>> Okay, let's go ahead and get started. Good morning again. Good afternoon. Good evening. My name is Susan Hillis. I would like to welcome you warmly to today's Global COVID-19-Associated Orphanhood Webinar presented by the Global Reference Group on Children Affected By COVID-19. We represent together over a dozen organizations, working globally to address the impact of COVID-19 on children and, more importantly, to address how we can respond to this current crisis affecting every nation. On today's call we'll provide updates about what we know regarding the magnitude of the problem, but our focus will primarily be on solutions that we can apply now globally in every nation. Next slide, please. Here you see the agenda. First, we will here from Dr. Andres Villaveces an overview of our work and a general summary of our findings. Next, we will hear from Dr. Juliette Unwin about the methodology we used to derive the estimates of orphans globally. And a real-time calculator that every one of can you use in your own country to see the magnitude of the problem there. Following, Drs. Lucie Cluver and Laura Rawlings will discuss evidence-based responses that focus on what we call the three P's -- prevention, preparedness and protection of families. Subsequently, Phillip Goldman and Phil Green will highlight real-life implementation of responses in the field now during COVID-19. We'll have a short 10-minute break for questions. You can feel free to enter them as the speakers are making their presentations. Then we'll close out with Dr. Alex Butchart from the WHO, who will focus on our Global Reference Group's estimates and actions in a global context. And, finally, professor Lorraine Sherr and Gretchen Bachman will highlight important lessons learned from the previous HIV pandemic. We will close this webinar with a time for questions and answers from the audience followed by a statement from the Associate Director and Global Chief of Child Protection from UNICEF, Mr. Cornelius Williams. With that I would like to introduce you to our first presenter, Dr. Andres Villaveces from the United States Centers For Disease Control. Over to you, Andres.

>> Thank you, Susan. And greetings to you all. It's a real pleasure to be here with you today. In collaboration with 16 experts from 12 agencies, CDC led a study published in "The Lancet" on July 2021, "Global Minimal Estimates on Children Affected by COVID-19-Associated Orphanhood and Death of Caregivers." The same day we also published a linked advisory report, "Children, The Hidden Pandemic." We know that orphanhood is important to public health and has adverse outcomes in children, including violence, adolescent pregnancies, infections and chronic diseases, and premature deaths. And it is recognized as an adverse childhood experience. Next slide, please. Before we begin with summarizing our results, I would like you to think of the people affected and of their voices. I would like to share with you these images that I took a few days ago in my home town in Washington DC. As a whole, this display represents the number of individuals who have died due to COVID-19 in the last 15 months in my country. A large proportion of these deaths are associated to orphanhood. From the ground and from above, you may see the magnitude of lives lost due to COVID-19 in one single country. Individually, you may also see the specific stories of people who died and of those who they touched. Each death in each family has ramifications that extend beyond time and place. During this entire presentation I would like you to think, as you process this information, that this problem represents many individuals, their histories, their lives and the lives of those who they touched or continue to touch in some way. Our work is focused in giving a voice to the voiceless who have been affected by the loss of a caregiver. Understanding their plight is important. As a global community, doing something about it is essential. We have, in the midst of these difficult times, an opportunity to nurture a better life through solutions that can strengthen families and can improve our global community. As for the voices, all of this work

began after listening to an African leader's pleading voice over the phone. If it comes here and takes our grannies, there will be no one to take care for the orphans. Next slide, please. The main aim of our study was to provide global minimum estimates of COVID-19-associated orphanhood and caregiver deaths using data from 21 countries that represented about 76 percent of COVID deaths in 2020. We used data from these 21 countries, accounting for that percentage to estimate global estimate -- to get global estimates of children affected by caregiver deaths. We defined orphanhood as the death of one or both parents, loss of primary caregivers, includes the deaths of the parents plus the death of one or both custodial grandparents, as you can see in the diagram. And primary secondary and caregivers constitute the two previous categories plus the death of at least one co-residing grandparent or kin. In regards to the methods, briefly, we used data on the average number of children per family and COVID-19-associated deaths, death rates. And with this data we were able to estimate the average number of children orphaned in each country by sex and age group. My colleague, Dr. Juliette Unwin will explain our process in more detail in the following presentation. Next slide, please. From March through December 2020, during the first 10 months of the pandemic, 1.8 million deaths left 0.9 million children affected by the death of caregivers. In the first five months of 2021, we saw double the impact in half the time. That is, 3.6 million deaths, and the number of children affected doubled to 1.8 million. We show trends in COVID-19 deaths in purple in this diagram and children affected by caregiver deaths in blue. Next slide, please. In this map, as you can see, this problem affects every country. The map depicts a series of countries that have the highest burden. And you can see highlighted Mexico, Brazil, India, the U.S.A., Peru, South Africa, where between 100,000 and 200,000 children were affected in each of those countries. At this, as this disease progresses, many more countries will be affected, and this problem will continue to grow. Next slide, please. Our paper is also the first to estimate how many children have been affected by the death of a caregiver due to COVID-19. In this paper we include a real-time COVID calculator -- which will also be explained in more detail -- we used to calculate estimates of COVID-19 in this example associated orphanhood in selected countries of concern after a COVID-19 surge July 2021. In the y-axis is represented by the number, represents the number of children affected by the death of caregivers. In the dotted vertical line shown, what is depicted are the countries that had a surge of COVID-19 cases. And as you can see, after those surges, there is a noticeable increase in COVID-19-associated orphanhood in children. Next slide, please. Next slide. Can we advance to the next slide. Thank you. CDC's investment in real-time monitoring, a priority for the U.S. government, can ensure pandemic-associated orphanhood does not remain hidden. During the HIV/AIDS pandemic in 1990, in the first year of reporting, there were 903,000 children orphaned. Comparatively, in the first year of reporting during the COVID-19 pandemic, more than 1.1 million children were orphaned. By the time the government appropriated the first PEPFAR investments for HIV/AIDS global response 13 years later, that number of orphaned children due to HIV/AIDS had grown to 15 million. After two decades of PEPFAR investments, we know what works to promote resilience for orphans and vulnerable children. We can use lessons learned to help children newly orphaned by COVID-19. Former Director Bill Foege, CDC Director, said, if we are maintain the reputation this institution now employs, it will be because in everything we do we will be willing to see faces. The faces like these children in a Mumbai food line whose mothers and fathers died in the April surge. Next slide, please. To link our data to action, our collaborators outlined an added pilar to emergency response called Care For Children. This pilar calls for a three-pronged approach, three P's. Preventing death by equity and vaccination and application of mitigation strategies. Preparing families for kinship fostering and adoption. And protecting children from violence, poverty and other social vulnerabilities. Our collaboration with CDC and other agencies'

communication team also led to an implementation strategy that eventually was featured by more than 830 U.S. and international media outlets in nine languages in 23 countries and territories with about 2.8 million social media impressions on multiple platforms. Our report, the calculator and the paper are also highlighted in the CDC's center for global health digital homepage. Next steps include ongoing interagency multilateral dialogues on the 200 million [inaudible] support families for children who have already experienced orphanhood and death of their caregivers. Our data, showing that every 12 seconds one child loses a parent or caregiver to COVID-19 suggests that the time to invest in children is now. Thank you for having me here today to share this overview of our findings. With that, it is now my pleasure to hand the call over to my colleague, Dr. Juliette Unwin from the Imperial College London. Next slide, please.

>> Thank you, Andres. And welcome to everyone joining us today. I'm going to spend the next few minutes talking you through our methodology and updating some of our results. Next slide, please. Our modeling methodology is heavily data-driven and requires three main pieces for our 21 study countries. The first piece is age or sex to segregated COVID-19-attributed deaths and or excess deaths. Secondly, age-specific fertility rates from birth counts in developed countries and population level surveys in less developed countries. And here we saw that male fertility is less regularly reported. So there's scope to improve these estimates if better male fertility data was available. And, thirdly, elderly people household composition data. Next slide, please. Our orphanhood estimate is simple. We work out on average the number of children and adult of each age and gender has and multiply that by the number of people in that age and gender category that died. We assume no person under 15 was a parent and that male fertility did not exceed 80 or their father could be older than 80 given they fathered the child when they were younger. We also did duplicate our data to ensure children whose mother and father died were not double counted using the secondary household attack rate and affection fatality ratio. The photo show children who have sadly been impacted by loss of caregivers due to COVID from our report. Next slide, please. To calculate loss of grandparent care, we consider two different metrics. Firstly, children whose primary caregiving grandparent died in households where the parent does not live. And, secondly, children whose grandparent died who live in the home and provide secondary care alongside parents. We separate these out because the care needs for the child are different. We use estimates of the proportion of grandparents over 60 who live in these different household arrangements and multiply this by the number of adults over 60 who died. We truncate grandparent deaths by 85 to avoid counting these adults who live in care homes, which accounted for a large number of deaths in this category in Europe and the U.S. especially. This method also is likely to produce an underestimate of orphans, since we assume at most each grandparent who dies leaves behind one child due to insufficient data on families and family sizes. Next slide, please. Despite our 21 countries covering around 76 percent of COVID-19-attributed deaths, this didn't give us a global picture of the orphans. We wanted to expand our analysis to include as many countries in the world as had reported COVID-19 deaths. Not all these countries had age/gender desegregated data, so we needed another method. We found that the ratio of children orphaned to deaths were strongly correlated to the total fertility rate. So we used this relationship, as depicted in the figure, to predict the ratio for the countries that we didn't have data for. The figure of this relationship is taken directly from our "Lancet" paper. Next slide, please. Using this method, we can get global minimum estimates for our three different categories that Andres explained earlier. Four months from, on from the end of our study period, 0.6 million more children

have lost a parent. 0.65 million more children have lost a primary caregiver. And 0.8 million more children have lost a primary and/or secondary caregiver. Next slide, please. Since our study was published new excess death data has become available for other countries. We have, therefore, used this historical information to update both our study periods and extension. These numbers are shown on the slide. This substantially increases the number of children who've lost care in our initial study period to nearly 2 million children for primary caregivers and 2.7 million for primary and/or secondary caregivers. In the past five months, we have sadly reached 3.4 million children who have lost a primary caregiver and 5 million who have lost a primary and/or secondary caregiver. Next slide, please. To help make our results as widely accessible as possible, we've produced two visualizations to occur alongside our results. And on the slide we can see a video of our real-time orphanhood calculator. This calculator can be found at the link at the bottom of the slide. Here we provide our up-to-date estimates of orphanhood and caregiver loss for almost all the countries in the world. To start, we see the Brazilian data from our paper up to 30th of April, with the numbers corresponding to our study. The blue line shows how this trend is increasing. And as you just saw, you can change the date using the pop-up calendar. It's also possible to change the country, as you just saw. And here we show the data for India. And these numbers, again, you can use the blue line to follow how this trajectory has grown. We showed Brazil and India here because they're two of our countries with the highest burden. Next slide, please. Our second visualization uses the Our World in Data tools. And here we display nine countries with the highest increase in the number of cases on the 7th of September [inaudible]. The web link is shown at the bottom of the screen again. You can use the add country button to add any additional countries, as you can see in the example here where we are now adding Thailand. You can hold your cursor over the trend line, and you point to see how these numbers are changing over time. And you can click the play button to see how these trajectories grow in time. Sadly, surges in cases may result in surges in deaths, which in turn result in surges in orphans. We have noticed that each month these change as the pandemic ebbs and flows around the world. The countries here are different to the ones highlighted by Andres earlier. Next slide, please. Our updated estimates, using newly available data, show that globally a minimum of 5 million children have experienced death of a mother, a father or a grandparent caregiver. As big as these numbers are, they're still only the minimum estimates. This means there is a hidden global pandemic of COVID-19-associated orphanhood that will have a serious intermedia and long-term impact on children and families for generations to come. Therefore, addressing the loss that these children have experienced and continue to experience must be one of our top priorities. And it must be woven into all aspects of our emergency response, both now and in the post-pandemic future. We now look at a situation where over the past five months a child has been orphaned every 6 seconds instead of the 12 seconds that Andres mentioned earlier. Thank you for having me here today to present on our methodology. I'd like to now hand over to my colleagues, Professors Lucie Cluver from the University of Oxford and Laura Rawlings from The World Bank Group. Next slide, please.

>> Thank you so much, Juliette. And Professor Rawlings and I will be talking next about the essential next step. Which is, where do we go from thinking about these enormous numbers and rapidly increasing numbers to what are the responses? And what do we know about how we can reach these children and adolescents. And if you go to the next slide, please. Before we start talking in detail about the evidence base, it's worth taking a moment to read something that a young girl who's recently lost

her father wrote just a few weeks ago in a school essay. And thinking about this means that, as we put together the evidence and the cost-effectiveness and the data, that we are going to be reaching these children and their families at a time of extreme vulnerability. And we need to think about delivering those services with sensitivity and care to their situations and recognizing that those situations will be very individual, whilst at the same time balancing that against a massive global need and need for a response. If you'll move to the next slide, please. So we're starting to see evidence of impacts of COVID-19 on children, and they're very closely paralleling the data and evidence that we've seen on HIV/AIDS orphanhood and parental illness. And so we see higher rates of poverty. And Linda Richter's work has been exceptional in that and showing that is one of the strongest drivers. Increases in mental health distress amongst both children and their caregivers. We see increases in child abuse and violence in the family. And that's really primarily due to the additional stress that the families are put under in these situations. We see increases rates of school dropout and sexual health risks. And both of those, most probably from the evidence, driven by poverty where children are unable to afford school fees and may find themselves in, having to have transactional relationships in order to provide food. Next slide, please. But the HIV/AIDS crisis, the ongoing HIV/AIDS epidemic can also teach us some valuable things about the leadership and what can be done. And we saw on the U.S. government's ring-fencing within their PEPFAR response, a ring-fenced 10 percent of money for orphans and vulnerable children. And Professor Sherr and Gretchen Bachman are going to talk about that later. But we've also seen other examples of leadership. For example, The World Bank and Kenyan government cash transfer for orphaned and vulnerable children, which UNICEF and Achenti [assumed spelling] did randomized control trial evidence of showing substantial positive impacts for children. We also saw examples of different international agencies and governments coming together. For example, the Children on the Brink work, which really brought them together to say that this is something that is a global challenge that we must address in a united and collaborative way. Next slide, please. So if we dive into it to what the data is suggesting is, are most effective ways of ensuring that children who are orphaned and affected by COVID can reach their full potential in their lives in safe and loving families. And we'll talk briefly through the three components of preventing caregiver death, of preparing family support and avoiding institutionalization. And, thirdly, the evidence base for protecting children from the negative impacts of orphanhood. Next slide, please. So, of course, prevent, this is actually things that we're very familiar with. We know that reaching caregivers and reaching families across the global south with vaccines is absolutely crucial for this and must be a real first priority in our response. Next slide, please. But we do also have to develop strong and really quite widespread responses to the 5 million children who are already affected. And those numbers are projected to be increasing rapidly over the next year. And so there's now substantial evidence, and if you look at the Lancet Commission on Deinstitutionalization of Children, that a first priority is to avoid orphanages and institutions for children. We've seen from work by Professor Chuck Nelson and others that there can be severe challenges with brain development and increased rates of physical and sexual abuse for these children. And so the alternative is to find the best family option, ideally within the child's family, own extended family. And if not in, through foster care. And then to monitor and support that family. And, of course, to strengthen the networks wherever possible around the family. If you go to the next slide, please. We've also got new evidence which can help us develop and understand how we can protect children best. And this is an example of a study in "The Lancet" of children primarily orphaned by HIV and AIDS. And we see that of 14 potential interventions, the most effective combination was a combination of a government cash transfer, this was economic support. Parenting support for the family looking after them. And going to a safe school

where they weren't exposed to violence. And we see that that combination results in a whole range of positive outcomes. Reductions in violence, victimization and perpetration. Improvements in mental health and healthcare attention, in school progression. And reductions in risky sexual experiences, which we saw are high risk for these children. If you go to the next slide. We're going to talk you through a little bit more detail about what some of those might look like in reality. And if we look first at parenting support, there's been a real increase in delivery of parenting support programs, mainly in group-based programs by U.S. aid, by PEPFAR, by UNICEF, by World Bank, by World Without Orphans. The whole range of international agencies, national governments and faith-based organizations. We've seen new innovations of hybrids, human-digital and digital versions, and that's going to be essential as we think about delivering services, especially to families in acute situations where they, it may not be possible to have anyone visit them. And we've seen cost-effectiveness studies. This was one in South Africa. Of $6 effectiveness to every $1 spent. And that was on the single outcome of preventing severe child abuse. If you move to the next slide. We've also seen very clear evidence of the effectiveness of ensuring access to safe education, particularly for girls. And this is really about making sure that children and adolescents can go to school, supporting safety in school. And when they're there, helping them gain life skills and protection against abuse. And, again, highly cost-effective. This was a study in Ethiopia. I'm going to move on now to my colleague, Professor Laura Rawlings, who's Lead Economist at The World Bank. Over to you, Laura.

>> Thank you so much, Lucie. And a real pleasure to be here with all of you today. I would like to pick up on the protect pilar of our three part prevent, prepare and protect model and focus primarily on the elements of economic support for vulnerable children and their caregivers. Cash transfer programs have expanded dramatically in the past decade. Some have called it the silent revolution. And they have been adopted even more widely as a response to the COVID crisis. Today 195 countries have mobilized social protection measures in response to COVID-19. And this is a four-fold increase since March of last year. And this scale up in coverage has now reached over a billion people. This uptick in social protection is mainly in the form of cash transfers, and these programs are vehicles that can be leveraged to address the orphans crisis. But what do we know about the performance of cash transfers and their promise for meeting this crisis? First, cash transfer programs provide a platform to reach vulnerable households. They are often targeted to the poor or used to reach specific vulnerable groups. Second, evidence from rigorous evaluations reveals the clear impacts that cash transfers have on increasing access to health and education services and on reducing poverty. And in some cases the impact of the cash alone has improved nutritional health and child development outcomes. But, third, and most importantly for our discussion today, is that, when the cash is combined with care in the form of parenting support, the impacts of the cash on children's outcomes can be boosted significantly. Evidence of cash plus care impacts on early childhood development outcomes from evaluations in Colombia, Madagascar, Mexico and Peru show that the addition of parenting support to income transfers resulted in significant impacts on children's development, including observations of improvements in language, cognition and socio-emotional skills. The cash allows parents to access valuable services and invest in their children and lessens the stress and depression associated with poverty. And the care equips parents and caregivers with the skills and practices they need to support their children. Next slide, please. So let's look now at what it will take to prevent, prepare and protect children. Now that we have looked at the what to do, this is really a look at how to do it. And this model is based on work coming from Stanford University of

collective impact. And it shows the elements that need to be present for collaborative action to reach our desired goal, which is to ensure that children reach their full potential in safe and loving families. There needs to be a commitment to innovation coupled with evaluation and learning so that effective policies and programs can be developed and scaled up. And, conversely, the ineffective policies can be reformed or ended. Also clear communication and engagement across stakeholders coupled with strong monitoring systems will help ensure transparency, accountability and effective implementation. Third, activities need to be coordinated across stakeholders to ensure complementarities and avoid gaps in coverage. And this is particularly important in efforts, such as this one, that call for working across multiple programs and a wide range of stakeholders. Finally, this work will only be accomplished if degree there are dedicated efforts, including dedicated financing. Next slide, please. So as we end, let's look now at who needs to be involved in this agenda. This work calls for efforts from a range of stakeholders. The public sector is a central actor, with those working in education, health, child protection and social protection and care at the center of the response. These public sector actors are called upon to step up efforts by introducing, adapting and expanding programs to address the COVID-19 orphanhood crisis. The public sector is essential to ensuring access to high-quality, affordable services. In many countries, however, those on the frontline care of support, including social workers and case managers, are overpaid and under-stretched. This means, particularly, that the role for communities, nonprofit organizations, faith leaders and the private sector -- many of whom are with us today in today's event -- also have a critical role to play. These actors are often very well positioned to reach vulnerable children and support families, to develop innovative solutions and to ensure the timely and effective delivery of high-quality support. So let me end with us focussing on a quote from Vito Russo -- in the next slide, please -- who is an LGBT activist, author and filmmaker who tragically died of AIDS. And let me read it in closing. "Some day, this crisis will be over. And when that day comes, people will hear the story that once there was a terrible disease all over the world, and that a brave group of people stood up and fought so that others might live and be free." Thank you, and let me now hand it over to my colleague Phillip Goldman, President of Maestral International. Next slide, please.

>> Thank you, Laura. And, Lucie, Laura, your presentation is a perfect lead-in for a discussion of how the prevent, prepare and protect agenda is currently playing out in one case study, Kenya. And then on how current approaches there might be scaled up within the country and perhaps beyond. Next slide, please. There are three COVID-19 drivers that are placing children at risk of family separation and residential placement in Kenya. Now, first we have the rapidly accelerating climb in the numbers of children losing primary or secondary caregivers, which was 8,500 by August 2021. Now, while these numbers started low, that steep curve in the increase is highly concerning, especially in light of low immunization rates in the country. Second, The World Bank estimates that there are some 2 million severe poor, newly severe poor in Kenya in the short period since the pandemic began. This is putting intense stressors on households facing the shocks of loss of employment and income, school closures and lack of access to basic services. Evidence shows poverty is the main reason children are placed in residential care settings. And, finally, the government of Kenya instituted public health measures to remove 13,000 children from residential children's institutions and to place them back with their families. Many of these children are now at risk of be re-traumatized and returned to those institutions. Next slide, please. There has, however, been an impressive mobilization in Kenya to respond to the secondary impacts of the pandemic, including the rapid deinstitutionalization process. So Changing the Way We Care is a

USAID global development alliance, which is currently operating in Kenya that is supporting the government and its partners to put family care for children at the center of the country's overall social policy. So along with UNICEF and other organizations on the ground, a rapid COVID-19 response mechanism was developed, drawing on the country's existing assets. The rapid response included the mobilization of social service workers. Now, there are thousands of them in Kenya. Children's officers. Teachers and technical instructors. County children coordinators. Officers within the National Council For Children Services. Probation officers. And child protection volunteers. Many of these have received case management training through U.S. aid programming over many years. And Changing the Way We Care and UNICEF has also provided training. An interagency WhatsApp COVID-19 response team was assembled. And because of the shutdown, virtual case management tools were quickly developed, and large numbers of children and families were, indeed, able to be reached. A 12-module webinar course on COVID-19 response for Kenyan child protection practitioners was developed and delivered. Roughly 450 practitioners attended each module. Some social workers set up open-air offices to maintain safe distance from children and families. Fifteen short messages for child protection staff, community leaders, religious leaders and others were delivered through the Viamo platform. Three-minute audio clips, in both English and Kiswahili were also distributed. Emergency cash transfers for families that were receiving children who had been institutionalized were provided to families in five counties. And the lessons of those specific transfers are being evaluated to inform Kenya's broader social protection program, which has been significantly scaled up with World Bank support. Changing the Way We Care also supported a range of family strengthening and parenting support programs. The government launched and just approved a comprehensive national care reform strategy, highlighting its vision and approach for strengthening families and providing alternative care when necessary. Meanwhile, the cabinet recently approved and forwarded to parliament a new children's bill with strong language on family strengthening. Next slide, please. So case management is one of the best tools that we have to deal with the complexities of COVID-19. Social workers typically aren't trained to address just one adversity or risk. They can be prepared to look at the multiple adversities children face. Poverty. Loss of parent. Disability. Health status. Violence. Risk of exploitation. And many more. And based on their assessment, they can help a vulnerable child and family to access available supports in the community. Some of these may be provided by community or faith-based organizations, others by government. Now, few communities will have all of these services available, but most communities will have some level of formal and informal support that will, indeed, be available to children and families. And let me stress that case management is particularly important for managing kinship care, foster care, adoption or the Islamic practice of kafala, as the children in the care system are often among the most traumatized and vulnerable by virtue of their loss of family supports. Next slide, please. So it all sounds great, but what I have outlined in Kenya is just the beginning, and the challenges are so daunting. There's a need to collaborate, to take the foundation that has been built in Kenya to scale. The prevent, prepare, protect vision is really about integrating children into a country's comprehensive social welfare agenda. Now, who can collaborate to make that a reality? Well, the government, of course. But there's also great power in bringing together the key development partners in Kenya, such as The World Bank, UNICEF, USAID, the EU and the African Development Bank among others. We need to see this agenda highlighted in national policies and much better resourced in Kenya's national budget. There's also a particularly important role that faith-based groups can play. There is so much selfless generosity going into children's homes by foreigners outside of Kenya. And as has been stated, those homes are really not doing, providing benefits for the children. They're doing harm. So much of that energy and funding

to be redirected to strengthening families and family-based care for children. A number of faith-based actors have launched performs of their care systems in Kenya. Changing the Way We Care, for example, is partnering with the Association of Sisters of Kenya. And a number of evangelical organizations are actively working on transitioning to family-based care in the country. Ultimately what we need is a joint public, private, faith-based effort around these five areas, which would transform the lives of countless numbers of Kenyan children for the better. And the next slide, please. So just to say, these approaches really do work. Francisca is a mother of three children from Konjuro [assumed spelling]. Her three children, aged 12 to 17, were in residential care until the government issued that order to reintegrate 13,000 children from children's homes into families due to COVID-19. Francisca's children came home, but she needed economic and social support. Changing the Way We Care was able to secure a cash transfer for her that she used, both for food and for expanding her poultry business. Cash was not enough. And here you see her receiving parenting support from a social worker. And, by the way the, social worker is the one at the center of this picture. We wanted to spotlight her role. Francisca receives monthly household visits. And the charitable children's institution [inaudible] house for children has helped her repair her home. A welcome indication that some of these residential homes are capable of transitioning to family-based care supports. The cash plus care approach is transforming the lives of her three children who would otherwise have faced serious challenges to their development and well-being and protection in residential care. They are at home with mom, and mom is getting supports that might have kept them from leaving in the first place. So with that, I'd now like to hand it over to my colleague, Phil Green from World Without Orphans. Thank you.

>> Thank you, Phillip. So we've seen what works, but how can we get programs that work to those who need them? Next slide, please. Faith and community networks can have a significant role because of three types of capital as describes by a UN Women report -- access capital, social capital, and spiritual capital. Access capital. Faith leaders are often gatekeepers to their communities. Not only that, as I'll illustrate in one of my examples, they have direct access to families. Social capital. Faith actors bring social influence and infrastructure, organizations, funds, buildings and people. In terms of influence, I'm sure most of us have heard examples of when an expert has spoken to a community, and then the community have turned to a faith leader and asked, is this correct? And the faith leader's response is all important. And in terms of infrastructure, many faith or community networks have well-established infrastructures that are likely to be around for decades to come. From addressing vaccine hesitancy to implementing family support programs, the influence and infrastructure of these networks are key. Spiritual capital draws and engages faith resources and authority through prayer, messages and sermons, sacred text and religious rituals. Faith can be a motivator for a guided, for guiding a desired course of action. It's often a faith leader who is the first to connect to the family before and following a bereavement, as they perform end-of-life rituals and conduct burials or cremations. This places faith leaders in a position to find these hidden children and connect them to support programs. I will now provide two examples of faith and community networks in action. Next slide, please. World Without Orphans is a collaboration of faith-based organizations and community networks in 80 countries, working to call on and equip national leaders to collaborate in solving their country's orphaned and vulnerable children's crisis. In March 2020, as countries around the world went into lockdown, there was 1.6 billion children out of school. We knew from previous health emergencies that the risks of violence against children increased significantly. We looked to identify evidence-based programs that would

equip our network to address the needs they had identified. The COVID-19 parenting tips developed by Parenting for Lifelong Health was one such program. First, WWO's network was able to rapidly support translation efforts, which meant that within six weeks the tips were available in more than 80 languages. Within days we were hearing that our partners were using the tips in their work with parents and caregivers. In Ukraine, for example, the tips were being distributed along with emergency food parcels. In the first three months, the total reach of the parenting tips was 60 million, with 20 million being attributed to World Without Orphans and our partners. Next slide, please. In Malawi, our partners, Forgotten Voices, demonstrated the variety of methods faith-based organizations can deploy, from faith leaders fraternities, to home visits, to radio stations. All benefiting from the compelling combination of access, social and spiritual capital that the organization and its leaders have built over many years. Also noteworthy are the tools and technical assistance that Parenting For Lifelong Health provided our partners in Malawi and other countries to evaluate the effectiveness of the parenting tips. Multilateral, bilateral and academic experts developed programs that work, but often unable to get them into the hands of those who need them most. Meanwhile, those who need them are desperately seeking programs to address the needs they see in front of them. This example shows how faith-based organizations and networks can effectively bridge this gap. Next slide please. This was all possible because World Without Orphans provided an effective structure. As a result of our extensive web of trust-based relationships built over many years, we were able to mobilize global networks and national organizations who were in turn able to mobilize local organizations, such as churches and congregations of various faiths who had direct access to their families. Networks provided the infrastructure for extensive reach. Organizations provided the infrastructure for rapid delivery. And because this infrastructure was already in place, the dissemination of the parenting tips was able to happen within days. Next slide, please. My second example is from Sri Lanka, where in 2017 an interfaith collaboration worked with the Ministry of Health, aiming to reduce the stigma associated with leprosy and increase contract tracing and thus to reduce the spread of the disease. The collaboration coordinated nationally saw the creation of local teams. Each team included a Buddhist, Christian, Hindu and Muslim leader. In a country where 99 percent of the population consider religion is important, an interfaith collaboration, bringing together the access, social and spiritual capital of each, had a synergizing effect and proved to be effective. The religious leaders used their spiritual capital to rewrite narratives around the stigma of the disease, their social capital to influence and mobilize and their access capital to open doors for the health teams who were responsible for the contact tracing. By 2018, districts without the interfaith program had contact tracing rates of 72 percent, while districts with the interfaith program saw contact tracing rates increase to 92 percent. Next slide, please. The World Health Organization and UNICEF, recognizing the impact of Sri Lanka's interfaith program, are now collaborating with Sri Lankan faith leaders during COVID-19 lockdowns. This has included health messages, the provision of emergency food parcels, and the dissemination of parenting tips. At the peak, they were connecting with 40,000 families each week via WhatsApp. Next slide, please. In conclusion, we know what works. We know how to prevent the deaths of parents and caregivers. We know how to prepare safe and loving family-based support services. And we know how to protect children at risk from childhood adversity and violence. I hope my presentation has provided a compelling case for why faith and community networks can be well placed to have a vital role to get what works to those who need it, and using the framework of access, social and spiritual capital can provide a foundation for effective engagement. Thank you for giving me the opportunity to present today. I'm now going to hand over to my colleague, Dr. Susan Hillis from the U.S. Centers for Disease Control and Prevention.

>> Thank you so much to all the presenters. And for those running the slides, I think we can turn them off for a few seconds and let the presenters who have spoken so far open back up your videos. We do have several questions that have come in, and we'll take about 5 or 10 minutes for questions and answers. And then we'll pick up with our last two presentations for the morning. And then we'll have a few more questions and answers after that. So, first of all, our first question is for Professor Rawlings from The World Bank. And there was particular interest in whether there are countries that, where you have seen these cash plus care models work? Particularly in the context of COVID? I think for many people, they hear about The World Bank, and they hear about these kinds of possibilities, but often with within their own countries they don't have examples of it really working. So thanks so much, Laura.

>> Thank you, Susan. And thank you very much for the question. Indeed, these cash plus care models have been rigorously evaluated in several countries where there have been randomized control trials that looked at the impacts of the cash alone and then looked at the impacts of cash when combined with parenting and caregiver support. So these models are really very appropriate for the orphanhood crisis and for addressing it. And we have evidence, as I had mentioned briefly, from Colombia, from Madagascar, from Mexico and Peru. And this evidence currently is more focused on younger children. And the evidence from these trials predates COVID, but the applicability to the COVID crisis is really quite clear because you see impacts, not only on poverty, but also on children's development and on parental practices. So as my colleague Lucie Cluver pointed out, these are the areas that we know are impacted through the orphanhood crisis. And as supported also through the Lancet Commission work that she mentioned, these are areas where we know that a combination of responses can be very powerful. So the short answer is we have the evidence. We have the practice. And these are effective replicable models. Thank you.

>> Yes, thanks so much, Laura. I think the question also was really getting at, are these effective models being used now in any specific countries in an ongoing way programatically? Do you have any information about that?

>> They are, because a lot of these models have been scaled up. And, interestingly, there are several examples from a variety of countries where there has also been practices around COVID and how to manage the COVID situation, right, in a number of countries. And there's also been a huge effort clearly on connecting children also with education providers and a lot of the remote learning. So often what we see is that the cash, when combined with these accompanying measures that can encourage through, often just through communication and through behavioral interventions, the practices and access to services that we want to see. And as I had mentioned, there's been a massive scale-up in these cash transfer programs. So you typically see that as a crisis response, but the real opportunity is to see that those don't get scaled back now, and that we really continue to build on this expansion that's now reaching over a billion people to introduce the kind of tailored support that is needed.

>> Thanks so much, Laura. Let's go on to Dr. Unwin. And there was a question about why you used "excess death?" And I think the question also is like, what does it really mean, the excess deaths? I think everyone's familiar with the COVID deaths. Can you a say a little bit more about that Ette?

>> Sure. Thank you, Susan. And so just to clarify what excess deaths are, excess deaths are any deaths above and beyond the usual number of deaths for that country in the age and sex desegregated bands. We decided to use both excess death and COVID deaths because there's not a consistent reporting system of COVID deaths globally. And in some countries there's different definitions of what contributes a different COVID-associated death. So we wanted to make sure that we encapsulated all the children who had lost care during the pandemic.

>> Great. Thank you so much, Ette. That was helpful. So there's a question about whether we know any governments who have actually taken this data that now has been out for a little over two months and really used it to help identify those children who have faced COVID-associated orphanhood or death of a caregiver and actually used this prepare, protect, prevent strategy that you're proposing? I'll turn that, let's see, I think Dr. Villaveces would be a great person to answer that question. Andres, are you able to help us with answering the question about whether any governments have been able to use these findings in a response?

>> Yeah, sorry. I was answering another question in the questions and answers. Yes, this is a really important question. I think a lot of governments have acknowledged that there is a huge problem. And measuring this problem is incredibly important. Getting a sense more accurately of how big this problem is affecting countries is extremely important, but that is the first step. The second step is to transition into this, all this action and all these opportunities and all these mechanisms that we have learned from to be able to actually address the issues, to prevent, to prepare and to protect the children and their families as they are affected. So first component, measuring the problem is really important for every country to address. But the second is to transition and to be able to, using that measurement of how big the problem is, to using and translating that to action. Thank you.

>> Great. Thank you so much. And I think for our last question before we return for the final presentations, why don't we ask Phil Green if he can comment, since you seem to have had some experience in this area. What can communities do now while we're really trying to catalyze a public and private and faith-based response? What do you see that communities are well positioned to do now for the very children that are at risk where they live and work and live, you know, just [inaudible] on their lives?

>> Thank you. And thank you for this fantastic question, because it's the desire of all of us as the authors of this report that this report leads to concrete action. And I think the first thing to say is there's a real risk that, when we're presenting an overwhelming problem, it doesn't lead to action. It leads to people

feeling overwhelmed. And we really don't want that to happen. We want this to lead to concrete action. And I think the first thing is simply that, at the community level, we need to identify who these children are and who their families are because so often they're currently, they're remaining hidden. And we need to make sure they're identified so they're not hidden. So we need to know who can, who needs the support. And the second thing I would say is that we need to then identify practical solutions that we are able to provide to those families in the points of crisis. And we hope that, the idea is in the report, some of the ideas you've heard today, for example, the parenting strengthening will give you concrete programs that you can begin very simply to use to work with families in need. And then the third thing I would say is that this is going to take collaboration. It's going to involve people coming together to figure out how you can best at community level connect with some of the things that are going to be going on nationally and build bridges between the families in need and what's been offered at national level to provide support. And I think community groups have a really important place to come together to collaborate to make sure we serve families and children well.

>> Great. Thank you so much. And I think that will close out this segment of questions. And we will have another one after the final two presentations. Thank you, again, so much for all these questions. We will now continue with the presentation by Dr. Alex Butchart from the World Health Organization. So over to you, Alex.

>> Next slide, please. Great. Thanks, Susan. I will give you a brief overview of the Global Reference Group on children affected by COVID-19 that put together today's webinar. And going forward we hope we'll be able to add value to the action of all the networks and agencies that are represented here and others. Next slide, please. Such a group is essential if we're to successfully translate data to action and address the so-called second-order impacts of COVID on children and in particular the consequences of losing parents and caregivers. As we've so forcefully heard from Lucie, these include poverty, violence and other adversities and vulnerabilities. And it's crucial that these second-order needs are explicitly addressed in mainstream emergency responses and actions. As Phillip and Laura have stressed, dealing with them cannot be an afterthought. Next slide, please. The [inaudible] reference group is work in progress. It will have up to 16 standing members, including the organizations cosponsoring today's webinar and 10 ad hoc members. The members will be chosen to optimize collaboration between multiple sectors, including governments, civil society, united nations agencies, academia and faith-based organizations. To keep it nimble the group will remain informal and will be hosted by WHO. Next slide, please. The reference group has four key aims. These are to raise awareness of the second-order impacts of COVID on children. To catalyze collective action to prevent these impacts and mitigate their consequences where they do occur. To ensure ongoing monitoring and evaluation and research. And to build capacity for the implementation of evidence-based interventions and the collection and use of data about the number and characteristics of children affected by the second-order impacts of COVID. By way of example, evidence-based interventions that the reference group will promote are those included in the multi-agency Inspire and Nurturing Care technical packages. As we've heard, interventions -- such as the trio of parent and caregiver support, safe schools and cash transfers -- can accelerate reductions in multiple areas of children, reductions in bad outcomes in multiple areas of children's lives and improve multiple areas of positive resilience. Next slide, please. So the referencer

group will have monthly meetings to coordinate the country-focused work of its member and issue progress reports every three months. It will also undertake collective appeals for increased investment in evidence-based interventions on an ongoing basis. Next slide, please. For more information, please don't hesitate to contact Susan Hillis at CDC or me at the e-mail addresses shown here. I'd now like to hand over to my colleague, Lorraine Sherr from the University College London. Thank you.

>> Good afternoon, everybody, and welcome to this fascinating coverage. I've been asked to try and look back at the lessons from previous pandemics -- we have SARS, Ebola and particularly HIV -- and comment on how this knowledge and evidence base would apply. Next slide, please. I think it's encouraging to note that we're not starting from scratch. The HIV pandemic has given us a lot of lessons, and we should take these onboard. It's helped us focus on what to consider, also what works and about being prepared. Perhaps one of the key lessons, and I see it's come up in some of the questions, is about really taking onboard the [inaudible] of need, not focussing narrowly on one group of children, not using a definition that might be erroneous when narrowed, but look at all children. With HIV, we looked at infected and then wider affected and in actually every child. And if you translate this to COVID, it does show us that there's pandemic vulnerabilities for every child. Things like educational, the whole family, the COVID restrictions and all the gamut of reactions. And it narrows down to the sort of wider child onslaughts, child-specific illness, long COVID and all the physical and mental health. And then that brings us to the peak of what we're focussing on today. And we've called it orphanhood not orphaned, because there's a complexity of if a child loses one or two parents. Many children only liver in a one-parent household. And a caregiver is, obviously and very most often, much broader than a parent. And HIV teaches us to be very sensitive to this. Next slide, please. Our first learning is get to children on the map. Child issues are often under the radar and we even called our paper "Under the Radar." Our learning was very clear, you cannot negotiate unless you're at the table. Children can't speak for themselves when they're very young, and they can make a lot of loud noise when their adolescent. Listen to them. We need to be listening to them, and they need to be at the table. There's excellent examples. For example, the PEPFAR OVC evaluation, which I did together with Miriam Zoll does look quite critically at how good we are at doing good. We need to be speedy, and we need to have sufficient reaction. When you react and it's insufficient, it causes more frustration and often falls flat and becomes problematic to re-fund. A real lesson is you need to evaluate because now we're sitting with COVID and saying where's the evaluation? And if there's no evaluation, there's no lessons learned. Innovation and creative is excellent and important, but also doing what you already know is equally important. Remember to reach the hard to reach. It's very easy to do programs and just count numbers. The easy to reach, the less affected, they can counted. But you have to go the extra mile for the hard to reach, and you need to fine tune real vulnerability. Next slide, please. I cannot really summarize the entirety of the literature. There was 20 years of research on HIV. But I've tried to think of some of the steps that we have to learn. Separation is traumatic and awful for children. Be aware of them. Many of my colleagues have spoken about violence and abuse, a real and dramatic problem that has long-lasting ramifications. Poverty is the underlying driver. And being forced into poverty by deaths and illness and country reactions is something we have to be very aware of. Education disruption is stark. Education is not only the loss of education, but the loss of an environment where other programs can be delivered, where referrals can be made, where another adult can pick up on a child. So the school closure is awful. And we have seen, for example, in Kenya when they start to reopen schools, there's a lot of children missing. A lot of

children don't come back, and we have to restart that. Stigma impedes all sorts of progress, and the sense of abandonment is a lifelong burden for people to bear. We have to be long-term in our lens, not just the short-term knee jerk reaction. This [inaudible] forever. If a child loses a parent now, that's a lifelong loss. There's a literature on reconstituted families, bring it to bear, this is going to be what happens. Ensure that we don't run the risk of only focussing on physical and look at mental health needs, very important. Gender difference is an umbrella that covers a lot, the gender of the person who's been lost as well as the gender of the child who remains. Different genders and different combinations are very important. Of course, the loss of both parents make it a much more severe problem. There's good evidence that with all these losses, risk behavior is enhanced. So you need to know that you have to help the child and the situation for its own reason, but also to help risk reduction. And be aware of the toxic stressors that shows that adolescents and children can take so much. And if you build on the shocks, which COVID really has done, there's, it's slightly takes its toll. Next slide, please. Just to quickly look at interventions with evidence. I know that Lucie and Laura have already spoke to some of these, as has Phil and Phillip. But I'd like to stress some of the work on community-based organizations as being quite well evidence-based and really important. Because communities or grassroots are the backbone support, and they remain long after the donors leave. And I think the approach from HIV would caution to support and not supplant other resources. Next slide, please. This is just to give you the data of a slide you've seen quite a lot about. But really the slide is that, if you bundle services together, if you create combinations -- and in this example, from this paper, it was cash transfers, safe schools and parenting support. When you put them in combination, it has multiple beneficial ramifications. Not only that, it enhances good things like retention and improved mental health. So look very cautiously at what programs are viable and how you can put them together. One program might not work, but two ideas might boost, have this booster effect, and this is really very promising. Next slide, please. So at this point, Ette, I will hand over to Gretchen Bachman from USAID, who will take you through some of the other wide lessons. Gretchen, over to you.

>> Thanks very much, Lorraine, for covering the evidence base in the work that we've done to support children affected by HIV. In our program at PEPFAR, we use this schematic of the circles to really remind ourselves as an approach that we need to look at all levels of response. And to help capacitate these different partners all the way from government, to community, to families and, importantly, to involve children themselves in the response. Next slide, please. So at the macro level, it's really key to capacitate country child protection and social welfare systems. They're very instrumental in identifying and rapidly responding to children without adult protection. And they're also very important in terms of, if you have something like a cash transfer program and helping families access benefits, including cash transfers -- I know this was mentioned earlier by Lorraine. But I just want to say that we found it's very important, when working at this policy and macro level, that we really think about being HIV sensitive and not HIV exclusive. So that's definitely a lesson I would carry forward to COVID. This approach of being mindful of the different ways in which children are vulnerable has definitely greater political and community support and is more sustainable. Next slide, please. So we found at the PEPFAR program that it's incredibly important to work to capacitate community leaders and community organizations. We've had the benefit of, you know, there are many organizations, international organizations, we heard from WWO, but at USAID, we've worked Catholic Relief Services, World Vision, Safe the Children Alliance. All are great organizations, great infrastructure. They really bring a lot of expertise, and they sometimes, or

they often bring their own financial resources as well. But in addition to those, we found it's incredibly important to really tap into the local networks that exist, and they can be faith or civil society. We know that these are the first line of support for families. And I think that they're also, especially indigenous groups, are very wary of how to administer programs that do not cause backlash against the children and families that they are meant to protect and support. The other thing that we've learned about working with organizations all levels, whether it's at the international or the local level, is that it's very important to have child safeguarding protocols in place. I know we think that, we often think that organizations set up to help children would never harm children. But, unfortunately, folks who do want to harm children sometimes seek out jobs in those types of organizations. So we want to be very careful that we have such protocols in place. And I've put in a link here for Keeping Children Safe, which is an organization that you can turn to to look for how to set up child safeguarding protocols and policies. Next slide, please. So family is really very crucial in terms of our response to children. The U.S. government plan for all children in [inaudible] emphasize how essential it is to strengthen families as opposed to interventions, such as institutional care that are really only stopgaps and don't provide the lifelong sense of belonging that families provide for children. Two types of support that we found incredibly helpful in PEPFAR, and we think will also be for children orphaned by COVID, are economic support. Again, things like cash transfers, but other modalities as well. And parenting programs that build understanding of child development and promote positive discipline. It's important that these interventions are for all families, children's families of origin, whether that's a single surviving parent, as well as extended family members, such as grandparents and foster parents who take in children when parents have died. Next slide, please. So at the center of our schematic, we talk about children and their role. Children are not only the ultimate beneficiaries, but they're also actors in their own development. Making opportunities for children to meaningfully participate will help build their strength, and it will make your programs better. Next slide, please. So we've talked a little bit about how important it is to monitor progress. And I think monitoring really needs to involve the community. At PEPFAR we have community monitoring, which includes community leaders, beneficiaries of the program that are actually monitoring and telling us what kind of a job we're doing and making things better. Because I think PEPFAR has done a good job at this, we've been fortunate to remain funded now for almost two decades, and that's really quite extraordinary for a program of this size. Next slide, please. So just to say, in the PEPFAR program, we have a range of indicators against which we gauge our success. But I think some of the key ones that we want to take away for thinking about COVID is definitely economic stability, incredibly important for single surviving parents, but also for those grandparent and other caregivers that are taking in children and where there's been a loss of a primary provider. Secondly, and I know Phil Green talked a lot about this, the positive parenting through Parenting For Lifelong Health and other parenting modalities. And, finally, education. How important it is that we ensure that children continue to live a normal life as much as they can, that they continue, for example, to be in school and to progress in school. Next slide, please, which I think takes us back to Dr. Susan Hillis at CDC. So over to you, Susan.

>> Thank you so much, Gretchen and the final panelists. We have a number of additional questions, and I'm going to take the prerogative as the lead author and moderator to quickly answer several of them and then turn the others over to the panelists who have been speaking. And maybe, [inaudible], we can just turn off the slides now and bring up the panelists with their faces, since this is the question and

answer session. We won't really need the slides again. So there were a number of questions in which we could hear in your writing the urgency that you're feeling about vaccines and advancing vaccine equity. And what is going to be done to promote this and to deal with the vaccine hesitancy. The main thing I would say is every single organization represented here agrees with you, feels this extreme injustice of the inequitable access and also feels great concern about the hesitancy. There are billions of dollars globally being invested in that. And the community influencers and leaders, particularly faith and community leaders have key roles to play and can really particularly address the hesitancy side. That is not going to be our focus right now as we're finishing these questions, because very few resources have been directly linked to COVID and the increase in orphanhood and death of caregivers. And so particularly of our three P's -- prevent death, prepare families, protect children -- we're focussing more on trying to really insist that increase investment needs to cover those last two, preparing families and protecting children. The other question I'll answer is, how do the number of children orphaned by COVID in the first year compare with the average number of children orphaned in a given year in a country? And roughly it's a 15 percent increase, substantive increase if you have the resources staying the same. So now I'll go ahead and turn it over to Lorraine. One of the things that, a question that was asked several times is, what kind of rehabilitation for children who are experiencing orphanhood from COVID works? And does that vary by country? And does it vary by age of the child? Over to you, Lorraine.

>> Well, I think we have to bring all our canons to bear on this one. It does vary by culture, and it does vary by age. You can see a kind of continuum, where younger children, their immediate needs of nurturing and care and the quality of subsequent care is the most important thing. As a child gets older, that kind of nurturing care, as they have some independence, say with a teenager, the balance changes somewhat. And then they have a complex range of different needs in terms of education, of support, of being there. We've seen that supportive parenting in the accelerator models is really good. A supportive parent isn't a parent who just gives a child things they need. A supportive parent is knowing where your child's going, setting boundaries, being available to talk, showing good role models and ongoing caring. So I think that does need to be age adjusted and certainly needs to be culturally adjusted. And there is a wealth of information and knowledge. And COVID might change it because, not only is the COVID part of the reason for them being in the situation, but it also curtails some of our responses. So the normal, you can't go to the school and [inaudible] the teacher if the school's closed. You can't get a referral to the health care if the whole infrastructure of health care is overwhelmed. So the context really will matter.

>> Thank you so much, Lorraine. That's really helpful. We're going to turn it, now to a question for Gretchen. There are some of the participants who are very actively working in countries have that extreme problems to this day with children affected by HIV-associated orphanhood and vulnerability and now they are overlaying on top of that the COVID-associated orphanhood and vulnerability. So I think there's two parts to this question. What are the takeaways from helping children affected by HIV who are orphans and vulnerable children that can be applied wherever you are to children affected by COVID-associated orphanhood, number one? And in those countries really dealing with both, what can you advise? Or what lessons are important that can be applied? Over to you, Gretchen.

>> Thanks, Susan. You know, I just want to start out by saying, I know we want to focus on definitely the children who have lost caregivers. But I do want to say that this administration, the Biden administration has been incredibly generous and focused on getting vaccines out. The agency where I work, USAID, has programmed over $9 billion to date in terms of things like vaccines, respirators, support to making sure that we have fewer orphans because we keep parents alive. And that was a hugely important lesson in the HIV and AIDS crisis that continues, quite frankly, in that, you know, once we started treating the parents and making them healthy, they were able to be there for their children. So I think a really important lesson and takeaway, and I think Lucie mentioned Professor Linda Richter earlier, but she definitely has been someone who I have learned so much from over the years about responding to HIV and AIDS. And one of the most important things is to not focus your program so specifically on children that you forget the parents and the families and the caregivers that are taking care of them; right? They are their frontline to any adversity. You need to work with the parents. Strengthen the parent, the foster parents, the kinship carers, because they are going to be there in the long-run for those children. I think in situations where we have already a great number of children who have been orphaned by AIDS in south Africa, that's in the millions, for example. You know, I think we have to be mindful that some children are, I hate to say this, but they have gone through multiple caregivers. They've lost their parents. Now they've lost their grandparents or the person who have taken them in. So finding them a safe family placement is going to be incredibly important. I think that, you know, we also, in the PEPFAR program, have to be extremely mindful of not losing the gains we've made in terms of keeping people on their treatment. You know, you can imagine with so much hardship and poverty, as Phillip pointed out, in Kenya and other places, that, you know, daily life becomes a struggle. The one positive thing I would say is there are a lot of resources that have been invested in -- not only by PEPFAR, but the Global Fund, by UNICEF, by WHO, The World Bank and others -- to really build up capacity to respond to children in adversity. And I think that tapping into those networks and expertise are going to be really important. Thanks, Susan

>> Thank you so much, Gretchen. And I see Cornelius, he just came on. We are so delighted to have Cornelius Williams from UNICEF headquarters, the Global Chief of Child Protection with us to offer some closing remarks. So thank you, Cornelius. And I'm going to turn it over to you now.

>> Thank you, Susan. And thank you all for inviting me to speak. The COVID-19 pandemic has triggered an unprecedented crisis for children, as you heard today. Combined with the other ongoing crisis children are facing, the pandemic has increased children's vulnerability many-fold. It has deprived them of their health, well-being, education and protection. And orphaned, the most important, depriving them of their mothers, their fathers or their grandparents, caregivers as we've heard today. As a result of the pandemic, 424 million people have been pushed into extreme poverty, more than them half of them children. The pandemic has impacted communities at large and weakened the traditional support systems that families usually had access to in times of need -- the extended families, the neighbors and the communities members. The pandemic [inaudible] initiated illness and death and depravation are harming the psychosocial well-being of children and families. For children on the move, children with disabilities and those living in humanitarian situations -- such as Afghanistan and Yemen -- the impact of the pandemic in humanitarian situations have been extraordinary to say the least. The strain on the

families due to death of parents and caregivers -- either directly due to COVID-19 or indirectly due to food insecurity, lack of access to health care and lockdown -- have worked together to increase the risk of family and child separation. And placement in unsuitable alternative care has significantly increased. The pandemic has also rendered existing care systems much weaker. Lack of appropriate parenting and psychosocial support, inadequate number of well-resourced caseworkers and social workers and the challenges in implementing standards of care have all suffered because of the pandemic. In terms of action, in UNICEF we advocate for five-point agenda to guide both immediate responses and the long-term investment end up making children, families and communities more resilient. One, we need to ensure an empowering child and family-centered response. The response must recognize the strength of children and families and build on it and [inaudible] more support the diverse needs and situations. Two, we need to create an economy that values and prioritize investment in parenting support and care by recognizing that caregivers are essential for children's protection and well-being. Three, we need to build an effective social service workforce by increasing funding, expanding the number and reach of caseworkers and adapting services to suit context changed by the pandemic. Four, we need to enhance resources for family-based care in the community by moving funds away from residential care towards family-based care. And, five, and finally, we need to collect data on children's care. Ensure all types of children and families are counted and considered in developing, delivering and evaluating policies and services as we have seen today. In conclusion, on the ground, in UNICEF, together with partners, some of them are here today, including all those here today, and particularly supports, we particularly support national efforts in preventing unnecessary family separation. Promoting family-based alternative care. And these priorities are especially critical for children and young people facing COVID-19, as you shared today, of their mothers, their fathers or their grandparents who provide their needs and nurture. In 2020, we in UNICEF supported 87 countries to provide alternative care to over 700,000 children without parental care. We are also dedicated to protecting children from violence, abuse and exploitation and to build in sustaining, effective parenting and caregiving support skills. We look forward to continuing and strengthening our partnership at the global and local level to improve systems that promote family strengthening and prevention and family child separation. And, finally, the final point is, as part of this, we're looking at scaling family-based alternative care for children. Let me take this opportunity to once again thank you all, and I'll turn over back over to Susan.

>> Cornelius, thank you so much for those inspiring words and just for UNICEF's leadership globally on behalf of children. This does conclude today's discussion. We apologize sincerely for questions that we could not answer. There just wasn't time. We will provide written responses to every question. A recording of this session will be posted on the website that was created particularly for this seminar. Thank you, again, with, really with all of our hearts for attending the webinar. There are 5 million children, at least, in the world who have been affected by COVID-associated orphanhood and death of their caregivers. And those children need every one of us here gathered today. And I'm convinced that acting together, using evidence-based approaches, we will be able to make a difference. Thank you so much, everyone. Goodbye.