child?* Generally yes, but not specifically mentioned.

● *Does the plan have a concern with the young child's right to express his or her views and have them taken into account?* To develop and adopt mechanisms for children's opinions and wishes to be expressed and taken into consideration when looking at care options and any other decisions affecting them. Different ways to listen to and consult with very young children need to be promoted to enable children aged 0–8 to participate in processes that affect them and to be valued for the contributions that they make.

● *Are there provisions to support parents in order to assist them in avoiding separation from their young children?* This could include financial, income-generating activities, cash transfers, and cash grants.

● *Small shelters springing up in urban areas can care for a few children and also work with caregivers, grandmothers, and teenagers so that children can return to their homes and remain at home.* These shelters often care for HIV-positive infants and young children.

Programming for young children (see Table 3)

1. *Are there health and nutrition programmes directed toward young children?*

- Ensure adequate provision of meals to OVCs attending schools and ECD centres by revising guidelines for school feeding programme and increasing the numbers of OVCs benefiting from the school feeding programme. (2004: Explore sources of financial support for the school feeding scheme, enabling it to expand horizontally to more schools, more children, more frequently and vertically down to ECD centres.
- Home-based care programs include psychosocial support, parental skills, home-caring practices, and children's rights, but no mention of age differences.
- Target preventative health care services for young children (0–3) in the care of the elderly or at ECD centres and strengthen growth monitoring to identify children in these circumstances who are not thriving.
- Improve OVCs' access to clean water and sanitation by various means, including (a) rainwater harvesting at schools and ECD centres; (b) providing boreholes and pay pumps in areas where they are most need; and (c) installing environmentally appropriate toilet facilities at schools and ECD centres.

2. *Programmes for HIV-positive young children that are holistic?* Not mentioned. (2004: ARV treatment exists but not described as holistic)

3. *Are there parenting education programmes to help families deal with child-rearing?* Generic family support groups, not age specific.

4. *Are there early ECDE programmes that are designed to meet the needs of children made vulnerable by HIV and AIDS?*
   - Expand early childhood development services for OVC, by (a) identifying children who are in most need of ECD services and removing obstacles to their participation; (b) expanding ECD facilities as necessary to accommodate such children; and (c) providing training to ECD teachers and caregivers to enable them to understand and address the needs of all children. (2004: To expand ECD services by assisting community facilities to accommodate more orphans; to register OVCs in ECD 1220 (2002). This activity is costed under "Community Support" in the OVCs cost model.)

5. *Care and support programmes?*
   - 2004: Example – Catholic AIDS Action trains home-based caregivers in psychosocial support, ensuring that children in households with relatives dying of AIDS receive counselling before and after the death of a caregiver, minimalising the trauma.
   - 2004: Support for ongoing ECD community initiatives could increase household and community capacity to provide holistic care for very young children affected by HIV/AIDS.

6. *Is there a system of birth registration in place to facilitate every child receiving services?* Yes, including not mentioning the name of the father.

7. *Is there a programme in place to prevent the transmission of HIV to young children that incorporates care of young children?* Not mentioned.

8. *Are there systems for adequate alternate care for young children without families?* Not mentioned.

9. *Are there supports for a child's right to play?* (2004: Play and recreation are an important compensatory experience for children who have suffered loss and distress. (Statement – no age mentioned).

Resources for young children in the NPA (see Table 4)

a. *Activities for capacity building for working with young children?* Not specifically Mentioned under ECD in Education goal. (2004: not specific).

b. *Monitoring and evaluation by age group?* No – the only indicator for young children is malnutrition rate and infant mortality. (2004: Yes – all analyses will be tabulated by age, gender, and region; specific indicator for feeding is by age.)

Evaluation

Situation analysis: 0
Bring OVCs into ECD centres, feeding programme: 2
Access to healthcare for children 0–3 who have elderly caregivers (not costed): 1
Monitoring and evaluation by age and gender: 0
Overall: 3

Nigeria

Federal Republic of Nigeria (2006)

Status of the plan and definition of vulnerabilities

a. Definition of vulnerability

Orphan: A child under 18 years whose mother, father or both are dead. (Note: Among Muslim communities a child is not considered an orphan if his father is alive.)

Vulnerable: A child at risk of facing increased malnutrition, higher morbidity and mortality, low school attendance and completion rate, abuse, and psychosocial consequences compared to the average child in the defined society.

AIDS orphan: "A child under the age of 18 years who has lost either the mother or both parents to AIDS."

Maternal AIDS orphan: A child under 18 years who has lost their mother due to AIDS; the total number of orphans from all causes in Nigeria was estimated to be 5 million in 1990, which rose to 7 million in 2003, and is projected to increase to 8.2 million in 2010 (UNAIDS, UNICEF and USAID 2004). In 2003 about 1.8 million of the 7 million orphans or 26 percent are orphaned due to AIDS.

A large number of children are made vulnerable by HIV and AIDS; however, a larger number is vulnerable not because of HIV/AIDS but because their familial, social, and economic realities expose them to more risks and deprivation than their peers. "The OVC's vulnerability becomes worse if the child is infected by HIV from birth or through breastfeeding and whether the mother (and father) is alive. Other factors that worsen vulnerability relate to whether they have relatives willing to care for them, whether they are allowed to go to school, how they are treated within the community, what degree of psychosocial trauma they have suffered from

their parents' death, what responsibilities they are left with (i.e., younger siblings). Importantly, orphans and other affected children are more likely to be malnourished or to fall ill. They are also less likely to get the medical and healthcare they need. Poverty, neglect and discrimination by adults in whose care they have been left are also contributing factors."

Identified in zonal meetings:

- orphans, especially those whose parents died after a protracted illness:
- abandoned children;
- children in child-headed homes;
- children on/off the street;
- children infected with HIV;
- child beggars, destitute children and scavengers;
- exploited *almajiris*;
- internally displaced/ separated children;
- children living with terminally or chronically ill parent(s);
- children living with old/ frail grandparent(s);
- children, especially girls, who get married before maturity;
- child domestic workers;
- children in exploitative labour;
- child sex workers;
- children with special challenges;
- trafficked children;
- children in conflict with the law;
- children of migrant workers, e.g., fishermen, nomads.

b. Situation analysis: Does it incorporate age groups?

Not mentioned initially; no numbers presented; but described under 'Education'. For healthcare:

"Discriminatory utilisation of healthcare by female young children because of preferences for sons, and poor attention by parents to such infants and high dependence on home remedy when the female children are sick."

c. Is there an ECD policy in place?

March 2006: Finalisation, production and dissemination of the National Policy on Child Development countrywide; working on a policy on family development. At present, there is no educational policy that specifically addresses the needs of OVCs. The National Policy on Education (NPE) provides for the establishment of pre-primary schools to cater for children aged 3–5 years, and according to the policy, "government shall encourage private efforts in the provision of pre-primary education". In the public sector, no provision is made for the establishment of pre-primary schools. By implication, OVCs of between 0–5 years are automatically out of the pre-primary schools scheme since private ownership of pre-primary schools connotes inaccessibility to OVCs because of the high fees charged.

d. Status of the NPA

- *National action plan for OVCs exists or is planned?* Five-year costed national action plan for OVCs exists or is underway.
- *National action plan adopted by government?* Not yet finalised.
- *National action plan with estimated costs and sources specified?* Yes.
- *Monitoring and evaluation plan?* Included.
- *Resources defined and roles of ministries defined?* Underway.

An age-based analysis of the situation, challenges, and opportunities for orphans and vulnerable children in Nigeria

Level/Age	What obtains	Challenges	Opportunities
Daycare and pre-primary, 0–5 years	1. Parents die, leaving children in need of care. 2. Children are kin-fostered or left in orphanages, still needing care. 3. Most pre-primary service providers are private, fee charging ones. 4. Household cash resources determine OVC's access to education at any level.	1. Competing demands on family income reduce chances of OVCs attending pre-primary education. 2. Lack of caregivers due to increased demands, deaths. 3. Lack of physical access to daycare/nursery school centres. 4. No daycare provision at offices of working-class caregivers. 5. Lack of database on the number, spread and kind of services offered by orphanages. 6. Changing family values with more emphasis on the nuclear family now leads to reduced extended family members. 7. Lack of government commitment to establishment of pre-primary schools. 8. No policy on fostering OVCs.	1. Universal basic education scheme has an output to plan for impact and basic education for orphans. 2. The African family system still provides a safety net for kin fostering. 3. Social/welfare service provided by welfare office. 4. Faith-based organisations can be useful.
Primary, 6–15 years	1. There is increased private sector participation, which dichotomises the system with respect to quality of service and cost. 2. Public schools are tuition-free but many of them lack basic facilities and render poor services. 3. Uniforms, books etc. have to be bought.	1. High fees charged in private schools. 2. Lack of facilities in the public schools. 3. Withdrawals of OVCs from school due to lack of funds or to take care of a sick relation. 4. Withdrawal, especially of girls to engage in IGA to augment family income or to be given out for marriage. 5. Lack of funds to purchase books, uniforms, school sandals etc. 6. Lack of physical access to education. 7. Increased workload due to death of parents 8. OVCs are sometimes caregivers so there are competing demands on their labour, and in most cases OVCs of this age have to withdraw from school to be full-time caregivers. 9. Strict time/hours for school attendance. 10. Cultural and religions practices that permit certain actions e.g., early marriage.	1. Some primary schools run morning and afternoon Shifts, allowing for flexibility in school hours. 2. African family support system provides kin-fostering UBE to prepare them for secondary education.
Post primary secondary school, 10–20 years	1. High fees are charged in both government and private schools. 3. Levies are also charged. Books, uniforms school bags etc are needed.	1. Fees are too high for OVCs. 2. Teenage pregnancies are common and girls are consequently withdrawn. 3. OVCs who are caregivers can not regular attend school because of increased workload. 4. Some girls are withdrawn for marriage. 5. Peer pressures are most prominent at this level. 6. Competing demands on family income reduce access to education. 7. Rigid school hours. 8. Lack of skills training reduces employability of secondary schools graduates.	1. UBE prepares OVCs for secondary school. 2. SME services provided by some NGOs and community based organisations. 3. African support system provides safety nets. 4. Some schools operate morning and afternoon shifts. 5. Increased awareness on girl-child education. 6. Energy saving devices e.g., grinding engines etc.

Does the plan reflect the general principles as applied to young children?
The plan is phrased in terms of the Child Rights Act, based on the CRC and the African Child Rights Convention. There has been consultation of stakeholders throughout the country. "Constitute or strengthen of institutional framework (Community health Action Committee or Village/Community Development Committee), orientation of such community groups and healthcare providers and building their capacity to respond

holistically and to collaborate on agenda to specifically meet the health needs of OVCs. The health response appears to be holistic: "Increase human resources and facilities for health promotion for child health and development at the community level".

Programming for young children (see Table 3)
1. *Are there health and nutrition programmes directed toward young children?* Review health policy and consider providing healthcare services free to OVCs; increase

Goals, activities, and responsible actors for ECD-related activities in Nigeria

To improve OVCs' enrolment in pre-primary schools	Formulate policy on public pre-primary education in Nigeria.	Federal government
	Pay advocacy visits to community leaders, caregivers/parents and policy-makers to sensitise them towards the importance of pre-primary education and other educational problems of OVCs.	FMWA, UNICEF, USAID, GHAIN, UNAIDS, NPC, NGO, FBO, AGC
	Identify pre-school-aged OVCs by community ward, local government authorities, state and federal levels.	FMWA, UNICEF, USAID, NPC, consultants
	Provide holistic scholarship to OVCs to cover fees, books, uniforms, exam registrations, school meal, transportation etc. where private pre-primary schools exist and or when public pre-primary schools are established.	Federal government, state and local government authorities, individuals and organisations
	Advocacy visits to churches/mosques to set up pre-primary education schools, which will be free for OVCs.	AGC, Task Force Group, OVC desk officers
	Integrate Western and Koranic school systems to encourage religious hardliners, caregivers and parents to send OVCs under their care to school.	State MOE, FME
To improve quality care of and instructions by teachers and caregivers	Build teacher/caregivers capacity in caregiving including guidance and counselling, psychosocial skills and interpersonal communication, and new approaches to OVCs' instruction in the case of teachers.	MOE, GHAIN, ENHANSE, UNICEF
	Establish counselling units in pre-primary schools where they exist now and or when public pre-primary schools are established.	FMWA, MOE
To improve the organisation of OVCs' educationa	Put in place a structural framework to coordinate educational activities/information of the school-going OVC.	Federal government, state and local government authorities

Abbreviations: AGC, Action Group Committee; ENHANSE, Enabling HIV/AIDS/TB and Social Sector Environment; FBO, faith-based organisation; FME, Federal Ministry of Education; FWMA, Federal Ministry of Women Affairs; GHAIN, Global HIV/AIDS Initiative Nigeria; MOE, Ministry of Education; NPC, National Planning Commission.

human resources and facilities for health promotion for child health and development at the community level; improve caregiver information.

2. *Programmes for HIV+ young children that are holistic?* No.

3. *Are there parenting education programmes to help families deal with child-rearing?* Yes.

4. *Are there ECDE programmes that are designed to meet the needs of children made vulnerable by HIV and AIDS?* Facilitate the increased enrolment of OVCs at all formal education levels, pre-school to tertiary level. Institute a holistic scholarship scheme for OVCs to take care of their education needs from pre-primary through vocational education schools.

5. *Care and support programmes?* Scaling up provision of home-based care for critically ill adults and OVC. Provide home-based care and treatment of opportunistic diseases for household with critically ill OVCs and adults that will include the provision of soap, bed nets, etc. education on hygienic practices assisting with the care of the sick, and childcare and household chores.

6. *Is there a system of birth registration in place to facilitate every child receiving services?* Planned.

7. *Is there a programme in place to prevent the transmission of HIV to young children that incorporates care of young children?* Includes feeding counselling.

8. *Are there systems for adequate alternate care for young children without families?* Not age-specific.

9. *Are there supports for a child's right to play?* No.

Resources for for young children in the NPA

a. *Activities for capacity building for working with young children?* Yes, in education.

b. *Monitoring and evaluation by age group?* No.

Strengthen the economic capacity of the OVCs and their households through the facilitation of OVCs and or their households into co-operative groups/societies for undertaking economic activities relevant in their areas/communities (rural villages/urban streets), establish income-generating activities, provide labour-saving equipments/technology and inputs (e.g., improved seeds and fertilisers) to individuals and households with OVCs, providing micro-finance facility through the local governments and civil societies.

Evaluation

Situation analysis: 1 (described under Education)
Programming: 1 for education plan
Costing: 1
Overall: 3

Swaziland

Kingdom of Swaziland (2005)

Status of the plan and definition of vulnerabilities

a. Definition of vulnerability

Orphan: A child less than 18 years who has lost one or both parents.

Vulnerable children: Children under the age of 18 years who satisfy one or more of the

following criteria:

- parents or guardians are incapable of caring for him/her;
- physically challenged;
- staying alone or with poor elderly grandparents;
- lives in a poor sibling-headed household;
- has no fixed place of abode;
- lacks access to healthcare, education, food, clothing, psychological care, and/or has no shelter to protect from the elements;
- exposed to sexual or physical abuse including child labour.

b. Situation analysis: Does it incorporate age groups?
No.

c. Is there an ECD policy in place?
Under development in 2005. Goal to review and finalise ECD policy (2006).

d. Status of NPA

- *National action plan for OVCs exists or is planned?* Policy 2003; plan 2005 for 2006–2010.
- *National action plan adopted by government?* Yes.
- *National action plan with estimated costs and sources specified?* Costs are estimated overall; not specific.
- *Monitoring and evaluation plan?* Yes.
- *Resources defined and roles of ministries defined?* Yes.

Does the plan reflect the general principles as applied to young children?
Discussed the plan in terms of child rights,

specifically:

- right to food;
- right to protection;
- right to education;
- right to basic services;
- right to participation;

Does the plan have an option for holistic programming for young children?
Argues for holistic programming for all OVCs. The NPA emphasises children's participation as a key issue. However, there is no discussion of giving young children the right to express their views. For example, the 'National Consultation Workshop with Children' provided valuable contributions from OVCs who are themselves experiencing the problems of limited access to health, education, psychosocial support, and basic needs, such as food and clothing. The children, given the opportunity to express themselves, gained confidence to articulate their needs, providing perspectives not gained from the adults, and they made proposals for an action plan to address their issues. But this was limited to older children.

Resources for the OVCs (2006–2010)
Focus on food production, income generating activities, other kinds of support; not linked to care needs for young children.

Programming for young children in the NPA (see Table 3)

1. *Are there health and nutrition programmes directed toward young children?*
   - The action plan seeks to ensure that guardians receive information to

provide care at home, and to know when to seek healthcare for the children through healthcare training. This can be achieved through healthcare training for caregivers.

- Improve health facility based referral and information systems.
- Expand and strengthen linkages between neighbourhood care points (NCPs) and health system, as they play an important role in community service delivery for OVCs.
- Ensure full course of childhood immunisation, vitamin A and other micronutrients supplementation, as well as routine healthcare for all children, especially OVCs.
- Vulnerable households, schools, and NCPs will be supported further to establish backyard trench gardening approaches.
- The government should be lobbied to provide free primary healthcare for OVCs (not yet available).
- By 2010, 100 percent of OVCs should be receiving food through 2520 NCPs. NCPs are used to increase the food in communities.

2. *Programmes for HIV-positive young children that are holistic?* The issues of HIV-positive children have not yet been adequately addressed, in either policies or programmes; plan to include feeding for HIV-positive children at clinics; plan to provide information on health, hygiene, nutrition, ARV/Cotrimoxazole prophylaxis for HIV infected/exposed children, and PMTCT for pregnant women.

3. *Are there parenting education programmes to help families deal with child-rearing?* Yes – recommended through the NCPs. It was recommended that NCP volunteers and guardians of the OVCs, especially for those under 5 years, should be trained to provide adequate 'home practices' in their roles as caregivers.

4. *Are there ECDE programmes that are designed to meet the needs of children made vulnerable by HIV and AIDS?* Prepare ECD operationalisation plan; operationalise the ECD policy, including training of caregivers in ECD; the NCPs should meet ECD needs; one indicator is ratio of OVCs to non-OVCs (0–5 years) accessing ECD; purchase equipment for them; water and sanitation.

5. *Care and support programmes?*
   - NCPs are intended to serve this need. As of December 2005, there were 435 community-run NCPs, with the support of over 1,300 community-based volunteer caregivers. These are receiving support from a range of international and NGO partners, as well as private sector and civil-society organisations. Communities are calling for NCPs in every neighbourhood as part of a nationwide strategy for grassroots-based, community managed service delivery to OVCs.
   - Volunteer caregivers are involved in creating an environment of care, which includes access to food, shelter, non-formal education, and psychosocial support. Vegetable gardens have also been set up at some NCPs, and should be expanded to enhance children's access

to nutritious food, and to develop basic life skills (such as gardening), while contributing to the sustainability of the community initiatives. The stakeholders recommended that the NCP initiative should have linkages with the health system.

- Rural Health Worker responsibilities should be expanded where possible to include provision of some basic health services (such as growth monitoring), so that minor ailments can be dealt with and preventative actions taken.

6. *Is there a system of birth registration in place to facilitate every child receiving services?* Improve birth and death registration system.

7. *Is there a programme in place to prevent the transmission of HIV to young children that incorporates care of young children?* Yes, and there is a plan to make it more holistic.

8. *Are there systems for adequate alternate care for young children without families?* Not age-specific.

9. *Are there supports for a child's right to play?* No.

Resources for young children in the NPA

a. *Activities for capacity building for working with young children?* Yes – for NCP caregivers, and for caregivers in households. Support for caregivers in terms of being able to cope with stressful conditions at the community level, and to be able to access and link vulnerable children, as well as themselves, to support services. Caregivers also need to be able to provide psychosocial care to traumatised children. There is a plan to

expand non-formal education services by strengthening the capacity of NCP caregivers to provide basic non-formal education, appropriate early childhood development and to empower OVCs with basic life skills.

b. *Monitoring and evaluation by age group?* No.

Evaluation

NCP programme reaches young children, including resources for caregivers: 1
Costed plan: 1
Overall: 2

Plan mentions young children but not clearly articulated, not included in monitoring and evaluation or situation analysis, and is mentioned as only one of the goals of the NCP, along with many other community initiatives, even though a large percentage of the children are under 7. Health plan is adequate for young children, but not free; response for HIV-positive children is extremely limited.

Zambia

Republic of Zambia (2005a); Republic of Zambia (2005b)

Status of the plan and definition of vulnerabilities (see Table 1)

a. Definition of vulnerability

This NPA addresses the needs of all children; it is not only intended to address the needs of OVCs. However, given that 16 percent of children have been orphaned[5], and that 67 percent of children

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5 *Republic of Zambia (2004) Situation Analysis of OVC. This figure is taken from ZDHS 2001–2002, and is expected to have risen. The figure refers to children up to and including 14 years, but excludes those aged 15–17, amongst whom the proportion who have been orphaned is higher (estimated at up to 30% amongst 18-year-olds).*

are being brought up in poverty[6], the majority of children can be classified as OVCs.

The 2005 Child Policy defines an orphan as a child under 18 who has lost one or both parents. Children have mainly been seen in the context of orphans, but more attention has to be given to uninfected but vulnerable children whose voices are rarely heard.

b. Situation analysis: does it incorporate age groups?

As they grow older, greater proportions of children have been orphaned. Even so, significant numbers of very young children lose a parent before the age of 5. In 2002, 12 percent of 5-year-old children had already been orphaned. Even more children lose parents during middle childhood and early adolescence. For the 14-year-olds of 2002, 31 percent of urban children and 27 percent of rural children had lost one or both of their parents.

c. Is there an ECD policy in place?

No.

d. Status of NPA

- *National action plan for OVCs exists or is planned?* 2005.
- *National action plan adopted by government?* Not sure.
- *National action plan with estimated costs and sources specified?* Year 1 costs only.
- *Monitoring and evaluation plan?* Listed indicators but not a plan.

- *Resources defined and roles of ministries defined?* Yes for year 1.

Does the plan reflect the general principles as applied to young children?

a. *Does the plan have an option for holistic programming for young children?* Yes, but not age specific.
b. *Does the plan protect young children from discrimination as individuals or as a group?* All children.
c. *Does the plan reflect a concern for the best interests of the young child?* Not specifically.
d. *Does the plan have a concern with the young child's right to express his or her views and have them taken into account?* Not specifically.
e. *Are there provisions to support parents in order to assist them in avoiding separation from their young children? This could include financial, etc.* Cash distribution, supporting caregivers in childcare.

Programming for young children (see Table 3)

1. *Are there health and nutrition programmes directed toward young children?* Access to free healthcare for incapacitated and child-headed households.
2. *Programmes for HIV-positive young children that are holistic?* and 3. *Are there parenting education programmes to help families deal with child-rearing?*
    Action 14: Strengthen and support childcare capacities amongst single parents and other caregivers
    Description: In 2002, 40 percent of children

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[6] *Central Statistics Office: Living Conditions Monitoring Survey (2001-2002)*

did not live with both their parents. This means that they were being brought up by a single parent or neither parent, as shown in the graph. The impact of this is that these children are at particular risk of not receiving adequate care. In particular, the increasing burden of care on grandparents, who may be too old to deal with these unexpected responsibilities, can leave children struggling as they face an ever less secure future. Community-based action to enhance childcare capacities exist, but should be expanded significantly throughout the country. Examples of best practice exist to encourage increased capacity for care of young children, improved nutrition, income generation, family counselling and psychosocial support. Whilst many of these services are being promoted through NGOs and community-based organisations, the Government of the Republic of Zambia (GRZ) has played a valuable role in monitoring and promoting best practice.

Target: Existing best practice in efforts to strengthen childcare capacity at community and household level are documented and disseminated. Expansion of effective services is facilitated through increased resource provision, and made available in communities in all districts. GRZ shares knowledge on best practices, and ensures effective monitoring of NGO service provision.

4. *Are there early child development and education programmes that are designed to meet the needs of children made vulnerable by HIV and AIDS?* and 5. *Care and support programmes?*
Action 11: Promote services that address

early childhood development, school health services, sport, play, and culture.

Description: Schools and other child-focused institutions can provide a range of services that support and enrich the development of children, particularly those facing difficult circumstances at home. The provision of ECD services, school health services, and opportunities for sport, play, and cultural activities enhance the development of children, by providing diverse stimulation, a sense of identity, and opportunities that allow normal development of healthy minds and bodies.

Target: The schools health service is revitalised in line with an approved plan of action, and offers specified services to all schools. Integrated ECD services available at community level, offering early education for children, childcare training for parents and caregivers, and relief for parents and caregivers struggling with ill health or other constraints. ECD services run by NGOs, and registered, supervised, and promoted by GRZ.

Indicators: Schools health service plan approved, and performance reports submitted. Resources specifically allocated to ECD services under PEPFAR and Global Fund allocations, expanding each year from 2006 to 2010, and doubling through that period.

6. *Is there a system of birth registration in place to facilitate every child receiving services?* Planned free and compulsory birth registration.

7. *Is there a programme in place to prevent the transmission of HIV to young children that incorporates care of young children?* In another draft.

8. *Are there systems for adequate alternate care for young children without families?* Not mentioned.

9. *Are there supports for a child's right to play?* Yes, right to play, sport and leisure – but no specific actions.

Resources for young children in the NPA (see Table 4)

a. *Activities for capacity building for working with young children?* Described need to improve capacities of caregivers.

b. *Monitoring and evaluation by age group?* No.

Evaluation

Situation analysis awareness of young children: 1
Planning in two places for young children: 2
But not costed, and not included in final plan of action. Plans are very vague.
Overall: 3

About the Bernard van Leer Foundation

The Bernard van Leer Foundation funds and shares knowledge about work in early childhood development. The foundation was established in 1949 and is based in the Netherlands. Our income is derived from the bequest of Bernard van Leer, a Dutch industrialist and philanthropist, who lived from 1883 to 1958.

Our mission is to improve opportunities for children up to age 8 who are growing up in socially and economically difficult circumstances. We see this both as a valuable end in itself and as a long-term means to promoting more cohesive, considerate and creative societies with equality of opportunity and rights for all.

We work primarily by supporting programmes implemented by partners in the field. These include public, private, and community-based organisations. Our strategy of working through partnerships is intended to build local capacity, promote innovation and flexibility, and help to ensure that the work we fund is culturally and contextually appropriate.

We currently support about 140 major projects. We focus our grantmaking on 21 countries in which we have built up experience over the years. These include both developing and industrialised countries and represent a geographical range that encompasses Africa, Asia, Europe and the Americas.

We work in three issue areas:

- Through "Strengthening the Care Environment" we aim to build the capacity of vulnerable parents, families and communities to care for their children.
- Through "Successful Transitions: The Continuum from Home to School" we aim to help young children make the transition from their home environment to daycare, preschool and school.
- Through "Social Inclusion and Respect for Diversity" we aim to promote equal opportunities and skills that will help children to live in diverse societies.

Also central to our work is the ongoing effort to document and analyse the projects we support, with the twin aims of learning lessons for our future grantmaking activities and generating knowledge we can share. Through our evidence-based advocacy and publications, we aim to inform and influence policy and practice both in the countries where we operate and beyond.

Information on the series

Working Papers in Early Childhood Development is a 'work in progress' series that presents relevant findings and reflection on issues relating to early childhood care and development. The series acts primarily as a forum for the exchange of ideas, often arising out of field work, evaluations and training experiences. As 'think pieces' we hope these papers will evoke responses and lead to further information sharing from among the readership.

The findings, interpretations, conclusions and opinions expressed in this series are those of the authors and do not necessarily reflect the views or policies of the Bernard van Leer Foundation.