Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners

The President's Emergency Plan for AIDS Relief
Office of the U.S. Global AIDS Coordinator
July 2006

Table of Contents

1. INTRODUCTION

1. A. Orphans and Other Vulnerable Children (OVCs) and the HIV/AIDS Pandemic

Because the Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) predominantly attacks people of childbearing age, its impact on children, extended families, and communities is devastating. When a parent dies of AIDS, his or her child is three times more likely to die – even when that child is HIV negative.[1] Besides facing an increased risk of death, children whose parents have died due to HIV/AIDS also confront stigmatization, rejection and a lack of love and care. They often suffer from emotional distress, malnutrition, a lack of health care, and poor or no access to education. AIDS orphans are also at high risk for labor exploitation, sex trafficking, homelessness, and exposure to HIV. Increasingly, extended families and communities in highly affected areas find that their resources are inadequate to provide the basics for all needy children. In communities hard hit by the double hammer of HIV/AIDS and poverty, there are millions of children who may not be orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are ill with HIV/AIDS might not receive the care and support they require. In extreme cases, roles in the household may be reversed and the children may become their parents' caregivers, often dropping out of school and becoming the breadwinner. Research indicates that these children, caring for sick and dying parents, are the most vulnerable of all. [2, 3]

The most straightforward way to meet the needs of vulnerable children is to keep their parents alive and well and thus prevent the children from becoming orphans. Treatment and palliative care, made possible through the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan), often make it possible for an ill parent to resume the role of caretaker and allow the children to reclaim their childhood. Yet even with treatment and care programs to improve survivorship and prevention programs to reduce HIV prevalence, the number of children being orphaned due to AIDS is expected to continue to rise in many countries. By 2010, the number of children orphaned by HIV/AIDS is projected to exceed 25 million, and the number of other vulnerable children will greatly surpass that number. [4, 5]

PEPFAR recognizes the urgency of addressing the needs of children orphaned or made vulnerable by HIV/AIDS with compassionate care. PEPFAR is committed to the development of evidence-based policies and the implementation of sound practices for the care and support of orphans and other children made vulnerable by HIV/AIDS. Our goal is to help these children and adolescents grow and develop into healthy, well-adjusted and productive members of society.

1. B. Scope and Purpose of Guidance

This document offers practical guidance for programs aimed at addressing the needs of children made vulnerable by HIV/AIDS. It provides key definitions, guiding principles, and important considerations for programming decisions. The guidance clarifies PEPFAR/Emergency Plan priorities and the activities that it will fund related to OVCs. It builds on the principles outlined in the *U.S. Five-Year Global HIV/AIDS Strategy,* and extends the vision and guidance of the President's Emergency Plan. The knowledge and evidence base underpinning this guidance continues to grow. With new experiences and learning over time, this OVC Guidance is expected to evolve. Updates will incorporate new insights, improved practices and lessons learned.

1. C. Foundation for OVC Guidance

This document affirms the agenda for responding to the OVC challenge detailed in *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children, Living in a World with*

HIV/AIDS, 2004.[6] It also adapts key concepts and principles from other internationally developed documents, such as the *International Protection of Children, Family and Property Relations,* Hague 1996[7], *Children on the Brink, 2004*[8] *and Africa's Orphaned and Vulnerable Generations*[9], applying them to the particular requirements of PEPFAR. These and other references appear in Appendix II.

2. DEFINING THE PEPFAR APPROACH

2. A. Defining "OVC"

A vulnerable child is one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened. In the international community, the term "Orphans and other Vulnerable Children," or "OVC" sometimes refers only to children with increased vulnerabilities because of HIV/AIDS. At other times "OVC" refers to all vulnerable children, regardless of the cause – incorporating children who are the victims of chronic poverty, armed conflict, or famine. Since the Emergency Plan focuses on those with increased vulnerabilities due to HIV/AIDS, this guidance defines "OVC" in the following way:

A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS.

Orphan: Has lost one or both parents to HIV/AIDS

Vulnerable: Is more vulnerable because of any or all of the following factors that result from HIV/AIDS:

- Is HIV-positive;
- Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);
- Lives outside of family care (e.g., in residential care or on the streets); or
- Is marginalized, stigmatized, or discriminated against.

The above operational definition identifies those who are potentially eligible for PEPFAR supported services, but does not identify those most in need of services. For programmatic decisions, each community will need to prioritize those children most vulnerable and in need of further care. Communities will also need to distinguish which core services each child needs to facilitate his or her age-appropriate development.

Children can differ greatly in their needs, capacities, and individual vulnerabilities. Needs also change as children age and rates of development can vary. It is important to address child-development issues with age-specific, child-focused programs that seek to preserve family structures as much as possible. While there is some variation in how different organizations define age categories,[10, 11, 12] the Emergency Plan recommends the following for programming purposes:

Age	Stage
Under 2 years	Infancy
2-4	Early Childhood/Toddler
5-11	Middle Childhood
12-17	Late Childhood/Adolescence

2. **B. U.S. Government Priorities and OVC Program Planning**

The mandate of the President's Emergency Plan is to bring compassionate relief and support to countries, communities, families, and children affected by the HIV/AIDS epidemic. The Emergency Plan uses a three-pronged strategy of prevention, treatment, and care interventions to accomplish this goal, and OVC programs are among the HIV/AIDS care interventions it supports. The U.S. Government country teams make programming decisions for PEPFAR, and thus for OVC programs, which receive approval in Washington through the Country Operational Plan and Reporting Systems (COPRS) reporting process.

OVC in-country programs need to be fully integrated into national strategies, as well as function within the context of Emergency Plan policy with harmonized planning, operations and reporting systems. Specifically, Emergency Plan programs need to be planned in accordance with "The Three Ones" principles for HIV/AIDS assistance. "The Three Ones" is promoted by the Joint United Nations Programme on HIV/AIDS and cosponsored by the U.S. Government. It seeks to promote harmonized programs by ensuring that all international partners agree to support : (1) one national action framework; (2) one national AIDS coordinating authority; and (3) one, agreed-upon, country-level monitoring-and-evaluation system.

The *U.S. Emergency Plan Five Year Global HIV/AIDS Strategy* identifies several goals for developing OVC programs: to rapidly scale up compassionate care for OVCs; to build capacity for long-term sustainability of care; to advance policy initiatives with direct outcomes that support care for OVCs; and to collect strategic information to monitor and evaluate progress and ensure compliance with Emergency Plan policies and strategies.

The design of each OVC portfolio should take into consideration the contributions of other Emergency Plan activities, including ongoing or planned prevention, care and treatment activities within the context of the network model of care. Leveraging other private sector and Government resources to supplement Emergency Plan and community efforts can be an indispensable strategy to expand coverage and ensure the sustainability of programs over the long term.

A multi-sectoral approach is needed to address the diverse and often complex needs of orphans and other vulnerable children. The core interventions children need for their well-being and future development are food/nutrition, shelter, protection, health care, psychosocial support, and education. A community-based response to these needs that preserves and supports families as much as possible is the primary Emergency Plan strategy. Mapping of existing and planned programs, HIV and AIDS prevalence rates, and vulnerability profiles are useful to determine where various kinds of interventions are most needed. The stage of the epidemic is another important consideration in identifying needed programs. It is also essential to weigh the priority of serving children most in need against the practical mandate to work in areas where the U.S. Government and its partners have an ability to respond effectively and quickly. Targeted evaluations can build on effective experience and lessons learned to identify sound practices and effective methods of quality service delivery.

OVC activities directly provide support to OVCs, and their caregivers, families, and community members; build the capacity of local organizations; strengthen monitoring and quality-assurance systems; and advocate for sound strategies, policies and national programs that benefit OVCs. The following is a useful way of categorizing these varied types of interventions:

1. Child Level – Ensure provision of core interventions that create opportunities for vulnerable children to grow and develop appropriate to the norms in their community and cultural context;
2. Caregiver/Family Level – Train and provide direct support to caregivers (including adolescent heads of household) to improve their ability to care for vulnerable children; and
3. Systems Level – Build local, regional and national capacity to strengthen the structures and networks that support healthy child development, to gather and use information, and to develop policy and program responses that lead to comprehensive and effective care for OVCs.

Each level of programming has different implications for scale-up, reach/coverage, cost effectiveness, impact and sustainability - all elements that must be considered when developing a comprehensive OVC portfolio. In addition, OVC programs must ensure that interventions meet quality standards and are appropriate for the context at each level.

3. IMPLEMENTATION OF OVC PROGRAMS

3. A. Guiding Principles

The HIV/AIDS pandemic strikes at the heart of family and community support structures. The Emergency Plan envisions a comprehensive and multi-sectoral approach that builds on community and family support structures, and engages communities to take action to care for and monitor the welfare of affected children. Programs supported by the PEPFAR should adhere closely to the following principles and sound practices:

Focus on the Best Interests of the Child and His or Her Family
The context and the needs of the children served must guide interventions, while respecting the duties and rights of living parents or guardians. Programs must implement effective measures to prevent gender inequity, mitigate further degradation of family structures, and reduce social marginalization and stigmatization. Care must be taken to ensure that services and materials provided for OVC do not generate jealousy and conflict in their social groups and families. Focusing interventions on the family unit and the community – and not only on the affected child—is usually the best way to promote the best interest of the child.

Prioritize Family/Household Care
The family is generally the optimal environment for a child to develop. Assistance programs should enable vulnerable children to remain in a loving family situation where they can maintain stability, care, predictability, and protection. Supporting family capacity, whether the head of household is an ill or widowed parent, an elderly grandparent, or a young person, helps build a protective environment for vulnerable children. Institutional care is not optimal for child development, sustainability, or cost-effectiveness. There are, however, instances when residential care might be the only practical alternative; for example, abandoned children, particularly HIV positive children, for whom there is no alternative. Every institution that cares for children should give priority to keeping siblings together. Also, it is important to encourage and maintain strong links with extended families, reintegration of children back into the community, and securing a stable, family-based placement.

Bolster Families and Communities
Families and communities have important roles to play in raising children. The Emergency Plan seeks to support interventions that strengthen the capacities of families and communities to make informed decisions regarding who needs what care and how best to provide it, especially for the long term. Urgent humanitarian needs often necessitate the direct, immediate provision of food, medicine, and other basic

social services to save the lives of vulnerable children. Sustainability requires fortifying the abilities of communities, local government, and indigenous institutions to continue providing for vulnerable children and their families after external assistance is no longer available. The Emergency Plan's goal of building the long-term sustainability of OVC interventions requires planning for this transition and for the continuity of service delivery to and by the community.

Nurture Meaningful Participation of Children
Children and their families should participate, to the fullest extent of their capacities, through the entire project cycle of planning, implementing, monitoring, and evaluating. Participation increases program responsiveness to the best interests of the child and his or her families, and improves the likelihood of making a measurable difference in their lives. Adults often need support in understanding the value of listening to children and taking action to engage children's capacities as actors, not just beneficiaries. Possible means for participation include involvement in community committees, youth mapping of interventions, input into program design, and developing versions of national plans of action, understandable for children.

Promote Action on Gender Disparities
Issues of gender are important in OVC programs. Careful attention should be given in conceptualizing and implementing OVC activities to ensure that differing needs of boys and girls are identified and addressed appropriate to their developmental stage. Girls and boys living outside of caring families often face additional discrimination and threats of violence, exacerbated for girls as they reach puberty. Within HIV/AIDS-affected communities, the girl child often faces a disproportionate level of risk and vulnerability[13,14] for exploitation, physical and sexual abuse, trafficking, HIV infection and burdens of caring for family members[15,16,17]. Programs must address these risks and strive to relieve the excessive burden that caring for family members often places on children and youth. Strategies for addressing these issues may include interventions that ensure girls have all that is necessary to continue in school, including secondary or vocational level schooling[18]. This may include ensuring funds for fees, transport, books and uniforms, and that there is family/caretaker support for staying in school. Other strategies include creating safe social spaces for pre-adolescent and adolescent girls, such as through youth centers or kids' clubs. These can provide psychosocial support, along with age-appropriate learning materials in the areas of reproductive health, nutrition, and HIV prevention. Linking girl heads of households to supportive local women's groups, faith-based programs, or local non-governmental organizations (NGOs) can also provide them with both psychosocial support and protection.

Respond to Country Context
Activities must be contextually relevant and responsive to variances in high and low HIV prevalence areas. In most instances, national orphan rates conceal substantial differences among communities affected in different ways by the epidemic. These local differences need to be considered when targeting OVCs. The identification of "hot spot" sub-regions with higher OVC burdens is important for making decisions about the allocation of scarce program resources. Activities also must be mindful and respectful of local, cultural, and religious values, and should seek to reinforce or include community norms that bolster the establishment of safe, loving, and secure environments for children, while attempting to change beliefs and practices that can cause harm to children.

Strengthen Networks and Systems; Leverage Wrap-Around Programs
Networks (e.g., Parent-Teacher Associations, co-ops) and systems (education, health) within communities offer opportunities for referral mechanisms and case management in delivering comprehensive support to children. Identifying and coordinating multi-sectoral responses is important to make certain that: a)

agencies play to their strengths; b) all core interventions are available for children and families in need; c) programs are sustainable; and d) children and their families have access to interventions outside the purview of the Emergency Plan funds. Mapping the existence of networks and systems is an essential step to leveraging funds and contributors beyond the resources of the Emergency Plan. U.S. Government Country Teams should institute a process for identifying and coordinating multi-sector responses to the needs of OVCs. The process should address partnerships with other U.S. Government agencies and programs, other international partners, United Nations agencies, host Governments, and the private sector to coordinate activities, share training opportunities, and exchange insights about sound practices among implementing entities. Using proportional funding to co-sponsor activities that reach beyond the Emergency Plan mandate can be another means of more holistically addressing the needs of vulnerable children and their families.

Link HIV/AIDS Prevention, Treatment, and Care Programs
A family-centered approach to prevention, treatment, and care relies upon functioning referral systems. Children of parents, families, or other caregivers who are benefiting from Emergency Plan programs need referral to OVC programs. Likewise, caregivers of vulnerable children cared for by Emergency Plan programs should obtain referrals to get needed support. Referring parents to anti-retroviral therapy programs should be a priority. When parents or caregivers are terminally ill, Emergency Plan OVC programs need to prepare families for the upcoming transition. U.S. Government Country Teams should consider formal mechanisms to facilitate inter-agency and inter-sector coordination to ensure that referral systems work for families. This effort can rely upon U.S. Government staff, or Country Teams can identify a partner to coordinate this effort. Linkages to prevention programs are also extremely critical, since OVCs are particularly vulnerable to sexual exploitation and trafficking, and thus risk becoming HIV infected.

Support Capacity of Host-Country Structures
The long-term impact of investments by the Emergency Plan will largely depend on the capacity of host-countries to assume responsibility for lessening the impact of HIV/AIDS on vulnerable children and their families. By providing technical assistance and investing in systems that strengthen provincial, district and national authorities along with NGOs, FBOs and CBOs, Emergency Plan funds can help countries scale up care for more OVCs while also improving the quality of care. Improving coordination between Ministries and clarifying their roles can contribute to more effective policies and programming for OVCs.

Country Teams and OVC partners should participate in and contribute to national planning efforts, including mapping, reporting systems and quality-assurance methodologies. PEPFAR OVC programs must be part and parcel of national HIV/AIDS strategies and plans, and OVC national plans of action, as well as have the active support and engagement of local and national Governments, and multilateral organizations and institutions.

3. **B. Core Program Areas**

Children and youth affected by HIV/AIDS often face an immediate crisis in the home. Meeting their immediate needs is vital to their current well-being but is also critical to their future. Basic or "core" needs include food/nutrition, shelter and care, protection, health care, psychosocial support, and education. Illness in the family or the loss of a parent or parents is extremely disruptive for children, and often seriously disadvantages their chances for obtaining basic living needs as well as for securing a place in school or future employment. Financial and material resources are often required to meet most of these needs, so economic strengthening is essential.

Working together, the U.S. Government in-country team and implementing partners need to ensure essential core support is available to identified OVCs. At the child level, the six core areas of a child's life (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and the means to maintain them (economic strength) should be regularly monitored. Comprehensive, quality services should then be designed to meet each child's specific needs. Please note, however, that this does not mean that each PEPFAR OVC program should provide all possible interventions for all OVCs. On the contrary, each partner should contribute according to their comparative advantage, and together with other providers, contribute to a well-coordinated and comprehensive set of interventions, regardless of the funding source or implementing partner. U.S. Government in-country staff should work closely with partners to determine what each program contributes in terms of program strengths, measurable results, and geographic coverage. The exact mix of care provided and the beneficiaries served will differ by location, according to existing community resources and the types and extent of a child's vulnerabilities. The Emergency Plan encourages programs to support the development of a menu of core interventions that will guide community-led decisions on service delivery to orphans and other vulnerable children. The Emergency Plan will support processes that allow families and community members to make informed decisions regarding the mix and extent of core programs. The menu of core interventions should reflect service mapping that identifies coverage gaps and opportunities, and be coordinated with Government and civil-society programs, existing documents, and/or planned interventions consistent with the capacity and priorities of the Emergency Plan.

The following section briefly describes each core program area. A listing of examples of activities, broken down by Child, Caregiver, and Systems Levels that Emergency Plan funds can support, as well as some activities that do not fall under Emergency Plan funding, appear in Appendix II. Careful consideration of the appropriateness to the national and local context is paramount. Other interventions, beyond those listed here, will be given consideration for Emergency Plan funding on a case-by-case basis during the Country Operational Plan review and approval process. The Emergency Plan also encourages collaboration and leveraging with other international partners for comprehensive service delivery, as described above.

3. B. ***1. Food and Nutritional Support***

Food and nutrition are important components of OVC support. Malnutrition underlies more than half of the deaths in children under five in developing countries[19]. The Emergency Plan works in many communities broadly affected by food insecurity. Food-security issues are extremely complex, and other organizations and international partners have strong comparative advantages in providing food assistance. Thus, a key precept of interventions supported by the Emergency Plan is to remain focused on HIV/AIDS. While the Emergency Plan funds can support food and nutrition for OVCs, ideally programs should leverage this support from other international or host-country partners. When food and nutrition activities are supported, they should be time-limited and conditional on the identification of more sustainable solutions. For additional information on the provision of food and nutritional support to OVCs, please see the Emergency Plan policy guidance, *Use of Emergency Plan Funds to Address Food and Nutrition Needs of People Infected and Affected by HIV/AIDS*[20], and the Report to Congress, *Food and Nutrition for People Living with HIV/AIDS*.[21]

3. B. ***2. Shelter and Care***

The HIV/AIDS epidemic overloads impoverished communities to the point where many children are left without suitable shelter or care. Those children who find themselves without a caregiver become highly vulnerable to abuse and stunted development[22]. While institutional care might seem like a logical response to this situation, in some cases, it can impede the development of sustainable solutions and often

does not meet the complex needs of children[23]. While there is sometimes a role for institutional arrangements, they are not optimal for child development, sustainability or cost-effectiveness. Given the number of OVCs, particularly in sub-Saharan Africa, and their complex needs, the most effective responses place families, households and communities at the center of interventions.

3. B. ***3. Protection***

The core values of this OVC guidance are rooted in the principles of child protection – developing and implementing programs that place the best interests of the child and his or her family above all else. Thus, programs should include efforts to confront and minimize the reality of stigma and social neglect faced by OVCs, as well as abuse and exploitation, including trafficking, the taking of inherited property, and land tenure.

3. B. ***4. Health Care***

3. B. 4. ***a. General Health Needs of OVCs***

OVC programs must take active measures to meet the general health needs of children at every age level. Programs must disaggregate health requirements and interventions by the age groupings listed in section 2.B (infant, toddler, child and adolescent), as the health needs and recommended interventions differ significantly among these groups, and programs should facilitate access to primary health care for OVCs.

3. B. 4. ***b. Health Care for HIV-Positive Children***

Without appropriate treatment, over 50 percent of children born HIV-positive die within the first two years.[24] The Emergency Plan considers the provision of HIV-related health care for exposed or infected infants a high priority. When ill or suffering from the onset of AIDS, children supported under OVC programs should have timely access to appropriate ART. Programs should make available other health care for children born to HIV-infected mothers and known HIV-positive children, and related support either through direct access to health providers, or, preferably, with arrangements and referrals established with programs such as providers of interventions to prevent the transmission of HIV from mothers to their children (PMTCT), or specialized pediatric ART providers. Monitoring skin, weight and vital signs, periodic CD4 and/or HIV testing for children and youth, and pediatric ART and ART adherence interventions for HIV-positive OVC are among the essential health care required for HIV-positive children. For further information on this topic, please refer to the *Guidance for a Preventative care Package for Children Aged 0-14 Year Old Born to HIV Infected Mothers*[25] and to the *Emergency Plan Report on Pediatric AIDS*.[26]

3. B. 4. ***c. Prevention of HIV***

Prevention of HIV is a priority health intervention in regions where the risk of infection is high. Programs should provide age-appropriate prevention activities for OVCs, including PMTCT intervention, as well as communication for behavior change targeted to appropriate age groups. OVC programs need to ensure vulnerable children get age-appropriate effective HIV prevention messages, including abstain, be faithful, and, as appropriate, correct and consistent use of Condoms (ABC), as well as avoiding injecting drugs and alcohol abuse. This is particularly true for programs that target adolescents and older youth. For additional guidance on the appropriate use of Emergency Plan funds to address preventive behaviors that help OVC avoid infection, please see the PEPFAR *Guidanc*e on *Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections, 2005*.[27]

3. B. ***5. Psychosocial Support***

Healthy child development depends a great deal on the continuity of social relationships and the development of a sense of competence. HIV/AIDS can undermine the fundamental human attachments

essential to normal family life and child development. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, followed by grief and trauma with the death of a parent. Cultural taboos surrounding the discussion of AIDS and death often compound these problems. Children and their caregivers need love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination. Programs should provide children with support that is appropriate for their age and situation, and recognize that children often respond differently to trauma and loss. OVCs sometimes turn to drugs and alcohol as a means of coping with this trauma. Programs must provide support to avoid these counterproductive activities. In addition, U.S. Government Country Teams must also consider the emotional and psychosocial support for frontline national staff who are working with AIDS-affected communities. Many of those who are providing support to others are living with the trauma of HIV/AIDS in their own lives. Psychosocial counseling, rotational duties, and other interventions might be necessary to prevent burnout.

3. B. ***6. Education and Vocational Training***

Research on children and AIDS demonstrates that education can leverage significant improvements in the lives of orphans and other vulnerable children[28]. Schools not only benefit the individual child, but can also serve as important resource centers to meet the broader needs of communities. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. An education is the key to employability and can also foster a child's developmentally important sense of competence. Countries and communities must identify the barriers to education (e.g., requiring a father to register a child, mandatory payments for uniforms, book or tuition fees) and define locally-appropriate strategies for attracting and keeping children, especially girls, in school. Programs must give special attention to the vulnerability of girls, by addressing the disproportionate levels of risk they face when leaving school at an early age. Schools must also be made safe for children, especially girls. In addition, vocational training is an important component of life preparation. Conversely, the lack of opportunity to learn a trade or the lack of a sponsor to enter vocational networks can compromise an adolescent's long-term economic prospects.

Education is an important area for leveraging additional resources at both national and local levels. Partnerships with education programs sponsored by external donors and governments often provide resources that can help to ensure that children affected by HIV/AIDS have access to education. Linkages with programs such as U.S. government's basic education program or African Education Initiative (AEI) implemented through USAID are helping expand educational opportunities.

3. B. 7 ***Economic Opportunity/Strengthening***

The loss of a parent or family member and the requirements of caring for the ill often result in OVCs and their caretakers experiencing diminished productive capacity and economic hardship. Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or to welcome OVCs into the household. Also, maturing children and adolescents need to learn how to provide for themselves and gain sustainable livelihoods. Linking OVCs and their families with programs providing economic opportunities is important. Look for programs that base their economic-strengthening activities on market assessments and undertake joint efforts with organizations that have strong experience and a high level of expertise in this area. Providing livelihood training without prospect of a job must be avoided. Food and fuel typically absorb the greatest share of household expenditures. Interventions that save household labor and expenses can relieve the burden of diminished capacity and perhaps allow families to allocate resources for more productive, remunerative uses.

4. REPORTING ISSUES

Regardless of the level or type of intervention, successful programs must ultimately result in a reduction in vulnerability and an improvement in the well-being of OVC. To evaluate improved well-being, and to ensure effective, quality programs, the Emergency Plan requires program- and national-level monitoring and evaluation. The amount of information required by the U.S. Congress on the progress of PEPFAR is limited to national total numbers of OVCs served (direct and indirect), caregivers trained, and monies spent. However, more detailed information is needed in-country on the program level to monitor and evaluate adequate progress toward improving the well-being of children affected by HIV/AIDS. U.S. Government country teams should support implementing partners and national Governments to develop coordinated monitoring-and-evaluation plans for OVC programs and community-based efforts based upon the UNAIDS principle of having one country-level monitoring-and-evaluation system.

Output and outcome data along with other records of measurable results are needed to track improvements in the well-being of children served and the effectiveness and quality of programs. U.S. Government country teams and implementing partners should allocate funds for surveillance, monitoring and evaluation, sharing lessons learned, and the assessment and reporting of results proportional to programming resources for OVCs (normally about seven percent of total program costs for strategic information). It is important for information regarding program results to flow in both directions. Extra efforts are often required to relay important findings in local languages and digestible formats to flow back to local partners, community institutions, caregivers, and to OVC beneficiaries themselves. Such efforts will enable the principle of genuine participation in OVC programming. This section briefly discusses three specific issues that need additional consideration:

4. **A. Direct and Indirect Targets**

Distinguishing between direct and indirect targets can sometimes be difficult. For PEPFAR, direct results or targets are uniquely identified individuals receiving services through service delivery sites directly supported by USG programs (interventions/activities). Those individuals are counted at the point of service delivery. Indirect targets are estimates of the number of individuals served as a result of the USG's contribution to system strengthening. System strengthening activities may include support to national, regional, or local activities such as policy development; logistics; protocol or guideline development; advocacy; capacity building; national or regional training; national management information systems, etc. (See PEPFAR Data Quality Guidelines, 2006. [29])

How to identify direct and indirect targets is further illustrated in the table below.

Distinguishing term	**Direct**	**Indirect**
Site-specific	X	
Uniquely identified individuals	X	
Count	X	
System strengthening		X
Estimate		X

4. **B. Measuring OVC Targets**

There are two direct targets related to OVCs at the national level: OVCs served and Providers/Caregivers trained. Starting with the FY07 SAPR and APR, measurement of the OVCs directly served target will be

divided into two subcategories: OVCs receiving primary direct support and those receiving supplemental direct support. If your country's OVC monitoring system is not yet able to provide this breakdown, you must write a one-paragraph justification for providing only total numbers of OVCs served. Additionally, work with your partners will be necessary to put such a monitoring system in place. Building on the above descriptions of direct and indirect targets, the following are definitions for the OVC targets.

Number of OVCs served by OVC programs:

Direct OVC Support: Direct recipients of support are OVCs whose status is regularly monitored across the six core areas (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and whose needs are addressed accordingly through PEPFAR and partner interventions. Economic strengthening should be evaluated according to its benefit to the six core areas.

> Primary Direct Support: Count OVCs who are periodically monitored in all six core areas and who are receiving PEPFAR-funded or leveraged[1] support in three or more areas that are appropriate for that child's needs and context during the relevant reporting period.
> Supplemental Direct Support: Count OVCs who are periodically monitored in all six core areas and who are receiving PEPFAR-funded or leveraged support in one or two areas that are appropriate for that child's needs and context, during the relevant reporting period..
>
> *Total Direct Support*: Sum of Primary and Supplemental Support.

Indirect OVC Support: Indirect recipients of support are OVC who are NOT individually monitored but who collectively benefit in some way from system strengthening or other interventions. For example:

- Estimated number of OVCs benefiting from a policy change or improved system (e.g. birth registration, inheritance laws, educational system).
- Estimated number of OVCs benefiting from the training of, or support for, caregivers.

An OVC may be counted under one category only (i.e. cannot be counted under both direct and indirect). In order to provide the national-level breakdown between primary and supplemental direct support, program-level monitoring will need to be done by core service area. Tracking gender is already required; tracking by age group may also be helpful for developing appropriate service strategies. Assistance can be provided by the TWG for countries needing to develop necessary monitoring systems.

4. **C. Double-Counting**

Double-counting is a challenge in accounting for support provided to OVCs, since there are many interventions and, often, multiple providers. The support individuals require also varies by individual, and from sub-population to sub-population, so no one standard package of care is always appropriate or effective. Double-counting of orphans and vulnerable children served can occur within a program when the same child is counted many times as a result of receiving multiple services. It can also occur when two or more implementing partners support the same child. Double-counting can also occur because of overlap between direct and indirect support. (See the Emergency Plan guidance on data quality.)[30] To

1 *Leverage* means that the services are being provided to the child through non-PEPFAR funds by either the same organization or a different one. Regardless, the PEPFAR funded organization that is providing the service and monitoring the OVC, must be tracking to ensure the child is actually receiving all the services which are being counted as a part of this result.

avoid double-counting, the monitoring and evaluation of programs demands much more detailed accounts than simply counting the number of children served. In general, the more detailed the accounts, the less likely there will be double-counting of the number of orphans and vulnerable children served.

5. CONCLUSION

Together with its partners, the Emergency Plan is committed to providing effective and significant support to the orphans and other vulnerable children affected by HIV/AIDS and, in the coming years, to turn the tide against HIV/AIDS. Supporting OVCs is a major priority of the U.S. Government. While scaling up is imperative, it is also important that programs reflect sound practices, are evidence-based; remain sensitive to the dynamics of the local epidemic, the cultural context of each country and the national strategy of host Governments; and work to meet the needs of OVCs in a measurable way. As the technical literature and sound practices evolve, the EP will undoubtedly revise and retransmit this guidance.

The challenges of a rapidly escalating population of HIV/AIDS-affected children in resource-poor countries require an accelerated and concerted effort. U.S. Government Country Teams should make their Technical Assistance (TA) needs known to their Country Core-Team Lead, who will inform the U.S. Government Technical Working Group on OVC. U.S. Government headquarters and field staff from other countries are available to assist Country Teams in designing, implementing and evaluating OVC programs. For information on the process for requesting TA, contact your PEPFAR country team leader.

Appendix I: ***Examples of Eligible and Ineligible activities for Core Program Areas***

Below please find illustrative examples of interventions PEPFAR funds can support for children affected by HIV/AIDS. This list is not intended to be fully comprehensive.

1. Food and Nutritional Support

Food and nutritional support are essential to sustaining OVC, but are often the most costly of interventions supported by OVC programs. Ensuring adequate food and nutrition throughout the stages of child development requires interventions and coordination at many levels. Working with national governments, communities and food agencies, the Emergency Plan contributes to achieving food and nutrition goals for OVCs, but in a way consistent with its mandate as an HIV/AIDS program. Emergency Plan funds support OVC food and nutritional support interventions at three levels. Please refer to the *Report on Food and Nutrition for People Living with HIV/AIDS*[31] for additional details. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Nutritional assessment and counseling;
- Weaning foods and other nutritional support for children under two years of age;
- Therapeutic and supplementary feeding of malnourished children based on anthropometric assessment and World Health Organization (WHO) guidelines; and
- Support to link children with other health and nutrition interventions provided by public or private health providers.

Caregiver or Family Level

- Training, course materials, and other program support for facility- and community-based counseling of families and caregivers on nutrition, diet and food preparation techniques.

Systems Level

- Development of policies and technical guidelines, training curricula and job aides for nutrition assessment and counseling;
- Working with appropriate national and District implementers to ensure targeting of OVCs for food and nutrition interventions and programs;
- Technical assistance and coordination with food industry to promote production of and access to nutritious foods, including fortified foods, for OVC; and
- Advocacy and resource mobilization for programs to address the nutritional needs of OVCs.

Emergency Plan funds for OVC cannot support:

- Strengthening the general administrative and management capacities of the food/agriculture sector that have deteriorated because of the impact of HIV/AIDS;
- School feeding programs for all school children; and
- Broad-based food-assistance and food-security programs

2. Shelter and Care

Working with communities, families and other international partners, Emergency Plan OVC programs should work to ensure no child goes without shelter, clothing, or basic personal hygiene. Yet, programs must meet these life-long needs through sustainable, community-based interventions consistent with and responsive to local circumstances. Partners who are working with OVCs affected by HIV/AIDS should work with other international partners, governments, local authorities, NGOs, FBOs and CBOs to identify OVCs with unmet needs, and to offer, when required, temporary assistance. However, to encourage sustainable, effective solutions that support children who are without shelter or care, Emergency Plan

programs should primarily intervene through referral and leveraging of other non-EP resources. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Assisting children and family members in identifying potential caregivers, prior to a parent's death;
- Reintegrating children who are currently in institutional care through family tracing and fostering;
- Providing access to temporary shelter for children in transition; and
- Supporting child- or youth-headed households in maintaining their homes.

Caregiver Level

- Supporting family reunification and temporary shelter to take children off the streets;
- Supporting referrals and access to programs that provide incentives for adoption or the provision of foster care.

Systems Level

- Strengthening community-based programs that provide temporary shelter for children in transition and longer term shelter for those with no community option;
- Strengthening family-based care models for children (i.e., extended families, local adoption, and foster care);
- Developing innovative community responses to provide care in personalized settings when family options are not available (live-in schools, drop-in centers, etc.);
- Providing quality-assurance monitoring for institutionalized care; and
- Strengthening reintegration programs and providing training to accomplish family tracing for OVCs who are leaving institutional care.

3. Protection

In many countries where PEPFAR is working, the national government and international partners have introduced governance and legal reform. In keeping with the Emergency Plan's focus on HIV/AIDS, partners who are supporting OVCs should find ways to incorporate youth-protection measures into ongoing or proposed reforms. Developing and implementing programs that place the best interests of children and their families above all else is a key value. All policy projects must have clearly delineated outcomes, e.g. an increase in number of registrations in X amount of time, etc. General policy work without specific outcomes should not be supported with PEPFAR resources. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Facilitating basic birth registration and identification necessary for long-term access to education, health care and social services;
- Providing community-based assistance to OVCs for inheritance claims;
- Strengthening child-headed households with the intent of promoting community support and prevent sibling separations; and
- Removing children from abusive situations into safe, temporary or permanent placements.

Caregiver Level

- Activities to support families and caregivers to better manage stress and improve parenting when they are in situations of chronic illness, are caring for multiple orphans, and have decreasing material resources; and

- Coaching caregivers to better access community and system-level support to which OVCs are entitled.

Systems Level

- Strengthening local community structures (such as Child Protection Committees) that carry accepted responsibility for monitoring and protecting OVCs;
- Providing training and support to frontline workers who are the "gatekeepers" – those most likely to come into contact with OVCs, including local NGO field staff, local volunteers, police, emergency hospital workers, school counselors and nurses, and staff of child residential care facilities; assist police in how to constructively deal with OVCs who are in violation of the law.
- Networking with programs that confront incidents of child trafficking and sexual abuse;
- Improving mechanisms/systems to increase birth registration, improve access to basic social services, and facilitate inheritance claims;
- Policy development, such as technical assistance to local authorities on improving the investigation, reporting and follow-up on cases of rape, abuse, and neglect;
- Reviewing and assisting in the development and strengthening of child law and protection services and policies, including adoption;
- Communication or multi-media campaigns to support social norms that protect children and prevent child abuse and exploitation (e.g., increase reporting and legal action); and
- Activities to reinforce or change social norms to increase the practice of will writing, succession planning, and the enforcement of inheritance laws.

4. Health Care

a. General Health Needs of OVCs

OVC programs need to take active measures to meet the general health needs of vulnerable children at every age level. This often means making sure the caretakers bring the child to a clinic for health care. HIV care is also an important element for these children, as they might have been exposed to HIV and require testing and care. Emergency Plan resources for OVCs can be used to support the preventive and primary health care needs of children. To be cost-effective, however, interventions should rely largely upon existing health programs sponsored by governments and international partners to ensure immunization coverage, maternal and health care (including antenatal and postnatal care, HIV testing, etc.). Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Referrals and linkages to child health care, including, but not limited to, immunization, growth monitoring, malaria prevention and HIV testing, where appropriate; and
- Provision of support for survivors of sexual or physical abuse, including Post-Exposure Prophylaxis (PEP) for rape victims, and education and messaging to prevent abuse.

Caregiver Level

- Training of caregivers to monitor children's health and gain access to available health care when services are needed; and
- Training of caregivers and guardians on how to talk to children about abstinence and safe sexual behaviors and support healthy life decisions.

Systems Level

- Training of HIV counselors, home-based care providers, traditional healers, educational staff and staff of PMTCT and ART clinics to identify, monitor, and make referrals to health care and basic social services for children and clients' children;
- Work with public and private health care providers to integrate HIV elements and awareness of the special vulnerabilities of HIV-positive OVCs;
- Training of health workers in the WHO integrated infant and young child practices course or similar; and
- Bolstering the capacity of public and private health providers to improve the provision of immunizations, growth monitoring, bed-nets, malaria and tuberculosis meds, diarrhea control and treatment, and other basic prevention and care.

Emergency Plan funds for OVCs cannot support:

- Purchase of vaccines (or bulk formulation for vaccines) for immunization programs
- Contraceptives

b. Health Care for HIV- positive children

PEPFAR considers the provision of HIV-related health care to exposed or infected infants a high priority. Appropriate health care services for children born to HIV-infected mothers and known HIV-positive children are described in the *Guidance for a Preventative Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers*.[32] Palliative care for HIV-positive children is outlined in *HIV/AIDS Palliative Care Guidance #1: An Overview of Comprehensive HIV/AIDS Care Services*.[33] The *Report to Congress on Pediatric AIDS*[34] is also a reference for a discussion of ART for children.

c. Prevention of HIV

Prevention of HIV is a priority health intervention, particularly among adolescents, and especially in regions where the risk of infection is high. Please refer to the *Guidance for Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections*[35] for complete details.

5. Psychosocial Support

Healthy child development hinges greatly upon the continuity of social relationships. Programs should supply both children and their caregivers with emotional support, as well as support local staff that serve on the frontline. To respond to psychosocial needs, examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Gender-sensitive life skills and experiential learning opportunities for OVCs that build resilience and self-esteem;
- Activities that encourage the integration of OVCs into traditional support systems within the community in order to increase the social and psychological well-being of vulnerable youth (mentoring, apprenticeships, etc.);
- Improving links between children affected by HIV/AIDS and their communities;
- Referral to counseling where available and appropriate, particularly for HIV-positive youth; and
- Rehabilitation/re-integration for children who are living outside of family care.

Caregiver Level

- Strengthening the capacity of caregivers to listen to and talk with children;
- Access to family-centered activities that address the dynamics and stages of illness, treatment, and/or pending death (e.g., communication on the disclosure of HIV status, ART, succession planning, grief counseling); and
- Activities that help children to give expression to their feelings and perceptions of loss and help in the preservation of attachment and personal history, (e.g., art therapy, memory box methodologies, etc).

Systems Level

- Increasing communities' understanding of and action on the psychosocial needs of children and youth and the responsive roles community members can take to improve social or psychological wellness, including roles in schools and religious organizations;
- Providing training in age- and situation-appropriate communication;
- Strengthening local capacities to provide psychosocial support for distressed children (e.g., training of clinicians and community workers);
- Providing opportunities for networking, training, and reflection for frontline local staff who work with local partners in AIDS-affected communities; and
- Further investigation and refinement of culturally relevant measures to promote psychosocial well-being and factors that contribute to improved child welfare.

6. Education and Vocational Training

Increasingly, stakeholders in the fight against HIV/AIDS are recognizing and promoting the fact that education can bring about significant improvements in the lives of orphans and other vulnerable children. A growing body of research from sub-Saharan Africa makes clear the importance of timely, cost-effective interventions to secure access to primary and secondary education as well as livelihood training for children affected by HIV/AIDS.[36] Children orphaned in the region are much less likely to attend school, and can be unable to care and provide for themselves as a consequence. If school fees are the issue, international partners or communities can intervene to keep OVCs in school. Longer-term solutions, however, lie in mobilizing the community to establish fee-reduction for the disadvantaged, in providing direct support to schools for improving education (using non-AIDS funding), and negotiating scholarships for the needy. Collaboration with other programs, such as with the Education for All Initiative, is an important way of leveraging educational funds.[37] Programs often must address additional factors to enable children to attend school, such as care-taking responsibilities at home, or issues of stigma. Recognizing the importance of education, examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Activities that encourage access to the formal education system for OVCs;
- Short-term, direct assistance to subsidize school-related costs (e.g., fees, books, uniforms) or to leverage cost-avoidance programs that lead to broader school access and completion and complement a long-term strategy for sustainability;
- Activities that encourage access for OVCs into early childhood development programs and services; and
- Activities that encourage access for OVCs to vocational training.

Caregiver Level

- Training and materials for health providers and caregivers on identifying vulnerable children and appropriate care procedures;
- Activities to monitor OVC status and to integrate OVCs into community social life; and
- Anti-stigma education, particularly education aimed at reducing the stigma faced by HIV/AIDS orphans.

Systems Level

- Community-mobilization efforts to keep orphans and other vulnerable children in school and/or to provide them with educational alternatives;
- Advocacy and technical support to provide school-based counseling services, flexible school schedules and school curricula that include life skills, business and household management, and agriculture training, plus establishing mechanisms to provide linkages with community- and faith-based organizations for referrals to school-based programs;
- Teacher training on how to address issues that often plague children from households affected by HIV/AIDS, such as how to identify children at risk and how to counsel and refer children; and
- Train parent-teacher associations in school communities to support and enable OVCs to remain in school, such as supporting fee waivers, tutoring and psychosocial support.

Emergency Plan funds for OVC cannot support:

- Strengthening the education system and general teacher training unrelated to the needs of orphans and other children made vulnerable due because of HIV/AIDS.
- Scholarships and other access interventions for non-HIV/AIDS OVCs.

7. Economic Opportunity/Strengthening

Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or OVCs who join the household. Maturing children need to learn how to provide for themselves and establish sustainable livelihoods. PEPFAR encourages the use of OVC funds for economic-strengthening activities, as well as cooperation and joint efforts with organizations that have strong experience and a high level of expertise in this area. This is particularly appropriate for interventions focused on adolescents as well as caregivers. Economic strengthening interventions should be market-driven and contextually relevant. Examples of potential interventions that PEPFAR programs may fund include the following:

Child and Caregiver Level

- Vocational and technical training;
- Livelihood opportunities (e.g., income-generating activities, links with the private sector);
- Small-business development and activities to promote entrepreneurism among older HIV/AIDS OVCs and caregivers;
- Household economic-strengthening activities focused on increasing coverage of school-related expenses, such as incentive-driven, conditional grants and training for HIV/AIDS OVC caregivers;
- Support for drip-kit irrigation and use of drought-resistant crops with gardens for child-headed households;
- Purchasing of seeds and tools for household or community gardens for HIV/AIDS OVCs;

- Setting-up small-scale animal husbandry for HIV/AIDS-vulnerable households, especially in collaboration with efforts supported by other international partners;
- Household laborsaving devices; examples include improved charcoal cook stoves that use 50 % less fuel than traditional stoves; improved pestles that reduce the amount of effort and time for women to pound grain into flour; and, high-density kitchen gardens that require little labor, but produce sufficient vegetables to meet household nutritional requirements.
- Activities that provide access to micro-finance, primarily opportunities to save, access credit, and, in some cases, access insurance;
- Community-based asset-building; and
- Establishing mechanisms to support community-based childcare.

Emergency Plan funds for OVCs cannot support:

- Any programs not directly supporting HIV/AIDS-affected OVCs.

Appendix II: *References and Endnotes*

[1] Mermin, J., Lule, J., Ekwaru, J.P., Downing, R., Hughes, P., Bunnell, R., Malamba, S., Ransom, R., Kaharuza, F. Coutinho, A., Kigozi, A., and Quick, R. Cotrimoxazole prophylaxis by HIV-infected person in Uganda reduces morbidity and mortality among HIV-uninfected family members. *AIDS 2005*, 19:1035-1042.

[2] Sengendo J, Nambi J. 1997. The Psychosocial Affects of Orphanhood: A Study of Orphans in Rakai district. *Health Trans Rev*, 7:105-124.

[3] Burman S. 1996. Intergenerational family Care: Legacy of the past, implications for the future J. *Southern African Studies*, 22:585-598.

[4] UNICEF, UNAIDS, USAID, 2004. *Children on the Brink 2004: A joint Report on New Orphan Estimates and a Framework for Action*, Washington DC, July.

[5] UNAIDS, 2002. UNAIDS reference group improved methods and assumptions for estimation of HIV/AIDS epidemic and its impact: Recommendations of the UNAIDS Reference Group and Estimates, Modeling and Projections, *AIDS*; 16 W1-16.

[6] UNICEF, UNAIDS, USAID, 2004. *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children, Living in a World with HIV/AIDS*, July.

[7] Hague Conference on Private International Law; 1996. *International Protection of Children, Family and Property Relations,* 34: Convention of 19 October 1996 on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-operation in respect of Parental Responsibility and Measures for the Protection of Children. Hague. http://hcch.e-vision.nl/index_en.php?act=conventions.text&cid=70 (Accessed May 24, 2006).

[8] UNICEF, UNAIDS, USAID, *2004. Children on the Brink.*

[9] UNICEF, UNAIDS, USAID, 2006. *Africa's Orphaned and Vulnerable Generations*.

[10] *Children on the Brink, 2004*, p.12 uses ages 0-5; 6-11; 12-17.

[11] Letter of March 2, 2006 addressed to Secretary of State Rice from Dr. Pamela Barnes, CEO, Elizabeth Glazer Pediatric AIDS Foundation.

[12] Since a standardized age grouping for USG was not found, the age categories of under 2, 2-4, 5-11, 12-17 were chosen based on the above two citations and discussions with child development experts.

[13] UNICEF, 2004. Girls, HIV/AIDS and Education. Pp 9-10.

[14] USAID Sara Project. 2004. Orphans and Vulnerable Children: Technical Consultation—Report. Pg 22.

[15] *Ibid*. Pp19-29.

[16] UNAIDS. 2003. *Fatal Vulnerabilities: Reducing the Acute Risk of HIV/AIDS Among Women and Girls*. CSIS, P 4-5.

[17] UNAIDS, 2004. Report on the Global AIDS Epidemic. P 40, 43, 52. http://www.unaids.org/bangkok2004/report_pdf.html

[18] *Ibid.* 77-78.

[19] Lang, Susan S. 2003. Malnutrition and Child Mortality. *Human Ecology*, Aug, Vol. 31 Issue 1, p 24.
[20] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *Use of Emergency Plan Funds to Address Food and Nutrition Needs of People Infected and Affected by HIV/AIDS,* May. (Document under final approval prior to posting.)

[21] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *Report on Food and Nutrition for People Living with HIV/AIDS*, May. http://www.state.gov/s/gac/rl/more/2006/c18025.htm.

[22] Foster G. 2000.The capacity of the extended safety net for orphans in Africa, *Psychology, Health & Medicine*, Feb, 5:1: 55-63

[23] Powell, G.M., Morreira, S., Rudd, C. and Ngonyama, P.P. 1994. *Child Welfare Policy and Practice in Zimbabwe*, Study of the Department of Pediatrics of the University of Zimbabwe and the Zimbabwe Department of Social Welfare, December, published by UNICEF Zimbabwe.

[24] H. Brahmbatt, et al. 2006. *Acquired Immune Deficiency Syndrome.* April 1, 41:4 504-508.

[25] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *Guidance for a Preventative Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers,* April 2006. (Document under final approval prior to posting.)

[26] The President's Emergency Plan for AIDS Relief, OGAC, 2005. *Focusing on Our Future: Prevention, Diagnosis and Treatment of Pediatric HIV/AIDS.* September. http://www.state.gov/s/gac/rl/more/2005/pediatric/.

[27] The President's Emergency Plan for AIDS Relief, OGAC, 2005. *Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections.* (Document under final approval prior to posting.)

[28] Nhargava A., AIDS Epidemic and the Psychosocial Well-being and School Participation of Ethiopian Orphans, Psychology, Health & Medicine, August 2005, V 10:3:263-275.

[29] The President's Emergency Plan for AIDS Relief, OGAC, 2006. Data Quality Guidelines. (Document under final approval prior to posting.)

[30] *Ibid.*

[31] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *Report on Food and Nutrition for People Living with HIV/AIDS*, May. http://www.state.gov/s/gac/rl/more/2006/c18025.htm.

[32] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *Guidance for a Preventative Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers,* April 2006. (Document under final approval prior to posting.)

[33] The President's Emergency Plan for AIDS Relief, OGAC, 2006. *HIV/AIDS Palliative Care Guidance #1: An Overview of Comprehensive HIV/AIDS Care Services.* February 3. (Document under final approval prior to posting.)

[34] The President's Emergency Plan for AIDS Relief, OGAC, 2005. *Focusing on Our Future: Prevention, Diagnosis and Treatment of Pediatric HIV/AIDS.* September. http://www.state.gov/s/gac/rl/more/2005/pediatric/.

[35] The President's Emergency Plan for AIDS Relief, OGAC, 2005. *Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections.* (Document under final approval prior to posting.)

[36] Bicego, G., Rutstein, S., and Johnson, K., 2003. Dimensions of the emerging orphan crisis in sub-Saharan Africa. Social Science and Medicine 56 (1235-1247).

[37] The President's Emergency Plan for AIDS Relief, OGAC, 2006. Report on Education. March. http://www.state.gov/s/gac/progress/creports/64213.htm.