Children and AIDS Regional Initiative

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Lessons from the Children and AIDS Regional Initiative (CARI): Child- and HIV-sensitive social protection in Eastern and Southern Africa

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Photos in this report were taken by Jerker Edström and Keetie Roelen with consent of those on the photos.

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Acronyms

ARV	Antiretroviral
AU	African Union
AusAID	The Australian Government's overseas AID programme
CARI	Children and AIDS Regional Initiative
CBCC	Community-Based Childcare Centre
CBO	Community-Based Organisation
CSP	Centre for Social Protection (IDS, UK)
DFID	UK Department for International Development
DSF	Douleurs Sans Frontières
EAC	East African Community
EC	European Commission
ESAR	Eastern and Southern Africa Region
ESARO	UNICEF Eastern and Southern Africa Regional Office
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
ICT	Information and Communications Technology
IO	International Organisation
JLICA	Joint Learning Initiative on Children and HIV/AIDS
MVC	Most Vulnerable Children
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PSS	Psychosocial Support
SADC	Southern African Development Community
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Education Fund
WFP	World Food Programme

1. INTRODUCTION[1]

Since the beginning of the 1990s, HIV/AIDS has greatly affected the lives of many around the world, and particularly in sub-Saharan Africa. Children are especially vulnerable to HIV and AIDS, and its adverse consequences are not expected to subside in the near future. In 2010, the total number of orphans in sub-Saharan Africa is expected to reach 50 million, with around 20 percent of those being orphaned as a result of HIV/AIDS (Webb, 2010). Although children have long been the forgotten face of the epidemic, they have recently become increasingly visible on the HIV/AIDS agenda (Yates, 2010a). Social protection is gaining momentum worldwide as a mechanism for poverty reduction and development. The HIV/AIDS pandemic and its detrimental effects can be considered a strong catalyst, if not the driver, for incorporating social protection in the response to childhood deprivation (Webb, 2010).

The Children and AIDS Regional Initiative (CARI) can be considered to have built on that momentum. The initiative represented is a five-year programme (2006-2011) to improve the wellbeing of orphans and children affected and made vulnerable by HIV and AIDS in terms of a large array of issues including health, education and child protection. CARI was funded by the UK Department for International Development (DFID) and the Australian Government's overseas AID programme (AusAID), operated under a shared logical framework and was overseen by the United Nations Childrens Fund's Eastern and Southern Africa regional office (UNICEF ESARO). The programme supported initiatives and interventions that respond to the needs of children affected by HIV and AIDS in nine different countries in the Eastern and Southern Africa region, including Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and Tanzania.

The choice of particular interventions to be supported at country level and implementation was led by the respective UNICEF country offices in consultation and agreement with national stakeholders. In an effort to learn from the wealth of experience built up through this programme, this study aims to document policies and programmes relating to child- and HIV-sensitive social protection within the CARI framework. Particularly, it focuses on lessons learned, best practices and challenges ahead in taking such interventions forward in the future and scaling up social protection as a response to children affected by HIV and AIDS. It attempts to reflect the shift made by UNICEF from service delivery to comprehensive systems support in the five-year project period and to support cross-country learning about successful and scalable models that might be replicated across the region. Furthermore, with increasing focus in UNICEF on initiatives to reach the poorest and most marginalised children, it pays particular attention to the equity aspects of child- and HIV-sensitive social protection.

This documentation explores child- and HIV-sensitive social protection implemented under the umbrella of CARI in five of nine selected countries within the Eastern and Southern Africa region (ESAR): Botswana, Malawi, Mozambique, Swaziland and Tanzania. During fieldwork for this study, assessments were undertaken by considering various programmes and policies and their performance individually, but also by looking at their linkages and complementarities to other programmes and service providers. The remainder of this report is structured as follows:

First, we discuss the wider remit of social protection and pay particular attention to the current debate around child- and HIV-sensitive social protection, particularly in ESAR. Second, the methodology is outlined for the documentation at large, including the various methods employed, the

1 This piece was originally drafted as part of an IDS/CSP Discussion Paper dated November 2010 on child- and HIV-sensitive social protection, including its concepts, instruments and measures, global trends and evidence and an overview of regional initiatives within and beyond CARI.

selection of country case studies, and some of the challenges encountered. Next, a synthesis of the findings across the five country case studies is presented to explore overarching themes and lessons learned. Finally, we draw a number of conclusions on the basis of positive and promising developments, challenges ahead and also the potential for expansion of social protection schemes. All chapters will detail the overall strategy for social protection in-country, the types of existing policies or programmes that are child- and HIV-sensitive, external or other influential systems or donors involved, the research questions and methodologies applied, and general findings and observations.

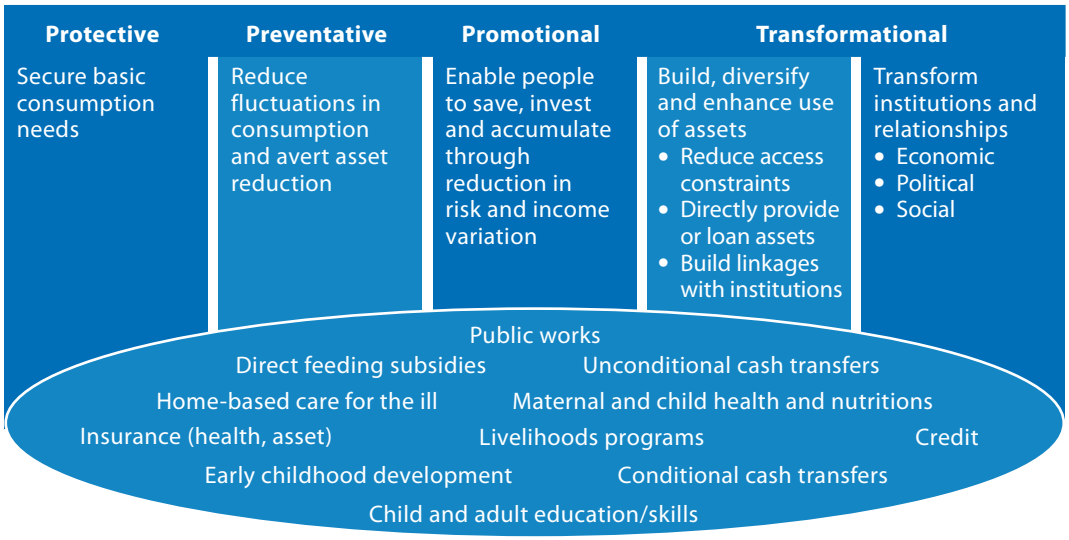
2. THE REMIT OF SOCIAL PROTECTION

a. Social protection as a response to children affected by HIV

Social protection has the potential to reduce poverty and vulnerability, as well as generate positive effects on economic growth and the rise of living standards (e.g. Hanlon, Barrientos and Hulme, 2010). Evidence firmly indicates that child poverty and vulnerability have long-term and far-reaching negative effects (e.g. Duncan and Brooks-Gunn, 1997; Barrientos and DeJong, 2006) and, as such, social protection can be considered to be a long-term investment in the society's future (Stewart and Huerta, 2009). Social protection is increasingly being recognised as part of an effective policy response to issues of poverty and vulnerability, both generally and in response to more specific contexts such as children affected by HIV and AIDS[2] (Devereux and Sabates-Wheeler, 2007).

However, it is important to point out that there is no consensus about what constitutes a child-sensitive or HIV-sensitive social protection measure, nor is there a commonly agreed-upon definition of social protection itself. While some definitions view social protection as a response to the monetary consequences of shocks only, and focus predominantly on cash transfers, other definitions consider social protection to be a mechanism or strategy to address wider economic and social inequities and vulnerabilities, including reducing the exposure to various shocks in the first place. Many frameworks for social protection at large have been developed, pointing towards different objectives, boundaries and classifications of measures and instruments. These include the comprehensive framework by Devereux and Sabates-Wheeler (2004), which categorises interventions along the lines of protection/provision, prevention and promotion (3P) and transformation. A schematic overview can be found in Figure 1, as adapted from Adato and Basset (2008), whilst a description is provided below.

Figure 1. 3P and T framework of social protection (from Adato and Basset, 2008, p. 2)



2 The 2009 Joint Statement by donors and international organisations (UNICEF, 2009) on child-sensitive social protection indicates that components of such a system include social transfers, social insurance, social services, policies, legislations and regulation. There is also growing momentum behind social protection and its value as a response for children with HIV/AIDS, as reflected in recent strategy statements by UNICEF and UNAIDS (Yates, Cheng, Chitnis, Odede, 2010). Social protection has emerged as a central recommended strategy for children made vulnerable and affected by HIV and AIDS, through the work of UNICEF and the Inter-Agency Task Team (IATT) as well as (connectedly) emerging as a central conclusion of the work of an international two-year learning initiative, JLICA (De Waal, Edström and Mamdani, 2008; Joint Learning Initiative on Children and AIDS, 2009).

Protection/provision (ex-post) schemes aim to smooth consumption and protect the existing assets of the chronically food-insecure households by providing recipients with predictable and adequate transfers of cash and/or food. This can include employment creation initiatives, improving access to services, and humanitarian-focused programmes (i.e. orphan and vulnerable child [OVC] reception centres).

Prevention (ex-ante) aims to prevent destitution and/or death during a crisis. These schemes encompass government-led social security (i.e. pensions), private insurance such as remittances and health insurance, and informal social protection systems at the community level (i.e. credit groups, funeral societies, community-based health care). In light of the discussion around HIV and its response, preventive measures can also refer to interventions particularly aiming to prevent transmission or infection of HIV. Although such measures would strictly be considered beyond the remit of social protection, it is important to flag the dual meaning of prevention in this context.

Promotion (ex-post) frameworks focus on the creation of physical assets and infrastructure (e.g. roads, soil and water conservation structures, schools) through labour-intensive public works, or the use of conditional cash transfers and education programmes for longer-term growth and development.

Transformative social protection concerns social justice and involves enshrining the rights of the individual through legislation (i.e. minimum wage legislation), promoting entitlement to benefits, eradicating marginalisation and discriminatory practices and creating 'demand-driven' local economies. As a long-term objective, social protection should aspire to reduce poverty and inequality through recognising and tackling the structural constraints that block people from attaining sustainable, positive change, and often serve to entrench and reproduce positions of disadvantage and inequality. Social protection is not merely embodied in a menu of instruments to reach a range of objectives, but should also be built on a forward-looking agenda that acknowledges the need for coordinated development activities grounded in political commitment to progressive distributional objectives.

Although this documentation seeks not to be constricted to a single definition or strict terminology of social protection, the approach of transformative social protection will be used as a frame of reference with respect to social protection at various points throughout it. It manages to address the structural inequalities and injustices that perpetuate children's vulnerable situation in terms of the intergenerational transmission of poverty (Devereux and Sabates-Wheeler, 2010). The importance of a transformative element that pertains to issues of equity and social justice, alongside other aspects of social protection, has also been recognised in the regional social protection strategy and framework of UNICEF in Eastern and Southern Africa (UNICEF, 2008), which specifies the particular elements of a social protection response that makes it child- and HIV-sensitive.

b. Child- and HIV-sensitive social protection

As mentioned above, there is no unified definition of child- and HIV-sensitive social protection, but one can identify a number of common pointers across the various concepts provided. The Joint Statement on Advancing Child Sensitive Social Protection (UNICEF, 2009), the UNAIDS Outcome Framework 2009-2011 (UNAIDS, 2010a) and UNAIDS Business Case (UNAIDS, 2010b) are key documents in this respect.

Generally, a child- and HIV-sensitive approach to social protection is one that recognises social protection to be not merely a set of interventions or specific policies, but rather a strategic and systemic social response to poverty, marginalisation and associated harms, that also protects vulnerable children in the face of challenges posed by HIV through links with other sectoral or issue-focused programmes. Social protection itself needs to be universal in application but tailored in formulation to be sensitive to the additional or specific needs of HIV and children, as social protection can serve as an important and broad-based strategy to prevent and mitigate the effects of HIV and AIDS.

The prime objective of child-sensitive social protection is to reach the most vulnerable and marginalised children and the families in which they are located, recognising that children face vulnerabilities inherently different from those faced by adults (Devereux, Hodges and Sabates-Wheeler, 2009); subsequently, protection from or mitigation of these vulnerabilities can benefit the child and society as a whole (UNICEF, 2009, CSP). Roelen and Sabates-Wheeler (2011) identified three types of vulnerabilities that can be considered particular for children, including specific biological and physical needs, high dependence on adults and institutional invisibility and voicelessness, and consequently call for a differential approach to social protection.

In relation to HIV, children (or adults) can be vulnerable in three distinct ways: vulnerable to becoming infected, vulnerable as a result of being infected or vulnerable as a result of the impacts of HIV and AIDS on family members or carers (Edström, 2007). Social protection measures can be considered to be HIV-sensitive when they include people who are either at risk of HIV infection or sensitive to the consequences of HIV and AIDS, needing particular support in accessing treatment or care and support. Such measures can reduce vulnerability to HIV infection (prevention), improve and extend the lives of people living with HIV (treatment), and support individuals and households affected by the virus (care and support) (UNAIDS, 2010b).

There is growing awareness that social protection systems may fill gaps in how individuals access and utilise health, education and community systems. Social protection programmes acknowledge *ex ante* vulnerabilities to infection and those related to living with the virus, partly because of intergenerational dynamics where children affected may grow up to become particularly vulnerable to HIV and infected themselves (Edström, 2007; de Waal, Edström and Mamdani, 2008). In addition, the era of treatment has also changed needs for social protection in terms of guaranteeing access to services. Table 1 outlines how different elements of a strategic social protection response at different levels can contribute to all three aspects of vulnerability in relation to HIV, thereby supporting better outcomes in HIV prevention and treatment, as well as care and support for those affected. A comprehensive strategy for social protection is not 'instead of' comprehensive strategies for HIV and health, but rather needs to be linked to such strategies in mutually supportive ways, thus becoming 'HIV-sensitive'.

It is important to note that 'sensitive' in this context does not mean focused or targeted. HIV-sensitive programmes must reach all vulnerable and affected children, beyond those in households that have lost a member to the virus (JLICA, 2009). Child- and HIV-sensitive social protection can be considered to refer to those schemes that acknowledge the specific and intensified vulnerabilities as a result of the threat of HIV, a result of being infected and/or the impact of AIDS on children, either directly or indirectly. Particular biological and physical needs (including nutrition, education, emotional care and antiretroviral [ARV] treatment if relevant), lower levels of resilience (due to illness or labour constraints), disintegrating systems of family and community support (as a result of the increasing burden posed by the HIV pandemic and its consequences),

Table 1. Linking social protection with HIV outcomes for sensitivity: indicative strategies and populations

	HIV prevention for most vulnerable to HIV	Treatment for people with HIV	Care and support for those affected by AIDS
Financial protection			
Social assistance protection for the poor	Transfers to the very poor supporting HIV prevention (incl. better access to education)	Transfers to poor PLHIV can improve treatment access and adherence	Transfers can mitigate the impact of AIDS on individuals and households
Livelihoods support for poor and vulnerable	Income generation or micro-credit to reduce HIV risk for poor key population groups	Access to economic empowerment for PLHA can prolong and improve life	Income generating activities, livelihoods strengthening, micro-finance for affected
Access to affordable quality services			
Social Health Protection for the vulnerable	Social insurance or public funding can reduce HIV risk (social security, public finance of RH, MH and HIV prevention services etc.)	Social health protection can ensure access to HIV and other health care and prevent erosion of savings	Preventive insurance measures appropriate for those affected (pension schemes, funeral clubs etc.)
Legal frameworks, policy, regulation			
Social justice for the marginalised	Legal reform, policy process, and protection regulation to reduce HIV risk (child protection and decriminalisation)	Protection of rights to health, treatment and work for PLHA (anti-discrimination)	Legal protection for affected (widows' and orphans' inheritance rights, birth registration etc.)

and feelings of stigma, taboo and grief, affect children beyond those who have lost a direct family member as a result of HIV or those who are HIV positive themselves. An approach to child- and HIV-sensitive social protection incorporating such issues thus also moves away from approaches focusing exclusively on AIDS orphans, as the latter do not address a broader range of children's vulnerabilities. Child- and HIV-sensitive social protection are linked in the sense that both types of social protection emphasise sensitivity to meeting the needs of specific groups in society rather than advocate for exclusive targeting of those groups (Devereux, Webb and Handa, 2010; JLICA, 2009; de Waal, Edström and Mamdani, 2008; Slater, 2004).

c. Child- and HIV-sensitive social protection in the Eastern and Southern Africa region

The region has the highest HIV prevalence rates in the world in combination with widespread poverty, and faces considerable challenges in mounting comprehensive social protection systems. The key stakeholders and organisations active in addressing these issues in the region include the African Union (AU), Southern African Development Community (SADC) , UNICEF and the Europena Commission (EC). Across the ESAR, a mix of policies and programmes that promote efficient labour markets reduces people's exposure to risks, contribute to enhancing their capacity to protect and cover themselves against lack of or loss of adequate income, and basic social services (Taylor et al., 2011) are the driving forces behind social protection programme design. However, a commitment to child- and HIV-sensitive programming remains less obvious, despite some moves to expand

health, social and development programmes (AU, 2006). In general, however, HIV/AIDS Strategic Frameworks are making increased mention of the role social protection could play in addressing vulnerabilities associated with the infection.

The development of social protection schemes in the ESAR can be considered to correspond with the multi-level approach to implementation as espoused by CARI; there is a blend of non-formal and formal mechanisms that contribute to the delivery of programmes, operating from the household and community level to essential services and to the national policy stage, or level. Most programmes are currently focused on providing economic, health-related or food-based support to vulnerable groups, and transformative frameworks and capacity building are not yet a significant part of the discussion (that is, beyond particular interventions focused on strengthening legal and regulatory frameworks).

d. Lessons and challenges for scale-up

The previous review and discussion of the role of social protection about the reduction of child poverty and vulnerability and the prevention and mitigation of the impact of HIV/AIDS on children pointed towards a number of pertinent issues regarding the scale-up of social protection programmes and interventions[3]. A number of recurrent issues at the core of current discussions in the region on the response to children affected by or vulnerable to HIV and the appropriate role for social protection were identified.

The first issue refers to the role of public (often more formal) and private or community-based (often less formal and civil society-based) structures with respect to the provision of social protection and services. On one end of the spectrum, there are arguments favouring a strong and leading role for government in scaling up social protection efforts, whilst a strong recognition and inclusion of non-formal structures is argued for at the other end of the spectrum.

Secondly, the appropriate care modalities for children without parental care are also heavily debated when discussing the appropriate response to needs of children affected by HIV and AIDS. By and large, family care is considered to be the preferred solution (often with reference to the 'resilience of traditional extended family structures') but there is also increasing recognition that such care structures have been and are being eroded, calling for a more profound reconsideration of alternative care options.

The third main area of debate concerns the role of different types of child- and HIV-sensitive social protection interventions. Cash transfers in particular have received a great deal of attention in recent years. Whilst they have been applauded for their potential beneficial impacts on a range of outcomes, questions remain about the need for other kinds of response mechanisms and how they would complement cash transfers in a broader comprehensive social protection strategy, sensitive to the special needs of vulnerable children, esoecially in light of the challenges brought about by HIV and AIDS. In particular, the wider availability of treatment may open up opportunities for moving beyond provision to promoting economic activity and productivity.

3 For a full discussion, please refer to the discussion paper that was prepared to guide and inform this documentation and report.

These three core issues, or major debates, informed the overall research questions for this documentation:

- What is the *role of non-state versus state actors* in the implementation of social protection services for children in the context of serious HIV epidemics?
- How do social protection programmes *support children 'through families' or/and support them in other ways,* and how does this address the needs of children affected or made vulnerable by HIV?
- What, if anything, is gained by *linking cash-based social protection programmes, or transfers, with other programmes*, such as psychosocial support services, with respect to mitigation of the effects of HIV and to support the adherence to treatment and prevention of HIV?

By addressing these three main research questions throughout the study and its country case studies, this documentation seeks to identify key lessons learned, opportunities for social protection and challenges ahead in the scale-up of programmes and policies across the Eastern and Southern Africa region.

3. METHODOLOGY

This documentation builds on the use of a number of different methods. These include the review of secondary literature (academic and non-academic literature, policy frameworks and strategies, policy reports and evaluations, and conceptual literature) and qualitative data collection and analysis by field visits, semi-structured in-depth interviews and semi-structured focus group discussions (FGDs) in five selected countries.

a. Formulation of research questions

On the basis of a broad literature review and a review of country-level initiatives and strategies – including from organisations such as UNAIDS, UNICEF HQ, UNICEF ESARO, AU, SADC and EAC – feeding into a discussion paper, overall research questions were formulated that guided the documentation at large and framed the synthesis discussion on findings and observations with respect to scale-up of social protection for children affected by HIV.

In addition to these overall research questions, initial country research questions were prepared for every country case study to inform the fieldwork and documentation, given a particular context. These questions built upon regional and country documentation of child- and HIV/AIDS-sensitive programming initiatives, which included a review of periodic reports and impact evaluations documenting various stages and aspects of these projects.

The actual planning of fieldwork revealed particular elements of research questions as more or less relevant or more or less open for investigation, given various country-specific opportunities and limitations. Country research questions or topics were adjusted to reflect those issues and programmes that appeared most pertinent and timely in the various countries under consideration, and frame the country case study discussions on findings and observation. In other words, the research undertaken for this documentation proved an iterative rather than linear process. It allowed for flexibility to assess the study's overall research questions to the best extent possible, given the countries' different contexts and opportunities for research.

b. Selection of countries and case studies

This documentation builds on five country case studies from the nine countries that were supported through the CARI programme. The choice of five countries out of nine CARI countries was informed by a number of considerations:

- Middle as well as low-income countries
- High-prevalence as well as lower prevalence countries
- Regional representation, or diversity
- Inclusion of at least one lusophone country

Based on these criteria, the list of selected countries included Botswana, Malawi, Mozambique, Swaziland and Tanzania. Of the three middle-income countries in CARI, i.e. Namibia, Botswana and South Africa, Botswana was considered to be the most appropriate for inclusion in this documentation, given the wealth of studies already available for South Africa and, to a lesser extent, for Namibia. Swaziland was selected as it is the country with the highest HIV prevalence rate in the region (and in the world). Malawi represents a low-income country with relatively high prevalence

rates but a large range of social and child protection initiatives, making it a particularly interesting case in terms of cross-sectoral linkages. Tanzania was selected for its fairly low prevalence rates and for its alternative take on the issue of vulnerable children beyond the remit of children affected by HIV (i.e. focus on Most Vulnerable Children [MVC], rather than Orphans and Vulnerable Children[OVC]). Also, as it is the only country from the Eastern African region, it was important to include it for regional diversity. Finally, Mozambique was included as one of two CARI-supported lusophone countries (Angola being the other country), its low-income status, fairly high infection rates and strong donor and NGO involvement. Table 2 provides basic indicators for the nine different countries and illustrates the considerations underlying the selection of countries for this documentation.

Table 2. CARI country characteristics

Country	HIV prevalence (% adult population)	% income poverty	% of orphans	HDI ranking
Angola	3	54	13	146 (0.403)
Botswana	24.8	31	14	98 (0.633)
Lesotho	23.6	43	10.3	141 (0.427)
Malawi	11	74	15	153 (0.385)
Mozambique	11.2	75	12	165 (0.284)
Namibia	13.1	49	18	105 (0.606)
South Africa	17.8	26	14.7	110 (0.597)
Swaziland	26	63	12	121 (0.498)
Tanzania	5.6	34	11	148 (0.398)

Sources: FAO, 2010; World Bank, 2010; UNICEF, 2010.

In each of the country case studies, particular policies, programmes or interventions were identified for inclusion in this documentation. The choice of programmes was informed by first, the range of programmes supported by CARI and secondly, by the extent to which such programmes were considered to provide insight into the study's overall research questions on the scale-up of social protection for children affected by HIV.

Furthermore, we sought to find a balance across all country case studies to ensure that all elements were given equal weight in the documentation. Depending on the nature of UNICEF's support and CARI-funded programmes in the particular countries, programmes and interventions under consideration ranged from policy-level advice by UNICEF to national discussions around social and child protection, on the one hand, to NGO- and community-based support of local initiatives, on the other. The documentation of this range of measures across various country contexts is intended to provide lessons learned and flag challenges or requirements for further investigation in terms of scale-up of social protection.

With reference to the choice of particular interventions and programmes under consideration, it is important to note that some of the research questions or particular elements are not limited to common definitions or understandings of 'social protection interventions'. For example, this study also documents programmes providing psychosocial support to children affected by HIV as well as child protection responses to cases of child neglect or abuse. Although such interventions might not strictly be considered to be social protection interventions, they are imperative for, and an integral element of, the response to vulnerable children and children affected by HIV, and may be important for effective and linked-up social protection strategies. As such, the research questions and selected programmes for documentation are guided by practice on the ground, rather than strict adherence to particular social protection terminology.

c. Qualitative research methods

Qualitative research through fieldwork and site visits based out of the UNICEF country offices was undertaken to collect evidence on a range of issues, including scaling of programmes, HIV/AIDS-sensitive targeting, enhancement of family-based and alternative care, improvement of supply-side constraints in basic services, and strengthening of monitoring and evaluation systems. The selection of sites for programme visits was made after the initial selection of countries.

Primary methods of research included semi-structured in-depth key-informant interviews and focus group discussions, with a local input requirement dependent on language barriers (in Malawi and Mozambique). Interview guides were developed to guide the semi-structured and qualitative interviews, rather than formalise or restrict discussions. Respondents were selected with the assistance of local stakeholders (i.e. UNICEF country staff, ministry counterparts and NGOs) on the basis of their ability to provide the information required for answering the research questions formulated for each country case study.

The composition and number of respondents varied for each country, but typically included a selection of government representatives, programme designers at the central, regional and/or local level, programme participants at both the individual and household level (interviews with orphaned children were conducted in a supervised school setting) and other stakeholders, such as social workers, community-based organisations and district-level officers. Language support was provided by local advisors and UNICEF ESARO field staff.

Findings from these qualitative methods were triangulated on the basis of existing studies, evaluations and policy reports, where available, and through continuous discussions with UNICEF. Particularly, with respect to the cash transfer schemes in Malawi and Mozambique, more quantifiable evidence from (impact) evaluations were available and used to verify results from this documentation.

It has to be noted that the methodology for this study was not intended to generate quantification of a statistical nature. Rather, it was chosen because it offers other unique advantages, such as a relatively direct reflection of analyses from below and the ability to capture how support, policies and outcomes are perceived from different vantage-points.

Although some of the particular case studies in this documentation present anecdotal rather than systematic evidence, they are considered to represent issues beyond one-off cases and important with reference to scale-up of child- and HIV-sensitive social protection. The triangulation of

perspectives enables the contrasting of subjective positions to build up a nuanced account. To the extent that findings build up a consistent picture, they can be seen to be illustrative rather than definitive. Stronger evidence about the scope or magnitude of particular issues would require more in-depth and systematic studies for each country and social protection programmes or interventions.

Despite the wealth of information collected and analysis undertaken on the basis of the methods discussed above, this study was subject to a number of limitations. These limitations include a relatively short period (five days) for country field visits to conduct discussions and interviews, as well as time constraints for individual meetings and group discussions. Furthermore, some bias might be expected from certain respondents' potential impressions that documentation might leverage resources to their organisations or centres. To reduce such bias, explanations of the objective of this study clarified the purpose of the documentation. Some bias might also be possible through the selection of centres and partners visited, which were primarily close to capital cities, which are key sites for UNICEF offices. Finally, the views of the consultants and assisting UNICEF staff may privilege certain perspectives. To mitigate these potential biases the consultants engaged in ongoing discussions with supporting UNICEF staff to ensure diversity of partners, programmes and households visited.

Finally, it has to be noted that this report presents documentation on lessons learned for scale-up of child- and HIV-sensitive social protection, rather than an evaluation. It aims to draw cross-country or regional lessons in terms of scaling up the social protection response to children affected by HIV and AIDS, but does not serve as an in-depth study of particular programmes or country responses in terms of social protection. The choice of particular programmes considered was guided by issues deemed to be imperative and pressing, given the prevailing challenges and debates in the various countries which were covered. As such, they are considered to provide insight into issues and discussions across the remit of social protection and enable cross-country learning.

4. SYNTHESIS OF FINDINGS

This chapter is framed around the three main research topics that were identified on the basis of the previous literature and document review. These include the role of formal and less formal actors, delivery and targeting mechanisms of care and support, and the balance between cash and cash+ schemes in the scale-up of social protection for children affected and made vulnerable by HIV. This chapter also reflects on new realities that are on the horizon and need to be taken into consideration in discussions around child- and HIV-sensitive social protection. The discussion of findings builds on the country case studies and as such, it builds heavily on the documentation of particular in-country programme and project interventions.

a. Role of formal versus non-formal actors and structures in providing support and services to children affected by HIV and AIDS

A number of lessons can be drawn from this documentation with respect to the potential and appropriate roles of state and non-state actors in child- and HIV-sensitive social protection. These include the importance and challenges of government ownership, harmonisation of programmes and interventions, and bottom-up and grassroots engagement.

With respect to questioning the appropriate roles of formal and non-formal actors, it is important to first clarify frequently used conflations of the concepts of sectors and formality: the distinction between state and private sectors do not map neatly onto a formal/non-formal divide, as private corporations and major INGOs are often highly formalised (i.e. structured along strict norms and strong hierarchy). Conversely, governments may sometimes operate rather less 'formally', with traditional authority structures and diverse local customs in place, particularly at the most decentralised local levels. The Malawi system for supporting families affected by HIV along with other development challenges is – at the local level – based on traditional authorities linked to chiefdoms, as is the case in many other countries, such as Swaziland or Tanzania. Countries have different levels of reliance on decision-making by traditional leaders, but it is important to recognise that systems of local governance cannot be assumed to function on the same bureaucratic and managerial terms.

Fieldwork in the five countries under consideration for this study showed that government structure and ownership is important for coherence and sustainability of programmes, especially as they are scaled up with heavy donor funding and involvement. Whilst Botswana is less dependent, in Malawi, Mozambique, Swaziland and Tanzania social protection programmes benefiting children are heavily donor-dependent and reliant on external financial resources. Most of these resources are typically earmarked for responses to HIV and AIDS, although there is also external support for broader poverty reduction and other child programmes.

Mozambique, for example, sees strong IO and NGO involvement in social and larger development programming through direct donor funding, rather than focus on support to government to build their capacity and systems. These limited options for capacity-building lead to frustration with government counterparts, as they feel locked into situations of poor coordination, administration and implementation, and see no short- or medium-term improvement by building appropriate skills and knowledge. Nevertheless, government counterparts in Mozambique do acknowledge that systems are perhaps not yet ready to absorb donor funding, nor are able to coordinate activities effectively and equitably on their own.

In other words, whilst government ownership and involvement might be a key aspect of building systems and sustainable structures, current levels of capacity and capability have to be taken into account to consider the extent to which governments can actually absorb resources and take on a lead role in coordination, administration and implementation.

In other countries, such as Tanzania, budgets for support to children and AIDS are also overwhelmingly donor-funded, typically coordinated through a National AIDS Commission, which – although 'government owned' – may present some challenges with respect to other areas of national policy and implementation, as resources are still tied to the response to HIV over other social concerns. In other words, the logic of the HIV response (heavily donor-determined) strongly influences what is possible to achieve in terms of social protection for children, and is often rather disjoined from other areas of reform in social policy and protection. Although some National AIDS Commissions are fairly powerful, even in the face of some donors, this may introduce certain imbalances in government architectures.

Most recognise a crucial role of central governments in establishing and legitimising equitable frameworks and rules of engagement for growth and development, as well as for social protection and meeting social needs. As reflected in the "Paris Declaration" (OECD/DAC, 2005) there is widespread agreement that donors, IOs and NGOs should harmonise efforts with governments' initiatives to maximise complementarities, value-addition and sustainability, rather than running disparate and uncoordinated schemes in isolation.

A quote in the European Report on Development (EC, 2010) postulates that *"[...] all the reviewed experiences, whether successes or failures, point towards one cardinal lesson: international assistance to social protection works better when it complements rather than supplants local efforts and initiatives. There can be no sustainable success without strong domestic ownership, backed if necessary and whenever possible by co-ordinated and aligned development partner support."* (p. 100).

In line with these recognitions, Mozambican government counterparts in health were particularly positive about their cooperation with international NGO Douleurs Sans Frontieres (DSF). DSF works together closely with government and local CBOs and aims to integrate its activities for disabled and home-based care in government and local structures. Government employees are seconded to work with DSF and local home-based care workers (coordinated by CBOs) in a bid for the transfer of knowledge and skills. Cooperation with the World Food Programme (WFP) with respect to health and social protection programmes was built on a somewhat different modality, with stronger autonomy on the WFP's side, whilst involving government counterparts in distribution of food transfers and packages. So, while we cannot readily generalise about NGOs as informal versus governments being formal, neither can we assume that multilateral UN programmes necessarily or always operate in closer collaboration with governments than do some NGOs.

In addition to the role of government and state actors, bottom-up and grassroots involvement has also proved to be crucial for buy-in and effective, efficient and equitable implementation at local level, and sustainability. Positive experiences of community involvement were found in Malawi and Tanzania, for example.

In Malawi, community committees are involved in the identification of eligible households for the Social Cash Transfer Scheme (SCTS), leading to great awareness and community ownership of this benefit scheme. Similarly, community committees in Tanzania are responsible for the identification of the Most Vulnerable Children (MVCs), assessment of their specific needs and ensuring that they

CASE STUDY: Comparing community-based child care in Swaziland's NCPs and Malawi's CBCCs

The somewhat organic development of community-based care for preschool children in Swaziland and Malawi presents an interesting illustration for considering how non-formal spheres can interface with formal national or district-level systems for social protection of children. In both countries, community responses to the daily care needs of children in communities affected by HIV and AIDS appear to have evolved around traditional forms of cooperation in care and mutual support at the community level. Whilst these initiatives have grown from the grass roots, respective governments and development partners in both countries have come in to assist and collaborate with many such care centres, with accompanying efforts and processes for formalising and institutionalising centres. Aside from the immediate care for children in need of supervision and support, these centres are recognised as providing a 'first point of contact' beyond the household, where young children can be reached in numbers during early childhood (in a similar – if less formalised – way to that in which slightly older children are reached through education in primary school, for example).

In Swaziland, NCPs vary in standards, but often provide daytime shelter, food, water and sanitation, some pre-school education and developmental activities, as well as a venue for reaching children with health care outreach activities, such as immunisations and de-worming. These centres are typically run by caregiver volunteers now approved by local community development committees and the centres are either supported by the community and/or by a partnering NGO (along with inputs and support from supporters such as UNICEF and PEPFAR).

In Malawi, CBCCs also vary in standards and also tend to provide a similar range of services for children with cross sectoral involvement. The centres in Malawi tend to be run by CBOs and to be rooted in the local community and, even though some also have the support of external NGOs, the linkages to official structures – like the Village Development Committees – are less direct (even if small communities sometimes mean that CBO staff also serve on such committees).

An important similarity across both examples is the extent to which the work is dependent on volunteer inputs. There are some incentives for engaging in this work, but in both countries the burden on volunteers appeared rather high, with a common finding that avenues for supporting these cadres more meaningfully need to be explored. In Malawi CBOs' access to government grants is available in principle, but far less so in practice, suggesting the need for strengthening abilities of government – or other intermediaries – to support CBOs. Swaziland's system has a greater role for intermediary NGOs, who support great numbers of NCPs and more effectively advocate for their needs. Whilst individual communities and community groups have limited access to higher level policy, a key area for development may be finding effective intermediary support structures, approaches to enhance sustainability as well as bottom-up influence.

are assisted. This involves a wide range of support services, often combining externally provided assistance with community resources, whether in cash or kind.

Similar committees and community groups were also found to play an important role in mobilising care for preschool children in connection with the Neighbourhood Care Points (NCPs) in Swaziland and the Community-Based Care Centres (CBCCs) and Children's Corners in Malawi. In Swaziland, the village-level authorities will typically allocate land for the NCPs, while the communities provide labour in the form of care volunteers. Many communities cooperate in the construction of centres, and sometimes provide food support when external assistance is limited or ends.

Photo 1
Carers and CBO members at Chikondi CBCC, Malawi

In Malawi, community-based organisations (CBOs) recruit volunteer caregivers, mobilise resources (including various funding modalities such as support from NAC, support by international organisations and NGOs and donations from the community) and organise the care and support activities. In many instances, these centres (or care points) play a much wider role, beyond their initial purpose of

day-care for vulnerable young children, and become a central point within the community for the provision and organisation of a wide range of care and support services. The sustainability aspect of community-driven approaches is primarily a case of contributing to the cost of care and support services. Care is by and large not sustainable in itself; it tends to be kept out of the formal economy, with households bearing the bulk of costs. It is a matter of who bears the cost. Currently, in the ESAR, communities are carrying much of the real and unaccounted for costs.

A bottom-up approach and strong involvement of communities, as discussed above, ensures that there is knowledge and awareness of the availability of programmes and how they work. Furthermore, it can allow for a feedback loop to policymakers at a more central level to improve and scale particular programmes and thus potentially provides an important mechanism to hold government bodies accountable in case of mismanagement.

In contrast, the largely top-down approach with respect to social policy in Botswana illustrates the consequences of a lack of local or community-level involvement. Government social workers are responsible for a wide range of social and child protection tasks at local level, but the semi-structured interviews showed that they feel rather disconnected from policymakers' decisions at central level. A lack of community involvement in the design and implementation of programmes places a large burden on social workers, who feel over-stretched, under-resourced and under-valued.

Although community involvement in the care and support of children is a potential strength, we also have to acknowledge its limitations. Given current financial constraints, there is a lot of volunteering or work with limited remuneration at community level for the performance of tasks and activities that are essentially civil servant jobs. In Malawi, only a small proportion of Child Protection Workers are employed as civil servants. The Permanentes in Mozambique, who identify eligible households for the PSA cash transfer scheme, work for limited remuneration. The MVC Committee members and Community Justice Facilitators in Tanzania also work as volunteers or receive small allowances.

One has to acknowledge the boundaries of community workers, when given on no or limited remuneration. For them to be able to do their work more effectively, be trained, feel valued and be respected by the communities in which they work, they need to be acknowledged and rewarded in some material way. In some cases, this might lead to the recommendation to absorb volunteers as fully paid civil servants. In Malawi, some Child Protection Workers are already employed as civil servants, to support the sustainability of their work.

To avoid the creation of tension between those working as government employees and those who volunteer, it may be worthwhile to absorb all workers into the government sector. In Swaziland and Tanzania, Child Protection Volunteers (LL volunteers and Community Justice Facilitators, respectively) work outside the paid government structure, but sit on different officially recognised committees to support children.

Whilst training and small incentives help in some cases, the linkages to formal government structures for child protection can be weak. In Tanzania, cross-sectoral Child Protection Teams are in place at district council level, but the Community Justice Facilitators have no formal connection with them. The extent to which the integration of volunteers into formal government institutions is a realistic option is clearly very dependent on financial and human capacity constraints in any given context. And, even if this cadre of civil servants were to be created, they would require the

CASE STUDY: Social workers in Botswana juggling their many different tasks

Group discussions with social workers in Botswana revealed a somewhat gloomy situation for the foot soldiers of social work. Whilst many have some specialised training, they feel themselves to be 'Jacks of all trades' and are organised as 'area officers' to cover some three to four areas each (which includes several villages). The range of tasks is large and includes community mobilisation, grants case assessment, psychosocial support, child protection and case work, probation work, mediation and referrals.

As a result, social workers face many challenges that include (i) too broad a range of responsibilities, (ii) too heavy area and case-loads with little means of transport, (iii) insufficient training and supervisory support for the tasks, (iv) inadequate resources for the work at hand and (v) insufficient support from higher levels, with no effective route of recourse for complaints.

With reference to the broad array of tasks, social workers noted that "*there's no specialisation, but there should be*", or "*if you are doing orphan work, you have to meet everything – education, health, food security, counselling*". The lack of appropriate resources in terms of training, facilities and transport was also evident from quotes such as *"We have no transport – there's only one vehicle here. We have it for two days maybe, then it's gone"* and *"In cases of PSS counselling there's no privacy. Other workers walk in to use the phone. Because of the working situation we end up breaking the principles of confidentially"*. The way in which social workers were assessed on the basis of tangible and countable outcomes was another source of frustration: *"In case work and PSS, it will look like you are not working and you get negative feedback on your targets"*.

The lack of support, and even direct interference, from higher levels was considered a serious obstacle and to undermine their work. Many noted the tendency for higher level officials to interfere with the work and assign them menial tasks such as picking up litter to clean up the area for an important visit, or referrals of individual cases for grant support from high levels, with urgency and pressure to approve grants. *"They should know that 'assessing the client'* [for a grant] *is never urgent. You'll find that most cases are 'not deserving', but you are put under a lot of pressure."* Several pointed out they have few avenues for complaints and one social worker explained that *"when I took a stand, this guy at DSS was making all sorts of threats about losing my job and so on. You don't have the support from above."* In general terms their perceptions of policy and politics at higher levels were not positive and several put this down to a lack of specialisation, such that *"if we had started with specialisation, we could have gone far."* Others complained of lack of career progression prospects and that *"it's rare to hear about an area officer getting a 'lift': We just hear about promotions at the top."* In general, there was disillusionment with the lack of clarity, consistency or integrity from higher levels and one participant felt that *"they can come down with a directive, but they should know the policy upstairs."* As noted by another social worker: "*If the situation was rectified downstairs* [in the field], *it would improve the situation upstairs* [at national/ policy level]."

Social workers clearly felt overstretched, overwhelmed and overruled, whilst underequipped, under-trained, undermined and unheard. As suggested: *"We need counselling ourselves, because we often have negative attitudes – we are sitting on heated charcoal and we have to jump."* The case illustrates the importance of striking an appropriate balance of a feasible set of tasks, with appropriate training, task delineation, support, and space for bottom-up involvement, voice or representation.

necessary means and resources (transport, training, time, office space, equipment) to perform their jobs to their full potential.

Botswana's social workers are fully fledged government employees, but still feel they cannot live up to their standards, due to having too many tasks and too few resources. In Swaziland, similar concerns arise with child-care volunteers in the Neighbourhood Care Points, who are being trained to become preschool teachers without being sufficiently remunerated or formally accredited for their extra levels of work and responsibilities. In other words, those working on the ground in the community to support families and children affected by HIV and other vulnerable children, regardless of whether they are part of a formal structure or not, need more support, attention and focus.

In addition, it has to be noted that, although crucial for the creation of a sustainable system to respond to issues faced by children affected by HIV, investment in government structures could be

carried out at the expense of developments in civil society. NGOs and CBOs are crucial in holding governments accountable for their actions. They oppose misuse of power, and carry out certain care and outreach tasks for which government institutions are less well placed.

Power structures and political interference are issues to be borne in mind when considering scale-up of programmes, as they can strongly disrupt their implementation. For example, social workers in Botswana indicated that they had to juggle requests by higher-level policymakers for individuals to be included as grant beneficiaries, although they did not strictly meet criteria for eligibility. Such interference creates unfair ethical dilemmas for field-level workers, but also undermines the social worker's position and credibility within a local community, not to mention the credibility of the grants system in question.

Photo 2
Male and female caregivers at CBCC/ Children's Corner, Mndolera, Malawi

Finally, it may be worthwhile to comment on a few points pertinent to analysing gender issues, although a more satisfactory treatment of the subject would require a different study. With respect to the role of formal versus non-formal actors and structures in providing support and services to children affected by HIV and AIDS, it will come as no surprise to the reader that the burden of care is predominantly borne by women at both household and community levels.

One observation in the field was that, in general, the gender composition of actors involved in structures could be characterised by a linear relationship between 'the proportion of actors who are female' and 'the distance from formal centres of power'. Care volunteers in the community tended to be predominantly female, while higher-level officials in government or NGOs were more likely to be male. There are exceptions, as women often achieve higher positions of power in areas such as social welfare and child protection (in Botswana and Mozambique, for example), but then such policy areas also tend to have lower status in government and society.

Also, whilst carers and social workers tended to be more often female, there were exceptions, such as in some CBCC centres in Malawi, where male child care volunteers were not uncommon. It is also important to stress that the level of formality (as in formal government structure versus community structures) is not the determining factor here, as traditional authority structures and chiefdoms appear to be typically male dominated. The proximity to actual decision-making power, be it in government, traditional or community-based structures, appears to be a strong predictor of whether positions are male or female dominated.

b. Family focus and alternative delivery mechanisms in the response to children affected by HIV and AIDS

One of the central elements to child-sensitive social protection, or any policy aiming to reduce child poverty and vulnerability for that matter, is the acknowledgment that children have limited autonomy and are highly dependent on others for the provision of their different basic needs (see Roelen and Sabates-Wheeler, 2011). Therefore, delivery mechanisms and the ways through which care and support is channelled to vulnerable children and children affected by HIV require careful

attention. The dependent position of children makes them subject to asymmetrical power relationships and therefore prone to neglect, abuse and exploitation.

Social protection interventions should ensure that children are truly protected and provided for and avoid the entrenchment or reinforcement of such asymmetrical relations. The way in which interventions are targeted and delivered is an important aspect of social protection design to address children's vulnerable positions.

The family is widely considered to be the most preferable structure through which to channel support to children, including those who are affected or made vulnerable by HIV and AIDS. A family focus has been widely advocated for over alternative options, such as institutional care or individual support for children through cash or in-kind transfers.

Photo 3
Children with their carers in Swaziland

Nevertheless, the gradual erosion of traditional care and support structures and practices might undermine families' capacities to care for and support children in the immediate and medium-term future. A reconsideration of the most appropriate approaches to a 'family focus' is becoming increasingly urgent, with a 'second wave' of orphans emerging. This means that many vulnerable children are increasingly becoming 're-orphaned', as a generation of grandparents grow older and pass away. This emerging reality has been identified by both UNICEF and NGO staff working on the ground and is considered to have important implications for medium- and long-term care modalities for orphans.

Rather than being responsive, now is the time to be pro-active. In light of limited and diminishing capacities of direct or extended family members, this raises a question of how to incentivise foster care for orphaned children. Especially, in contexts with high prevalence rates and many HIV orphans, cash or in-kind transfers are now considered as options to reward families for fostering those orphans who are not direct relatives. In Malawi and Mozambique, for example, there are considerable struggles to strengthen and increase foster care for children, and options for installing transfers for foster families are being discussed. Options under consideration include the instalment of cash or in-kind transfers to foster families, with or without an element of means-testing.

Scrutiny of existing examples, however, calls for caution about such options, as they may have negative side effects or create perverse incentives, which holds for both cash and in-kind transfers. For example, partners in Mozambique are considering such incentive schemes on the basis of food rather than cash, due to a fear of misuse of cash. Cash transfers are considered to be prone to misuse, and thought to be spent on items that will not directly benefit children in foster care. The provision of food or in-kind transfers, rather than cash, is considered to reduce negative side effects by avoiding misspending of money and to be of greater benefit to foster children.

An example of the creation of perverse incentives can be found in Botswana, where orphans are sometimes said to be considered 'assets' for accessing food vouchers through the OVC support programme. The OVC support programme is a universal scheme that distributes food vouchers to all orphans, regardless of their or their carers' living situation. Various respondents indicated that the fairly generous benefits have led to fights over who should care for orphans and, as a result, benefit

from those transfers. Given the unintended but potential negative effects, any such orphan-targeted initiative should go hand-in-hand with a strong monitoring and evaluation system to ensure that orphans do indeed benefit from the transfers. The need for cross-sectoral linkages becomes evident here, as such monitoring efforts require a strong child protection system and, inherent to such a system, case management. If foster care for orphans is only motivated by economic incentives, orphans are likely to be placed at risk of neglect, abuse or exploitation. Subbarao, Mattimore and Plangemann (2001) emphasised the importance of altruism in foster care for orphans to avoid the creation of such adverse incentives. Therefore, it is suggested that benefits targeted towards orphans should not automatically cover all of a child's expenses, and that close monitoring and support by social workers or community members is necessary.

Having said that, it has to be noted that there is a delicate balance to strike between the required support that orphans, vulnerable children and carers need to make ends meet, and support that would lead to negative externalities. Hence, we do not mean to suggest that fostering households who are in genuine need of support for the additional economic burdens imposed by foster care should not qualify for support.

As found in one research study on a UNICEF/WFP-supported take-home food rations programme in Malawi (Edström et al. 2008), households with orphans were relatively worse off than other households, on the whole, and those caring for many orphans even more so. Whilst the study did find some evidence of a potential migration of children into the programme villages from nearby unserved areas, it also found that the benefits did support households which were struggling to care for orphans in a relatively progressive manner (in the sense of particularly poor households with heavy dependency burdens receiving more support, since rations were targeted to each child).

In other words, the assistance to foster families by income or in-kind support unmistakably holds the potential to mitigate the effects of HIV and AIDS and to help children and their carers to cope. Those caring for orphans often struggle to provide for the children and meet the overall family's needs, and such transfers are found to respond to some of that demand. Nevertheless, the extent to which transfers can incentivise foster care beyond direct family relationships without the creation of negative side-effects and perverse incentives is uncertain. More research and analysis is required to investigate potential impacts of foster care benefits, both positive and negative, to provide more conclusive evidence. Hence, any (pilot) interventions with the purpose of increasing the numbers of children in foster care should be undertaken with caution and strong monitoring systems in place.

More widely, the appropriate ways to reach children raise questions with respect to targeting and the extent to which vulnerable children are being reached. The examples above pertain to direct targeting of orphans but, as postulated above, child- and HIV-sensitive social protection does not merely refer to targeted or focused interventions but rather to the range of interventions that have an either direct or indirect impact on children affected by HIV and AIDS. An exclusive focus on orphans is now increasingly considered inappropriate due to issues of stigma, but also inadequate because of mounting evidence suggesting that poverty might be a more relevant marker for vulnerability than orphanhood per se.

Akwara et al. (2010) pointed out that *"[...] there is increasing evidence that many of the vulnerabilities faced by children affected by HIV/AIDS are poverty-related [...], such that targeting children based upon HIV-specific criteria may be misguided"* (p. 1067).

CASE STUDY: Mozambique's active engagement in residential care standards

Although family and foster care is widely recognised as the preferred option for children outside of parental care, government counterparts and various stakeholders in Mozambique have engaged in active discussions on the improvement of services through residential care.

The Ministry of Women and Social Action (MMAS) is responsible for policies on child protection and alternative care and has committed to strengthening care for children in shelters and care centres. In collaboration with UNICEF and other partners, discussions of minimal standards of residential care were formulated and agreed upon in 2010. In addition, the existing number of centres and numbers of children residing in such centres have been mapped to get a better indication of the magnitude of residential care in Mozambique.

Centres that were found not to meet the minimum quality standards were asked to change or close down. A particular area of intervention pertains to formulation of exit strategies by education or college places. Whilst some children remain in residential care until 26 or 27 years of age, the possibility to take part in educational programmes, college or livelihood skills may make children more independent and leave residential care earlier. In terms of HIV, quality standards stipulate that all children entering residential care should be tested and receive treatment and regular check-ups if found to be HIV-positive.

In sum, despite the clear acknowledgement that residential care is an option of last resort, the strong and constructive engagement is likely to have a positive impact on children for whom other types of care are not an option. Challenges remain and particularly pertain to large numbers of children in residential care that do have family members who might provide alternative care. Re-integration with families for such children as well as the assessment of options for strengthening foster care and adoptions should thus go hand-in-hand with efforts to strengthen residential care.

Finally, resources for monitoring and re-enforcement of minimum standards and re-integration efforts pose a considerable challenge, as MMAS has limited human and financial capital. The scale-up of any intervention concerning alternative care, be it residential or foster care, thus requires capacity building of the main responsible government body.

Comments by those responsible for programme design and delivery of the universal OVC support scheme in Botswana confirm this point by suggesting that although the in-kind transfers may provide crucial and necessary support to some, it is not necessary for others, as some families are able to provide, even without the benefits. The fact that benefits are awarded to orphans without any consideration of the family's actual living conditions has been said to create resentment at community level, and with social workers. Nevertheless, although direct targeting of orphans or children otherwise affected by HIV might lead to considerable inclusion errors and not present the most effective way of identifying those in need, the most appropriate way of reaching vulnerable children is far from evident.

The way in which eligibility criteria for primary and secondary beneficiaries of the PSA cash transfer programme in Mozambique are defined, for example, clearly leads to children in need being excluded from the programme. Experiences in Malawi with the SCTS cash transfers scheme are more positive, with children representing a large proportion of the programme's beneficiaries. Tanzania's focus on MVC rather than OVC has also helped to broaden the policy perspective of which child is considered vulnerable and in need in the Tanzanian context, although reflections on the ground suggest that the local identification process is biased towards children with immediate and material needs.

In sum, this documentation does not allow for clear-cut suggestions on the most appropriate and effective way to reach vulnerable children. More in-depth investigation and analysis of the particular targeting mechanisms is required to draw conclusions about coverage, take-up and inclusion errors. However, the various examples from the five different groups do show that context is specific and that a one-size-fits-all approach will not work. Eligibility criteria and targeting mechanisms need to be in line with the programme's objective (i.e. overall poverty reduction,

strengthening care and support for orphans, promoting livelihoods, for example) and account for the reality on the ground (i.e. poverty levels, HIV infection rates, role of grandparents in orphan care, extent of foster care).

In addition to issues pertaining to family and foster care, the documentation of CARI interventions also points towards challenges in terms of alternative care options for children affected by HIV.

Although alternative options such as temporary shelter or longer-term orphanage care are considered to be 'last resorts' for children by most policymakers, international organisations and donors, the reality on the ground points towards the importance of these alternative solutions for children who are not supported by families or family-focused schemes, who fall between the cracks. The reluctance to consider and critically discuss these second- and third-best policy options is likely to reinforce and exacerbate patterns of vulnerability for such children, who already belong to the most marginalised.

In Botswana, for example, community-based care volunteers – 'Bommabana' – complained about the poor standards of care and facilities for children in orphanages, while several social workers admitted that referral of orphaned or abandoned children to an orphanage – such as an SOS village – is not an exception, but rather common, since other options are rarely available. Fieldwork revealed that this was also common in Malawi. Rather than de-prioritising the debate, there is a need to engage with this reality and aim for ensuring minimum standards, quality control and complementary services.

For example, in Mozambique, whilst it is recognised that residential care is not the preferred option, the recognition of this reality for many children has made development partners engage with government counterparts on formulating minimum standards, a system of quality assurance and a monitoring database. Such positive engagement, coupled with capacity building of the relevant government bodies and implementing partners (including NGOs and CBOs) and in tandem with preferred policies such as strengthening foster care, is an important step in ensuring that all children without parental care or who are affected by HIV are adequately protected and cared for.

Finally, the question of 'family focus or alternative delivery mechanisms in the response to children affected by HIV and AIDS' also risks being loaded with a number of gender assumptions. Whilst family care is recognised as being preferable for children's welfare, the shape and form of such care is usually assumed to fit a fairly standard gender-segregated division of labour, with women bearing the brunt of unpaid care work. 'Traditional extended family structures' are often alluded to, but at field level, people struggle with balancing work and care in poor communities and often reflect on how these traditional structures are changing, or becoming eroded.

At the level of the organisation of production and reproduction in the broader economy and society, it is also relevant to point out that the communal care of children (such as in CBCCs, NCPs or schools) is an important element in creating the space for economic empowerment of women or – at least – for women's participation in income generation. The fact that the provision of these care and support services for children remains predominantly a voluntary activity remains problematic for equity in the distribution of labour. Female care volunteers often have few other options for income-generation, thereby perpetuating the invisibility of unpaid care work.

c. The role of 'cash+' schemes within the remit of child- and HIV-sensitive social protection

The review of literature and policy documentation made it evident that the role of social protection as a response to HIV has been largely dominated by discussions around cash transfers and their potential benefits. It is, however, also widely recognised that children have needs beyond those that can be met with transfers directly. In this section, we discuss the role of and balance between cash or transfer schemes and other 'cash+' interventions.

In terms of the appropriate role for direct transfers and broader social protection interventions, examples from various country case studies point towards a pragmatic but delineated hierarchy in the prioritisation of needs. The importance of support beyond the immediate and material is strongly acknowledged across the board, but the extent to which the actual response moves beyond, for example, food or cash transfers, to include aspects like psychosocial support (PSS), depends greatly on resources. Whilst support in lower income settings like Malawi, Mozambique and Tanzania tends to focus heavily on the material needs of families with children, the response in Botswana provides for a range of transfers, as well as specific programmes to provide orphans with structured counselling and psychosocial support. In other countries, such as Swaziland, psychosocial support is starting to be linked with local care services for children through the training of care volunteers in PSS, even if coverage and quality of counselling may remain modest.

These examples are not intended to say that non-material needs are only being considered in contexts where more resources are available. They do, however, suggest that financial, logistical and practical constraints limit the effective implementation of, for example, PSS or care and support services when other, more immediate, needs go largely unmet. The scale-up of social protection programmes for children affected by or vulnerable to HIV clearly needs to take account of the specific context and the set and magnitude of particular needs to avoid unreasonable demands and expectations of social protection.

If capacity is limited, both in financial and human terms, one has to be cognisant that a large-scale social protection response might not move beyond addressing the immediate and material needs of children affected by HIV. Whilst cash or in-kind transfer schemes might be put in place, there may be little scope to address needs of a psychosocial nature or non-material support. That said, it appears that transfers do tend to improve access to health and education services, and so indirectly support HIV prevention and treatment objectives.

However, one should be cautious to attribute direct impacts beyond the immediate provision of cash, food or other services to specific programmes. Especially in terms of HIV, it is difficult to draw firm conclusions about the potential impact of programmes such as the provision of cash and food transfers, beyond the mitigation of the effects of disease and stigma, on wider issues such as the adherence to ARV treatment or prevention of HIV[4].

Although certain specific studies point towards the positive impact of cash transfers and microfinance on sexual activity (see Baird et al. 2009; Pronyk et al, 2006), evidence is thin on the ground

4 Even though we know that orphaning combined with poverty and lack of social networks (often connected to education) is associated with higher vulnerabilities to sexual risk and STIs in late teenage years and early adolescence, it is extremely difficult to attribute direct causality or the relative importance of additional inputs – e.g. cash or education – on specific levels of infection, or – indeed – whether that is exactly how the causal pathway works, even if very plausible.

CASE STUDY: Ark 'n Mark and PSS in Botswana

Although the important role of various cash and non-cash schemes has been discussed in relation to child- and HIV-sensitive social protection, the majority of programmes and interventions struggle to stretch beyond an immediate response to basic and material needs. Although many services and programmes aim to move beyond such an immediate response, including CBCC's in Malawi and home-based care in Mozambique, the practical reality proves that this is often not the case due to lack of resources in terms of time, money and appropriate training.

As a middle-income country, Botswana can be considered a context less prone to such resource constraints and indeed extends its response to children affected by HIV to include, for example, psychosocial support (PSS). NGOs can be considered the main implementing partners and the youth wilderness retreats by Ark 'n Mark provide a particular example showcasing the value of interventions that consider children's non-material needs.

The wilderness retreats target orphaned children between primary and secondary school, building on traditional rites of passage customs but utilising various psychological counselling techniques. In combination, these methods enable orphans to process grief and loss, to build social skills and friendships, as well as practical life-skills and relationship skills. Discussions with boys and girls who attended the retreats recently (i.e. one or two years before) or longer ago (i.e. five or six years ago) point towards the large and beneficial impact that these retreats have had on their lives. By means of songs, drama therapy, work books and rites of passage, children were able to share their experiences and emotions and regain hope and confidence in future life.

One orphaned girl (17 years old) indicated that after the retreat she found the confidence to talk to her uncle, in whose home she was living, and confront him about his differential treatment of her in comparison to his own children. A 17-year-old boy from Otse started a dance and music group with his friends. Although these stories provide anecdotal rather than structured evidence, they do point towards the unmistakable influence of PSS interventions on children's individual lives and, as such, the important role they have to play in a response to children affected by HIV.

Challenges are plentiful, even when resources are available, and include the lack of follow-up, role of volunteers and engagement of parents and carers. Nevertheless, scale-up of social protection interventions for children affected by HIV should be cognisant of the important role that PSS has to play.

and more in-depth analysis is required to investigate the impact of transfer schemes with respect to material and non-material needs.

The role of cash+ schemes strongly depends on the cooperation between various sectors and clarity on which sector is responsible for particular programmes or aspects. For example, Mozambique might be characterised as having sector-confined and primarily 'vertical' programming in terms of child protection, social protection and health, with a strong need for strengthened cross-sectoral linkages. In Malawi, one can observe more linkages, either formally put in place or more spontaneously formed, but challenges remain in effectively linking social protection programmes and child protection. The experience in Tanzania has been slightly more positive, where Community Justice Facilitators play active roles in most vulnerable children's committees, and are working directly on cases of child protection. In contrast, whilst more typically employing food assistance or care services, social protection and child care efforts in Swaziland have reasonably strong connections with getting vulnerable children into and attending school, as is the case in Tanzania. The Community Justice Facilitator approach in Tanzania also links child rights advocacy and child protection to support for school attendance.

Photo 4
Graduates and staff of Ark 'n Mark programme, Botswana

Generally, it can be said that the need for cross-sectoral linkages and a systems approach towards addressing the needs of vulnerable children is widely recognised in all countries, across all levels (i.e. central and local) and by all partners (i.e. government, international organisations, donors, NGOs and CBOs). It is considered to be key for social protection or other interventions to be inclusive and comprehensive, ensuring that all children receive appropriate care and support. With this acknowledgment, case management is considered to be a crucial issue in the establishment of linkages across sectors, and linking up cash and cash+ schemes to provide holistic support to children affected by HIV and AIDS. Being able to track a particular case is imperative to respond to a child's specific needs, be it in terms of nutrition, care, education or child protection. These particular needs might pertain to outcomes directly, but also concern access to services that help a child to achieve such outcomes.

Having said that, experiences with case management in the region are thin on the ground. Initiatives are being discussed and consideration of pilot programmes are under way, for example in Malawi, but there are no specific examples from which to draw lessons as yet. The widespread acknowledgment of the importance of linkages and potential role for case management is encouraging, however, and provides a good basis for future developments. Challenges include capacity issues across different stakeholders and at different levels of policy-making and implementation. The reliance on volunteers for child protection or psychosocial support, for example, can compromise potentials for integrating their work with relevant government instances and services. Similarly, the strong focus on transfer schemes in most countries and the concurrent difference between support to bodies designing and implementing those schemes, versus other sectors, might form an impediment to rolling out case management across all sectors.

The role of different social protection interventions should also be considered in light of the changing context with respect to HIV treatment. The availability of and access to ARV treatment has improved radically over the last decade from a situation with low proportions of HIV infected adults and children taking medication, to increased coverage in many countries (see Temin, 2010; UNAIDS, 2010). Evidence suggests that social protection has positively contributed to people's access to take-up of and the effect of treatment through better ability to get transport to health facilities, making treatment and care affordable, and improving nutritional status, which improves patients' tolerance for antiretroviral therapies (Temin, 2010). Given the situation of improved access and initial take-up, efforts are now needed to ensure that patients adhere to treatment consistently. The concurrent improvements in medical and physical conditions also allow for social protection interventions that consider HIV-infected persons to be productive, and therefore aim to improve their economic activity. As such, the social protection response would move beyond strictly protective to more promotive. The role of cash transfers within this shift of response has to be reconsidered accordingly, ensuring that the provision of such transfers actually meets the needs of its recipients.

In considering linkages between transfer programmes and other services, the array of potential gender considerations increases exponentially. One has to consider the various ways in which child- and HIV-sensitive protection strategies can reduce vulnerabilities for girls and boys when they become young women and men, and simultaneously regard the gendered dynamics of various service sectors. When considering HIV prevention objectives in connection with child protection or education, for example, it is clear that boys and girls are equally relevant, albeit sometimes in slightly different ways. Adequate attention to such gender dynamics and dimensions

CASE STUDY: Community Justice Facilitators realising rights in Tanzania

Asis, Abela, Issa, Juliet, Hamis and Masudi are six young Community Justice Facilitators, who work as volunteers in Temeka municipal district of Dar es Salaam along with 12 other peers. Like CJFs in other parts, they focus on raising awareness of children's rights at community level and work on individual cases of child protection, as well as serve on local Most Vulnerable Children's (MVC) Committees. Apart from finding children in difficulty and working through the committee to get them social support, they also pursue cases and often connect individual children with other services and organisations. They have identified several cases of abuse and rights violations and often report these to the police, with the result that cases have gone to court and offenders have been punished. As one example, a local 12-year-old boy was recently orphaned for a second time and went to live with his stepmother, who bribed an official to change the title deeds to his father's house and then expelled the boy from his home. The case was picked up the CJFs, who reported it to the police and supported the boy in court, where the ruling went in his favour. The corrupt official was fired and the house put in the boy's name to be rented out until he turns 18 (when he takes charge), with the rent helping to pay for his school fees. He is now also supported by the MVC Committee.

Whilst child protection volunteers like these typically have good working relations with the police, 'children in conflict with the law' is a difficult area and one of increasing importance in urban areas in particular. Having said that, it can also happen that officers of the law end up in conflict with children and their rights. This can put CJFs in a position where they need to support children against the word of a police officer to protect the rights of the child. In an ongoing case, an 11-year-old boy was allegedly accidentally shot in the stomach by a police officer whilst challenging the police over why they were arresting and taking away his father. The boy was left with a destroyed urinary system and a catheter after hospitalisation. There is reportedly little police cooperation in this case, but the CJFs are pleased to note some prospects in that the officer is seeking to settle out of court.

to integration and linkages clearly needs a concerted focus at country level, as this is highly complex as well as context-specific, with deep historical roots and momentum.

Photo 5
Boy in Tanzania shot by police

d. New realities

The documentation has pointed towards a number of 'new realities' that should be acknowledged and be part of any discussion on the role and scale-up of social protection. Most countries in the region have a recent history of the provision of care and social protection as reliant primarily on extended family or community-level coping mechanisms or other informal supportive practices. Not surprisingly, it is often said that these need to be built upon to scale up the protection and care of children in African contexts and, to some extent, this can be witnessed as happening in practice in, for example, the Neighbourhood Care Points (NCP) in Swaziland, the CBO-run Community-Based Care Centres (CBCC) in Malawi, or the work of local Most Vulnerable Children's Committees (MVCC) in Tanzania, albeit if the latter is somewhat less 'traditional'.

Yet, in all countries, the capacity of 'traditional coping systems' to absorb increasing burdens of care and support, brought about by HIV and other crises, was put into question across the board. Whilst very few saw additional protection and care programmes and efforts as undermining traditional modes of support (an exception to this might be OVC grants in Botswana being seen by some as overly generous and creating perverse incentives which work against the interests of children), there appears to be an increasing recognition of a need to deal with and internalise 'new realities' that may require different approaches to care, social protection and child protection which are both more formal and more complex. These new realities relate to broader trends in demographic dynamics, such as urbanisation and the ageing of carers, or to new technologies.

CASE STUDY: Young carers in Malawi

Thako and Kafele (fictitious names) are 17- and 11-year-old brothers who have been living together in Mchinji district since their mother passed away in 2009.

They have been left to fend for themselves, as their father moved away more than ten years ago after a divorce, and they have no family to fall back on as they are not from this village. The two brothers receive cash benefits through the Social Cash Transfer Scheme (SCTS). The family received such benefits before the mother passed away, but with one person less in the household, the amount has now been reduced.

Thako indicates that the level of benefits is not high enough to support all their needs but that it helps to buy food and school materials. Both Thako and Kafele are in school and the local CBO helps by paying for Thako's secondary school fees. From time to time, they also attend the CBO's Children's Corner to play football, sing in a choir and do drama with peers. They also receive a meal there and occasional nutritional supplements or school supplies. The boys do not receive any help from other villagers besides being offered piecework on their land to earn some extra money. They do have a plot of land of their own on which they grow maize for their own consumption. Since both Thako and Kafele are both going to school, they hire labourers from other villages to work on their land if they have money available.

Although Thako and Kafele are resourceful in caring for themselves, they find it difficult to make ends meet. Transport to school, which is six kilometres away for Thako, and fertilizer for their land, are things they are struggling with. In addition to the practical and material needs, they have not received any support in dealing with the loss of their mother and concurrent grief. As the oldest brother, Thako feels great responsibility to care for and support his brother, Kafele, and struggles to combine school with the need to work on their land or do piecework for extra income.

Although SCTS benefits are useful, the collection of transfers during pay-day forces Thako to skip school every month. Scale-up of social protection interventions to support young carers should acknowledge and respond to these complex realities, in which the provision for immediate basic needs is compounded by feelings of loss and grief and great sense of responsibility.

Urbanisation: although large proportions of the most poor and vulnerable population can still be found in rural areas, urban poverty is growing rapidly (see Baker, 2008). This shift of rural to urban poverty does not only have implications for the mere location of poverty and vulnerability but also for the 'face' of poverty and vulnerability and the realities that children face. Social protection should recognise the way in which urban poverty differs from rural poverty and adjust its response accordingly. Care and support for children affected by HIV within more traditional family or community structures are less likely in the face of urbanisation and thereby coupled with a higher likelihood of children living on the streets and fending for themselves. In relation to that, children's needs are likely to move beyond immediate nutritional, educational and health issues but will also involve the need to protect them from abuse and violence. For example, in Malawi, there was a realisation that the numbers of street children in Lilongwe are growing but also that this is not yet reflected in the formulation and extension of social protection policies. This also means that the types of problems and vulnerabilities faced by children are changing, which impacts on the types of support and protection they need, such as support for legal representation and access to justice for children who find themselves in conflict with the law.

Photo 6
Waiting in line to collect SCTS benefit in Mchinji district, Malawi

Second wave of orphans: the majority of debates around care and support structures for children affected by HIV take place against the backdrop of the current situation in which large numbers of orphans and other vulnerable children are cared for by their grandparents, and, in particular, their grandmothers. Respondents from various organisations, however, have indicated that scale-up of social protection efforts to address needs of children affected by HIV should recognise the fact that such a care structure may no longer be available in the medium- to long-term. The current generation of grandparents is slowly disappearing and with a lost generation, in many contexts resulting from the HIV pandemic, a 'new wave of orphans' is envisaged. The HIV/AIDS epidemic has changed family structures dramatically in the last two decades by wiping out the middle generation of adults (both men and women) and leaving behind the old and young to support each other (Apata et al. 2010). In face of the ageing generation of grandparents and lack of carers from the middle generation, young children now cared for by the elderly will be confronted with a period of renewed orphanhood if the grandparents pass away. Many of these orphans will have just reached adulthood, and might no longer be classified as child-headed households, but are young heads of household and primary caretakers nonetheless. Discussions about incentivising foster care and considerations of alternative care as well as debates around needs of young household-heads with many young dependents, will require increased attention.

Innovation: technological advances and the use of ICT for development (ICT4D) is a rapidly growing phenomenon. It provides many opportunities to developing countries, also in terms of social protection and provision of social services, with leapfrogging technologies that allow for reaching out to more people at lower costs. Despite the cost-saving opportunities and efficiency arguments, however, one also has to be wary of potential negative side-effects. The replacement of time-consuming and staff-intensive physical payments of cash transfers with payment through mobile phones or smart cards, for example, might reduce costs but also remove the opportunity of direct contact with beneficiaries. Given that those beneficiaries are likely to be amongst the most vulnerable groups, pay-days might present a rare occasion for them to be in touch with extension workers and learn more about care and support services, as in Malawi, where there are considerations to replace physical payment with smartcard payments on a pilot basis. The use of computerised Geographic Information Systems (GIS) software to map the neighbourhood care points in Swaziland may hold the promise for a more rational and coordinated scale-up of services for equitable coverage. In light of technological advancements and the opportunities they bring for a more effective and efficient delivery of transfers, a fine balance needs to be struck between opening up new opportunities and the loss of existing ones. When moving to scale, new technologies have to be exploited by making sure that the benefits outweigh the loss of direct contact with beneficiaries.

Connected to all the above trends and new realities, we should also note that gender aspects are changing at many levels, as is our understanding of gender itself. We now better appreciate how gendered identities and practices change dynamically over generations and alongside broader social changes, such as those described above. In particular, we have a better understanding of how adolescence is partly about creating separate identities as women or men, though not necessarily by following handed-down norms but rather in response to the order of previous generations (this is particularly recognised in terms of 'boys becoming men').

It is clear that future-looking strategies will need to shed much of our accumulated 'conventional wisdoms' about what boys and girls – or men and women – are and can do, as well as in what

particular ways girls and boys can be vulnerable. With increasing urbanisation and smaller family units and younger heads of households – or, with younger children's increasing access to information technology, as well as new possibilities for developing programmes and approaches using such technologies – it is also clear that risks as well as opportunities will increase for children in societies affected by HIV. The needs for better linking responses to the impacts of AIDS on children with gender equitable approaches to empower adolescent girls and boys to face HIV-related risks more securely as they mature, are ever increasing.

Our understanding of how social protection can support such linkages and strategies is gradually increasing, but applied operational research will need to be continuously developed and experiences of young peoples' engagement in programmes (such as in community justice facilitator programmes in Tanzania, or psychosocial support in Botswana) suggest that they are a relatively untapped resource in such learning.

Finally, the documentation exercise also clearly underlines the need for keeping an open mind and a broad perspective when discussing the role of social protection in the response to vulnerable children or children affected by HIV. Although definitions are important and useful to frame and focus discussion, they should not be an inhibiting factor when considering the multidimensional and multi-sectoral response that these children require. Issues that are widely considered to belong to social protection go hand-in-hand with concerns of child protection as well as health and education. Although we recognise that health and education policies are generally beyond the immediate remit of social protection, we also acknowledge their integral importance in addressing the needs of children and the importance of social protection for ensuring equitable access to essential services. Any consideration of scale-up should bear in mind that the response to children affected by – and/or made vulnerable to – HIV is a cross-cutting concern, requiring close consideration of and consultation with other sectors and their requisite policies. As such, a strict adherence to definitions and mandates of social protection might work as a restricting rather than enabling factor.

6. CONCLUSION

This documentation of child- and HIV-sensitive social protection in the Eastern and Southern Africa region aims to identify lessons learned and challenges ahead with respect to scale-up of policies and programmes and, as such, to stimulate cross-country learning. Despite the diverse set of countries under consideration, their different contexts, and particular measures and interventions, a number of overarching issues appear at the forefront across the region and point towards particular areas of attention when moving forward in this debate.

As already pointed out by others, the reality is that social protection is still quite thin on the ground in the ESAR region (particularly in low-income countries) and many challenges need to be addressed in the near and far future. That said, promising developments are also under way and we wish to acknowledge and draw those out before discussing the challenges ahead.

First, this study showed that there are strong attempts to move away from stand-alone programming towards more substantive and harmonised systems-building. There is broad acknowledgment by all stakeholders that efforts to improve the lives of children affected and made vulnerable by HIV need to go beyond fragmented service delivery and that more effective, efficient and sustainable results can be reached when programmes are adequately linked with well-functioning referral systems in place. A particular example of trying to put this recognition into practice is the debate around the development of new case management systems, which was considered crucial to make services work for children in almost all countries under consideration. Current reality on the ground is that such harmonised and coherent systems are not yet in place and nor are they likely to be so in the near future. Nevertheless, the shift in mindset that has already begun among most partners – including governments, bilateral donors, international agencies and NGOs – is a first and necessary step to work towards a more systematic approach to child- and HIV-sensitive social protection. In addition, the informal and spontaneous linkages that have been formed, largely at community level, are encouraging in taking efforts forward and to take systems approaches to the next level.

Secondly, the evidence base for social protection efforts is gradually growing, both globally and within the region. A range of pilot interventions as well as more established programmes are being subjected to rigorous evaluations and are resulting in a steady flow of new evidence about what works and what doesn't. Such programme or pilot-specific studies do not present universal truths and should not be interpreted as such, as particular context should always be borne in mind. They can, however, provide valuable insights into particular issues of design, implementation or administration, which may also be of relevance in other situations. This documentation is a case in point as it built strongly on the evidence available throughout the entire research process. A notable research project with respect to social protection in the ESAR is the UNICEF/Save the Children and University of North Carolina supported Transfer project, which is doing robust quantitative and qualitative analysis of scale-up of cash transfers in Eastern and Southern Africa.

Against the backdrop of these positive and promising developments, a number of notable challenges and lessons learned need to be addressed in moving the agenda of child- and HIV-sensitive social protection forward in Eastern and Southern Africa.

A first challenge pertains to advancing the growing acknowledgment of cross-sectoral and harmonised thinking about social protection by putting theory into practice. As is clearly illustrated in this documentation, the needs of vulnerable children are multidimensional and the response to children in relation to HIV therefore inherently needs to be cross-sectoral. CARI-supported projects

within the remit of child- and HIV-sensitive social protection fit areas of child protection, social policy, health and education sectors. Although such sectors may often operate separately, they have profound combined effects for children. Strengthening links between – and harmonising different elements of – the response to children affected by HIV has been and remains a major challenge in addressing children's wide range of intersecting needs. In terms of the scale-up of programmes, explicit effort is required to establish those linkages to ensure a comprehensive and coherent response to children's needs and rights in terms of nutrition, health, education and protection. Despite the wide acknowledgement of the important role that social protection can play, one has to be cautious to maintain a balance with programming in other areas that are equally vital for children. Especially with respect to the link between social protection and child protection, the increased focus on (and consequent flow of resources to) social protection in the region could further undermine certain weak – or poorly positioned – agencies responsible for child protection, or psychosocial support. As such, scale-up of social protection should seek to create a level playing field across all stakeholders involved.

In addition, a strengthening of linkages across interventions should not only build on formal structures but also recognise and support informal linkages and community support systems. This documentation suggests that those linkages that are already in place are largely spontaneous and informal, linking stakeholders and different service providers at the local level. Lessons are to be learned from those experiences, both positively and negatively, to support a more systematic approach towards addressing the needs of children affected by HIV. One particular lesson learned in this documentation pertains to the aspect that efforts should be directed towards both the supply-side and those demanding services. Systems-strengthening should address the financial and human capacity of a large range of service providers, including government, CBOs and NGOs and create sound referral mechanisms across their services. By the same token, children and their carers should be aware of the services available, their right in demanding such services, eligibility in taking part in services and means of accessing services. Such awareness and knowledge encourages bottom-up involvement, take-up of services and a feedback mechanism about the quality and availability of programmes and interventions. The creation of cross-sectoral linkages and harmonised systems-building thus needs to be a two-way street to be effective and efficient for reaching out to those in need.

A second challenge that is particularly pertinent to the Eastern and Southern Africa region relates to children affected by HIV or similar crises and who live without or outside of parental care. In light of eroding traditional care and support structures and the declining generation of grandparents currently caring for many orphans, active engagement in discussions and new ideas for alternative care are crucial to provide children with the appropriate care and support in the medium- and long-term. In recognition of the need for alternative solutions, discussions about the incentivisation of foster care by cash or in-kind transfers are under way in many countries. Similarly, options to strengthen adoption regulations are being investigated as legal frameworks across the region can be considered to be rather weak. In light of the widespread acknowledgement that the provision of care in a family setting is the preferred option for all children, engagement in discussions around residential care such as shelters and orphanages are less common. A lack of positive and constructive debate around living standards and care criteria in residential care might pose a real danger for children living in such care arrangements as their marginalised and vulnerable situations are likely to be exacerbated and further entrenched. As such, a combination of efforts is required to ensure that a minimum level of care is provided to all children, making sure that no one falls through the cracks. Initiatives to incentivise foster care need to be further investigated, assessing possible benefits as well as the creation of potential negative side-effects or perverse incentives. Legal frameworks for adoption need to be reconsidered and strengthened to make this a more viable

option. Finally, minimum standards for residential care need to be set, monitored and enforced in tandem with the preferred policy options to create a comprehensive policy response.

Thirdly, scale-up of child- and HIV-sensitive social protection presents the challenge of how to move beyond a reactive response to children's immediate and basic needs to account for their developmental and future needs, vulnerabilities and potentials, all within resource-constrained contexts. The large majority of programmes assessed as part of this documentation appeared to play an important role in the mitigation of poor living conditions, short-term effects of HIV or other shocks by providing transfers in the form of cash, food packages, nutritional supplementation or basic needs kits. An impact on more medium-term and comprehensive needs, however, was less evident. Psychosocial support, for example, was listed as an inherent objective of many support programmes for children or OVC, but practical and resource constraints often prevented that support from actually being provided. The majority of countries in this documentation face considerable capacity constraints, pertaining to financial as well as human resources, and the scale-up of a response to children affected and/or made vulnerable by HIV thus faces considerable challenges in trying to move beyond immediate impact mitigation. Against the backdrop of limited resources, clear considerations of the objectives of the response to children affected by HIV are required. Scale-up of child- and HIV-sensitive social protection faces a trade-off between extending coverage of programmes and interventions that respond to children's immediate needs and limited coverage of more comprehensive measures that have the potential for a longer-term impact beyond direct material needs. The appropriate balance will depend on a number of factors, including programme objectives as well as political priorities and capacity constraints.

Fourthly, scale-up of child- and HIV-sensitive social protection should also take account of the region's new realities that have the potential to positively and/or negatively alter households' traditional coping mechanisms and sources of resilience. The HIV pandemic has proved to be one such shift in reality, since the early 1990s, but lack of an early and widespread recognition of this new challenge resulted in a largely ad-hoc and piecemeal response. Considerations of the future role of social protection should not fall victim to a similar mistake. New realities on the horizon are likely to change the face of social protection and its role in the response to children affected by and made vulnerable by HIV. They include urbanisation, technological changes and an emerging second wave of orphans as children find themselves 're-orphaned' due to loss of current carers. These new trends can be considered to be a mixed blessing. They bring new opportunities in terms of targeting, implementation and delivery of child- and HIV-sensitive social protection, but at the same time, they might result in lost opportunities, challenge current practice and require new thinking in terms of an appropriate and adequate response. Connected to this, it is also important to stress the need for future strategies to account for gendered dimensions at multiple levels, in ways which keep up-to-date with changing realities at all levels – changing family structures, social norms and evolving youth cultures, service cultures and trends in the gender profiles of manpower, as well as deeper gender shifts in the broader economy and political participation.

Given these different lessons about actors and sectors, about reaching children within and beyond typical family settings, and about linkages which can enhance the child- and HIV-sensitivity of social protection and care programmes, 'scaling up' itself requires some consideration. Divergent contexts and historical trajectories speak against blanket prescriptions, blueprints or 'magic bullets', so the emphasis must be on developing effective, transparent and legitimate processes for establishing appropriate policies on social protection, care and child protection. How a society decides

to protect and care for its children (and how to pay for that) must become part of the social contract. Given the findings of this documentation, we can point to good examples (and some less good ones) for inspiration, but we do so with the proviso that strategic systems for social protection should join up and link transfers and protection for the poor and vulnerable to other essential services – and do so in HIV- and child-sensitive ways. Rather than thinking in terms of blueprints or magic-bullet interventions, 'scalability' can be considered in four dimensions, all – conveniently – starting with 'S' as well. These four are: Sensitivity, Simplicity, Saleability and Sustainability.

Sensitivity is what this study has primarily aimed to explore. The extent to which programmes, interventions and measures in response to children affected by HIV really do benefit them proves to be the result of complex and inter-linked factors but mostly context-specific. There are no universal truths to build on and every programme and intervention should be considered in its own regard.

Simplicity can be thought of differently as applied to, for example, a national programme of a grant income transfer (e.g. keep it simple so you qualify if you are poor, rather than also on ten other criteria) or a community-driven response (where you might want to keep it simple in the sense of building on what is happening already and what people have shown they can do). These first two dimensions of sensitivity and simplicity can be considered in conflict with each other; advocating for straight-forward responses on the one hand whilst arguing the need to be specific to particular contexts on the other hand. However, these two dimensions can go hand-in-hand; by considering the degree of sensitivity of social protection in terms of HIV, children and gender, we do not aim to build differential social protection approaches for all different groups in society. Rather, a sensitive lens serves as a reminder and tool to assess the extent to which social protection interventions can accommodate the needs of particular groups, however simple or complex the design of such an intervention.

Saleability is important, because it refers to what can be justified politically and what is perceived as fair, or 'fair enough'. The reason communities responded quickly to orphans is that most people can easily conceive of an orphan as in need – whether or not s/he is. Some types of transfers are also seen as more acceptable because they are seen to be 'deserved' or their recipients as 'deserving'. This saleability is important also because it connects with the last S, Sustainability.

Whilst a complex area in itself, this is fundamentally about 'who bears the costs'? or 'who is going to keep paying for the poor and vulnerable'? Too frequently, however, realistic strategies end up being about compromise and, particularly in this case, cost-sharing. In community-level programmes, that means sharing between communities, households and 'the state' (as well as external donors), whilst for national level programmes this results in sharing between households or consumer and taxpayers and external donors. 'Who pays for what' strongly influences what gets developed and this shifts over time, as economies grow, taxation systems develop, or donors lose interest.

In sum, the potential for social protection in being a significant part of the response to children affected by HIV in Eastern and Southern Africa is clear and strong. However, the appropriate shape and form requires careful consideration vis-à-vis the challenges ahead and the countries' particular contexts. Unique risks make for unique opportunities and child- and HIV-sensitive social protection should seize those opportunities to act as an appropriate and strategic response to the needs of children affected and made vulnerable by HIV.

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