



Programming for Impact:
A review of the literature and lessons from the field on
programming for vulnerable children



Since 1943, Catholic Relief Services (CRS) has held the privilege of serving the poor and disadvantaged overseas. Without regard to race, creed or nationality, CRS provides emergency relief in the wake of natural and man-made disasters. Through development projects in fields such as education, peace and justice, agriculture, microfinance, health, HIV and AIDS, CRS works to uphold human dignity and promote better standards of living. CRS also works throughout the United States to expand the knowledge and action of Catholics and others interested in issues of international peace and justice. Our programs and resources respond to the U.S. Bishops' call to live in solidarity-as one human family-across borders, over oceans, and through differences in language, culture and economic condition.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ALNE	Accelerated literacy and numeracy education
ARV	Antiretroviral
ART	Antiretroviral therapy
COC	Community Outreach Center
CRC	(The United Nations) Convention on the Rights of the Child
CRS	Catholic Relief Services
CPC	Child Protection Committee
DIC	Drop-in Centre
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
IAP	Integrated AIDS Program (Ndola Diocese, Zambia)
IMCI	Integrated management of childhood illness
MLC	Mavambo Learning Centre
OVC	Orphans and Vulnerable Children
PEPFAR	The President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PTSD	Post-traumatic Stress Disorder
PVO	Private Voluntary Organization
RAAAP	Rapid Assessment, Analysis, and Action Planning Process
STI	Sexually Transmitted Infection
SARO	Southern Africa Regional Office
TB	Tuberculosis

Forward

The Southern Africa Regional Office (SARO) of Catholic Relief Services (CRS) made the area of Orphans and Vulnerable Children (OVC) programming a regional priority in October 2006. The criteria used to choose this priority included areas: where new knowledge is urgently needed, where great investments are being made, where the risk of poor design or implementation are of concern, especially with regard to the principle of “Do No Harm”, where there is potential for growth and impact and, areas which are critically important to achieving CRS’ HIV strategy. The OVC priority meets all of these criteria and has been endorsed by the CRS country representatives from Zambia, Zimbabwe, South Africa, Malawi, Angola, Madagascar, and Lesotho.

Throughout 2007, SARO has been involved in efforts to advance current understanding of and quality of programs which meet the needs of vulnerable children. The strategic objective for this year was “to identify and promote best practices for addressing the needs of orphaned and vulnerable children”. To this end, SARO took part in a multi-country assessment of PEPFAR funded CRS OVC programs. This multi-country assessment which included programs in Haiti, Tanzania, Kenya, Rwanda and Zambia, provided the opportunity to pilot the CRS OVC Wellbeing Tool, a new measurement tool which measures wellbeing from the child’s perspective. The potential to measure outcome level indicators, like wellbeing, is an important step forward in improved programming.

Specific regional outputs for this year included increased incorporation of advocacy and child protection into OVC programs including the development of a training manual on child protection and protecting childhood, increased collaboration with local and regional stakeholders and the completion of the good practices exercise.

Executive Summary

To secure a healthy and bright future, children need to have a childhood, to grow, to play and learn in an environment which is safe, stimulating and life giving. Yet, for many children, particularly children in sub-Saharan Africa where HIV infection is most prevalent, this childhood is in peril. Children coping with the illness or loss of their parents too often are also coping with poverty and discrimination (UNICEF 2004). The needs of orphans and vulnerable children are threatened on multiple levels. These threats must be addressed so that all children have the opportunity to become productive members of society.

Forty three (43) million children in sub-Saharan Africa below 18 years of age have been orphaned and only a small percentage of these vulnerable children are being reached with support services. To reach a greater percentage of children will require decentralized yet holistic community based approaches, well trained community based staff and an increase in funding. To efficiently meet the needs of such large numbers of vulnerable children will require greater clarity on what works well, what programs are sustainable and what interventions have been successfully replicated.

This booklet provides a review of CRS supported OVC programs in southern Africa that have been identified as models of good practice. These models are supported by a review of the literature and lessons learned from a variety of disciplines including child development, child protection and child health. Four programs are reviewed including one on integration, one on accelerated learning, one on the use of a novel monitoring and evaluation tool, and one on drop-in centers within community-based OVC programming.

This exercise, carried out during 2007, has provided insight into what it takes to respond effectively at the community level. For example, well trained and empowered community based volunteers are key to the sustainability and reach of a program. Community volunteers are the eyes and ears of a program and actively work to ensure that children's vulnerability is reduced and that children are protected. The ability to remain flexible and to mature and change as new needs arise is also seen as a key aspect of successful programs. Innovation is key to improved programming as has been shown by the development of the novel child participatory monitoring activity called Station Days. The development of a caring relationship between an orphan and/or vulnerable child with one or more caregivers is also important, enhanced by community-based service delivery. Good practices in OVC care and support programming build on existing community assets, actively include adults and children, and are able to incorporate new ideas and structures to develop sustainable, replicable and community accepted approaches which improve vulnerable children's wellbeing.

Chapter

1

“There can be no keener revelation of a society’s soul, than the way in which it treats its children” — Nelson Mandela

Introduction

This booklet presents a review of the literature as well as identified good practices in the care and support of vulnerable children. The purpose of this paper is to provide busy program managers with a broad review of current evidence and clear recommendations for improved programming for vulnerable children. This document presents a systematic review of Catholic Relief Services (CRS) supported good practices in Southern Africa that respond to the care and support needs of vulnerable children and the communities in which they reside. It is hoped that through this review of the literature and current CRS programs, clear recommendations and options for greater scale up, effectiveness and sustainability of programming can occur. The ideas and evidence presented here may also be used as an advocacy tool to increase both the reach and funding available to ensure all children the opportunity of a healthy and affirming childhood.

Why is it necessary to have a document such as this?

Sub-Saharan Africa is the region hardest hit by HIV and AIDS. The HIV pandemic has had profound and lasting consequences on macro and micro-economies, basic food security, and available human resources especially for education and health services. Forty three (43) million children in sub-Saharan Africa below 18 years of age are single or double orphans and only a small percentage of these vulnerable children are reached with support services. To reach a greater percentage of children will require decentralized yet holistic community based approaches, well trained community based staff and an increase in financial support.

It is estimated that annual funding for vulnerable children and their communities needs to be increased four fold (Stover et al., 2007). Increased funding must be applied in a thoughtful manner so that good practices in the care of vulnerable children are able to be scaled up. Effective programs need to meet vulnerable children’s immediate needs, while also fostering long term growth and resilience. Programs and practices should ideally begin with needs assessments, be subject to evaluation and refinement, and have processes and effects documented. In this way, we can insure that our responses to protecting children and their childhoods are in their best interest and lead to improved wellbeing.

Background

To secure a healthy and bright future, children need to have a childhood, to grow, to play and learn in an environment which is safe, stimulating and life giving. Yet, for many children, particularly children in sub-Saharan Africa where HIV infection is most prevalent, this childhood is in peril. Children coping with the illness or loss of their parents too often are also coping with poverty and discrimination (UNICEF, 2004). The needs of OVC are threatened on multiple levels. These threats need to be addressed so that all children have the opportunity to become productive members of society.

Given the large number of children who have and/or will inevitably lose one or both parents over the next decade, local, national and regional responses need to be far-reaching yet also effective and efficient. UNICEF (2003, November) offers a sobering reminder of where we are in the crisis,

“As staggering as the numbers already are, the orphan crisis in sub-Saharan Africa is just starting to unfold...By 2010, HIV/AIDS will have robbed an estimated 20 million children under the age of 15 of one or both parents, nearly twice the number orphaned in this age group in 2001. The largest increases will be in countries with the highest HIV rates, such as Botswana, Lesotho and Swaziland...” (p. 10)

The joint UNICEF/UNAIDS/USAID report *Children on the Brink* (2004) provided a comprehensive review of the current and projected magnitude of the orphan crisis explaining that the number of children orphaned will continue to increase over the next decade and that while Asia has the largest absolute number, sub-Saharan Africa is home to the greatest proportion of child orphans (UNAIDS/UNICEF/USAID 2004, July). As the number of orphans increase, other trends will include a high prevalence of double orphans (children who have lost both parents, often to HIV and AIDS) and an increasing proportion of maternal orphans (children who have lost their mothers). Also, the age distribution of children is important to consider. Since the overwhelming majority of orphans are over the age of 6 and many are becoming adolescents, care and support programs must respond to their unique developmental needs (UNAIDS/UNICEF/USAID 2004, July).

Orphan and vulnerable children programs are diverse and often develop out of the interests and experience of individuals, church-based efforts, civil society outreach programs and through the work of national and international non-government organizations. Early responses to the care and support needs of children orphaned by AIDS were well intentioned yet often ad hoc. As the magnitude and the extent of the crisis have become clearer, dedicated projects and entire organizations have developed to respond to the unmet care and support needs of OVC. Some organizations have developed expertise in a particular area such as psychosocial support, school feeding or child protection, while others are able to attempt a more comprehensive or holistic response. These responses may still lack coordination, systematization and incorporation at all levels of civil society so that as many children as possible can be assured of the basic inputs to secure a healthy and stimulating childhood.

A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (UNICEF, 2004) has been offered. The Framework builds on the programming principles provided by in the Children on the Brink series (UNICEF, 2002 and 2004) that were modified at a global consensus conference in 2004. The five core strategies set forth in the Framework are as follows:

1. Strengthening the capacity of families to protect and care for OVC by prolonging the lives of parents and providing economic, psychosocial and other support;
2. Mobilizing and supporting community-based responses to provide both immediate and long-term assistance to vulnerable households;
3. Ensuring access for OVC to essential services, including education, health care, birth registration and others;
4. Ensuring that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities; and
5. Raising awareness at all levels through advocacy and social mobilization to create a supportive environment for children affected by HIV.

Some programming guidelines in implementing these core strategies include:

- Focusing on the most vulnerable children and communities, not only children orphaned by AIDS;
- Defining community specific problems and pursuing locally determined interventions;
- Involving children and youth as active participants in the response;
- Attending to the roles of children, men and women, addressing gender discrimination; and
- Linking HIV prevention activities and care and support for people living with HIV (PLHIV) with support for vulnerable children.

CRS Values and Approach to OVC Programming

Catholic Relief Services was founded in 1943 by the Catholic Bishops of the United States. Our mission is to assist the poor and disadvantaged, leveraging the teachings of the Gospel of Jesus Christ to alleviate human suffering, promote development of all people, and to foster charity and justice throughout the world.

Working through local offices and an extensive network of partners, CRS operates on five continents and in 98 countries. We aid the poor by first providing direct assistance where needed, then encouraging people to help with their own development. Together, these approaches foster secure, productive, just communities that enable people to realize their potential.

As the official international relief and development agency of the U.S. Catholic community, CRS is also committed to educating the people of the United States to fulfill their moral responsibilities toward our global brothers and sisters by helping the poor, working to remove the causes of poverty, and promoting social justice.

CRS Guiding Principles

As the official international Catholic relief and development agency of the United States Conference of Catholic Bishops, Catholic Relief Services draws upon a rich tradition of Scripture and Catholic Social Teaching, which serve as the foundation for CRS' Guiding Principles. Acting as a guide to what a just world might look like, these Principles are shared across religious and cultural boundaries and articulate values that are common among people who seek to promote and work towards true justice and lasting peace. The Guiding Principles provide the basis for all decisions relating to CRS management, programs, and investments as we strive to respond to the mission of the Agency and to the needs of our brothers and sisters throughout the world, regardless of creed, race, or nationality. As staff and collaborators within CRS, we recognize our special responsibility to use our talents, and the resources under our stewardship, to encourage active solidarity on behalf of one human family and to creatively promote more just societies in our world. We espouse these principles and hold ourselves accountable to each other for them.

Catholic Relief Services Guiding Principles

Sacredness and Dignity of the Human Person

Created in the image of God, all human life is sacred and possesses a dignity that comes directly from our creation and not from any action of our own.

Rights and Responsibilities

Every person has basic rights and responsibilities that flow from our human dignity and that belong to us as human beings regardless of any social or political structures. The rights are numerous and include those things that make life truly human. Corresponding to our rights are duties and responsibilities to respect the rights of others and to work for the common good of all.

Social Nature of Humanity

All of us are social by nature and are called to live in community with others—our full human potential isn't realized in solitude, but in community with others. How we organize our families, societies and communities directly affects human dignity and our ability to achieve our full human potential.

The Common Good

In order for all of us to have an opportunity to grow and develop fully, a certain social fabric must exist within society. This is the common good. Numerous social conditions—economic, political, material and cultural—impact our ability to realize our human dignity and reach our full potential.

Subsidiarity

A higher level of government—or organization—should not perform any function or duty that can be handled more effectively at a lower level by people who are closer to the problem and have a better understanding of the issue.

Solidarity

We are all part of one human family—whatever our national, racial, religious, economic or ideological differences—and in an increasingly interconnected world, loving our neighbor has global dimensions.

Option for the Poor

In every economic, political and social decision, a weighted concern must be given to the needs of the poorest and most vulnerable. When we do this we strengthen the entire community because the powerlessness of any member wounds the rest of society.

Stewardship

There is inherent integrity to all of creation and it requires careful stewardship of all our resources, ensuring that we use and distribute them justly and equitably—as well as planning for future generations.

CRS Programming for Vulnerable Children in Southern Africa

CRS supports country programs and offices in 8 countries in southern Africa: Angola, Botswana, Lesotho, Madagascar, Malawi, South Africa, Zimbabwe, and Zambia. Lesotho and Botswana carry the highest HIV prevalence burdens globally and South Africa has the largest absolute number of PLHIV. While the prevalence of Angola and Madagascar remain well below other sub-Saharan countries, their proximity to high prevalence countries and known risk factors such as gender inequality, extreme poverty and internal displacement, make these countries particularly vulnerable to the spread of HIV infection.

As of May 2007, CRS SARO supported 106 projects. In fiscal year (FY) 2007, 20 of these 106 projects provided care and support to OVC either as the primary or a secondary programming component with an approximate value of 8.6 million USD in public and private funds. These projects reach more than 126,000 OVC (Table 1),

Table 1: SARO's OVC Projects by Country

Project title	Country
BOTUSA CRS OVC Program	Botswana
MOVE OVC Pilot Project	Lesotho
FELANA DAP	Madagascar
Mzuzu HIV and AIDS and food security project	Malawi
Zomba Integrated HIV and AIDS Project	Malawi
Dedza Integrated HIV and AIDS	Malawi
Lusubilo Orphan Care Project	Malawi
Diocese of Tzaneen- Phase II	South Africa
COC St. Mary's Phase II	South Africa
Winterveldt Care and Support	South Africa
AIDSRelief	South Africa
Catholic Institute of Education (CIE)	South Africa
CHAMP-YES	Zambia
CHAMP-OVC	Zambia
RAPIDS	Zambia
Integrated Peace Building & Partnership	Zambia
AIDSRelief	Zambia
STRIVE	Zimbabwe
HIV/AIDS Partner's Project (CORE)	Zimbabwe
CLHA	Zimbabwe

Chapter

2

Improving Vulnerable Children's Quality of Life

Quality of life implies that certain factors are present to deal with the stresses and strains of normal life. These include, in basic terms, provision of essential materials (food, clothing and shelter), physical protection, social support and alleviation of pain. Beyond these “basics”, all people strive for times of joy either through play, cultural festivals, worship, recreation, sports, art, music and a wide variety of social gatherings. For vulnerable children, meeting basic needs and quality (life giving, enriching) experiences are jeopardized. Whether through hunger, violence, lack of access to education or health care, social isolation, or loneliness, a vulnerable child's quality of life and prospects of healthy development are compromised.

The declining economic security and diminished quality of life of vulnerable children and their communities has been documented (Bhargava & Bigombe, 2003; Heymann et al., 2007). Seriously ill guardians and primary caregivers are unable to work and incur substantial medically-related expenses (Andrews et al., 2006). Orphaned children most often live in female and/or grandparent headed households that, in resource poor countries, are more likely to be impoverished, compared with households where fathers are present (Monasch & Boerma, 2004; Shetty & Powell, 2003). Women, in general, earn half the salaries of men, widows are often denied property rights, and the elderly population is rising, aging and increasingly unable to meet basic needs in the absence of family support. Households with orphans are more likely to have an increase in the "dependency ratio" i.e. the income of fewer adults is sustaining more dependents (Monasch & Boerma, 2004; Andrews, 2006). These economic realities can contribute to the challenge of unstable living situations and reduced quality of life for vulnerable children.

Another challenge to vulnerable children's wellbeing is poor nutrition (Africa's Orphaned Generations, UNICEF, 2003). Malnutrition affects one in three children in Africa and affects orphaned and non-orphaned children alike (Foster, Shakespeare, Chinemana et al., 1995; Monasch & Boerma, 2004). Recent studies have found a cumulative effect of orphan status and extreme poverty as contributing to greater malnutrition and ill health (Miller et al 2007, Watts et al 2007). However, stunting and being underweight have recently been found to be more common in double and maternal orphans compared with non-orphans (Watts et al., 2007; Miller et al., 2007). Malnutrition can have serious consequences. It can lead to stunting, cognitive delays, and increased death rates.

A third challenge is limited access to health care and poor hygiene that can lead to recurrent infections and infestations (Shetty & Powell, 2003; Watts et al, 2007). Infant and child mortality rates, regardless of a child's HIV status, have been increasing since the HIV epidemic began (Foster, 2000; Miller, 2007). As children move from one living situation to

another, routine vaccinations and other preventive care can be interrupted. Potential guardians have expressed concerns about taking in children living with HIV, possibly related to uncertainty about caring for an ill child who might face an early mortality (Freeman & Nkomo, 2007). Although there has been a recent increase in the number of children accessing antiretroviral therapy (ART), children living with HIV consistently have less access to ART than their adult counterparts and only 1 in 10 children receive life saving drug treatment (UNICEF, 2007).

Orphans, especially female orphans, are more likely than other children to receive inadequate schooling (Monasch & Boerma, 2004; Andrews, 2006). In particular, children who have lost their mothers (Case & Ardington, 2006; Evans & Miguel, 2007) and children in the lower socioeconomic strata (UNICEF, 2003) receive less education. In Tanzania, for example, it has been shown that school attendance rates for children whose parents are alive and who live with at least one of them is 71%, but for double orphans it is only 52% (UNAIDS/UNICEF/USAID, 2004).

In a unique longitudinal study, school attendance was found to begin to drop two years before the death of a parent, to drop sharply again in the year of the death, and to remain at a lower level for at least three years after the parental death (Evans & Miguel 2007). It was also found that academically stronger students were less likely to show decreased school participation following the death of a parent. School disruption can result in a discontinuity in education and in gaps that make learning more complex material difficult to achieve.

“Lacking adult protection, girls, street children, and those in child-headed households are particularly vulnerable to exploitation” (Gilborn, 2002). In turn, children without adult care become susceptible to sexual abuse, pregnancy, sexually transmitted infection (STI), HIV and exploitive child labor (Foster & Williamson, 2000). Early sexual experiences can come about out of economic need, through rape, or because of lack of parental supervision. Education is fundamental to child development and wellbeing. Without adequate basic education, children grow up lacking basic knowledge and skills to protect themselves.

Access to Essential Services

Improved access to adequate nutrition, comprehensive health care, stable living situations and appropriate education for vulnerable children begins with needs assessments within the local community (Working Group on Orphans and Vulnerable Children/DFID, 2004). Each community can best define who the most vulnerable residents are and who should be targeted for assistance, including elderly- and child-headed households. Approaches that foster community ownership and generate a community response without providing direct services are the most empowering, yet providing direct services can bolster local ownership and capacity. Each community thereby identifies its own challenges and takes an active role in determining its direction.

Essential services should be combined in a holistic way. This includes a focus on children’s education, nutrition and overall health (medical, dental, and psychological) as well as on primary caregiver or guardian health and employment. Health records should be comprehensive, with assessments scheduled and tracked at regular intervals. Children should

be evaluated for evidence of physical or sexual abuse with services provided to address any uncovered abuse. Genuine access to educational opportunities relies on the child being in the best of health and properly nourished. School health programs for older children should include focus on life skills and self-care. Common sense tells us that no one program can cover all these services; a holistic package of care involves multiple providers working together.

Community care partnerships with a broad spectrum of stakeholders can be instrumental in insuring access to these essential services. Partnerships can provide structure, capacity building and a means of channeling external resources into communities. The partners can develop community plans with specific resource requirements and evaluation, ensuring transparency to the wider community. There may be local development funds which use new methods of raising community capital and self reliance such as micro financing and internal savings and lending.

Needs assessments and follow up evaluations should use consistent measurement across communities so that results can be compared. For example, a social risk assessment matrix can help identify risks to and from social groups, and the importance of those risks to achieving the goals of a reform (Working Group, November 2004). The efficiency and cost effectiveness of different community-based services should also be assessed. Health disparities may emerge or persist when the public sector fails to reach families due to insufficient implementation of policies (Miller et al., 2007). The potential for families to be reluctant to access needed services because of fear of stigma and discrimination should also be considered (Andrews et al, 2006). Community ownership which begins with needs assessments and continues through project development and evaluation allows communities to modify and adapt their strategies as needed.

One area where community ownership and oversight needs to be expanded is in care and treatment of pediatric HIV. Children's access to ART has fallen short. Children are over-represented in AIDS-related deaths, which points to their lack of access to essential care. Over two million children are living with HIV yet most have no access to care or treatment (Global Movement for Children, 2006). In a rapid situational analysis of how to expand children's access to antiretrovirals (ARVs) in South Africa , researchers from the University of Cape Town recommend greater community involvement, through public awareness campaigns and education of patients, caregivers and teachers (Khan, 2006).

Key Components of Programs for Vulnerable Children

This section presents important guiding principles which should inform OVC program development and evaluation.

Identify What is in the “Best Interest of the Child”

A focus on “the best interests of the child” ensures that each individual child’s needs and rights remain at the heart of any decisions and subsequent interventions. The United Nations Declaration on the Rights of the Child (1959) states, “The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.” (Principle 2, ¶ 1)

A thorough discussion of this term, while beyond the scope of this paper, implies certain fundamental rights of children. There is no one standard definition of what is “the best interest of the child” and interpretation may vary between cultures and through application of various ethical principles. Especially in cultures where children are not seen as individuals in their own right or having opinions that matter, OVC programs will need to work sensitively toward this guiding principle, advocating for full enactment of the United Nations Declaration in signatory countries. Yet, all children deserve individual protection from physical and psychosocial harm and the guardianship and protection to develop in a secure, nurturing and stable environment. In line with the principle of a child’s best interest, is that of “Do No Harm”.

Do No Harm

While the intention is to do good, it must also ensure that no harm is done either through or because of programs targeting vulnerable children. Much has been learned about beneficiary selection and how certain methods of targeting and program design can increase stigma, discrimination and resentment amongst non-beneficiaries. Innovations have shown, for example, the use of block grants to schools in exchange for enrolling a certain number of vulnerable children, removes the risk of stigma associated with individual targeting.

The potential for increased stigma and discrimination is always a risk in targeted assistance programs which enroll beneficiaries based on HIV status or orphan status. Targeting should start with those that are most vulnerable irrespective of other criteria. To further reduce the risk of inadvertently harming a child, targeting should also be community driven and owned.

Vulnerable children need extra care and protection so that interventions which are meant to improve children’s wellbeing and reduce vulnerability do not unintentionally harm a child. Systems and structures should be developed, i.e. “checks and balances”, which assess the outcome of targeting, beneficiary selection and the impact of any inputs on how a child is viewed or cared for. A child’s vulnerability should not be increased through being a beneficiary.

In addition to carefully executed targeting, adequate training of staff members who work directly with children is an essential component of quality programs. Staff members are responsible for ensuring that children are not exploited or harmed inadvertently through activities or by program staff. At a minimum, staff training should include the basics of child development, child rights, and local as well as international child protection laws. Adequate training should be followed by supportive supervision and mentoring of staff.


Staff members who work with vulnerable children are at risk of burnout and need time for debriefing and for mutual support. Adequate training and supportive supervision enhance the quality of any program and should be encouraged.

Recent experience has highlighted the importance of the Do No Harm guiding principle. Staff, volunteers, benefactors and visitors to programs may be tempted to use stories, pictures and personal experiences of OVC to raise funds or to raise the profile of the plight of vulnerable children. While it is important to share success stories as well as to get the word out, these efforts should never be at the expense of an individual child. Thus a principle, a standard or code within each program must ensure that systems are put in place and measures are taken to minimize the chance that any harm is done in the process of doing good.

The desire to use pictures and stories should be tempered by the need to first and foremost respect and uphold the best interests of each child. In a digital and internet age, this need to Do No Harm and prioritize child protection has been clearly demonstrated. Pictures and stories which can quickly reach a target audience in a developed country can just as quickly return to inadvertently disclose a vulnerable child's identity, his or her plight and his or her HIV status. Every effort is required to ensure that no harm is done in such endeavors.

In response to the inherent risk of working with vulnerable children and the sometimes tremendous desire to spread the word, UNICEF has recently compiled a list of principles for media when interviewing children.

Table 2: UNICEF’s Do No Harm

<p>DO NO HARM: UNICEF’s¹ 6 principles² for interviewing children.</p>	
<p>1. The dignity and rights of every child are to be respected in every circumstance.</p> <p>2. In interviewing and reporting on children, special attention is to be paid to each child's right to privacy and confidentiality, to have their opinions heard, to participate in decisions affecting them and to be protected from harm and retribution, including the potential of harm and retribution.</p> <p>3. The best interests of each child are to be protected over any other consideration, including over advocacy for children's issues and the promotion of child rights.</p> <p>4. When trying to determine the best interests of a child, the child's right to have their views taken into account are to be given due weight in accordance with their age and maturity.</p> <p>5. Those closest to the child's situation and best able to assess it are to be consulted about the political, social and cultural ramifications of any reportage.</p> <p>6. Do not publish a story or an image which might put the child, siblings or peers at risk even when identities are changed, obscured or not used.</p>	

In addition to the guiding principles of “the best interests of the child” and “Do No Harm”, as well as those embedded in Catholic Social Teaching, programs for vulnerable children focus on key interventions which aim to improve wellbeing. Although each program and ideally each community decide what are the priority needs of children in their area, broad guidance is available.

The President’s Emergency Plan for AIDS Relief (PEPFAR) provides programming guidance for working with OVC (July, 2006). This programming guidance outlines seven core program areas: food and nutritional support, shelter and care, protection, health care, psychosocial support, education/vocational training, and economic opportunity/strengthening. Figure 1 presents guiding principles for implementing PEPFAR’s seven core areas of OVC programming.

¹ Adapted from www.unicef.org/media/media_tools_guidelines.html retrieved 2/28/2007.

² Although originally intended as a list for journalists and media, these principles are an excellent guide in working with children in general and protecting their best interests.

Figure 1: Guiding Principles for Vulnerable Children Programs



“Prioritize the family” and “Bolster families and communities” from Fig. 1 above, recognize the fundamental role a family system plays in the development of a child. Families take many forms, which all contribute many common things to the development of children. The functions of a family, whatever form it takes, are numerous. From meeting an infant’s most basic physical needs to nurturing, socialization, intellectual stimulation and providing role models, the family is the basic medium in which children grow and develop (Kostelnik et al, 2002). Families provide the basic values, beliefs and customs which shape a child and which carry them into their first experiences in the wider community (Kostelnik et al).

As children grow and their interaction with the wider community and peers matures, the influence and importance of the wider community increases. Peers play an important role in

What is Social Competence?

A child’s social competence is reflected in his or her ability to relate and communicate with peers as well as adults. Learning to interact with others is an important part of a child’s development. One’s ability to get along with others is a strong predictor of future achievement both in and out of school.

Early interactions and experiences are important to the development of social competence. Play holds an important role in this socialization process. Competent adults, able to respond appropriately to children with special needs (e.g. related to trauma, disability, temperament) also have an important role in helping children achieve social competence.

Reference: Resources on Early Learning retrieved 8/31/2007 from www.illinoisearlylearning.org/faqs/socialcomp.htm

providing feedback on the social acceptability of one’s behaviors and in the development of social competence (Kostelnik et al). Functional and safe schools, religious communities, government and recreation services all become important factors in the development of children who are both physically and mentally healthy and who possess the ability to function successfully in the wider society.

PEPFAR/OGAC (July 2006) recommends three intervention levels for OVC programs. These levels focus on the child, the caregiver/guardian and family, and systems. As described above, interventions at all levels are needed to protect children currently orphaned

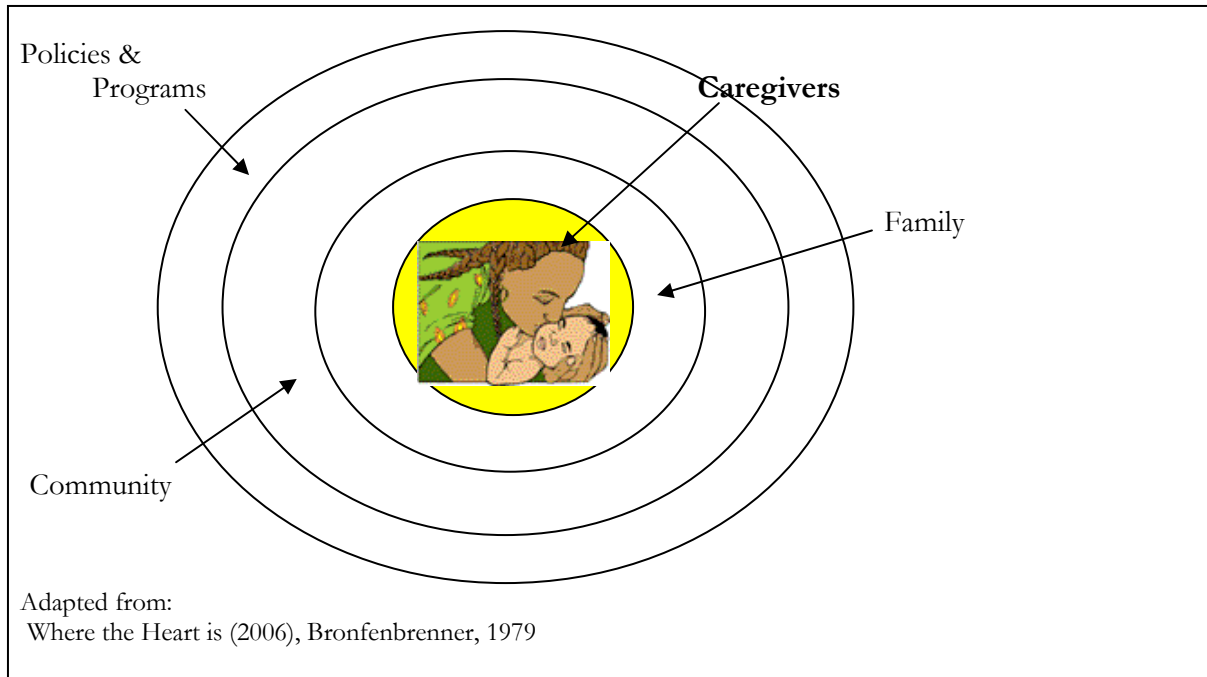
and made vulnerable, as well as to build lasting social structures which protect all children. Vulnerable children can experience profound losses and disruption at all three levels.

With the death of a parent, a child’s personal safety and sense of security are compromised. With the loss of the primary caregiver, the home environment is disrupted and many children experience secondary losses and continuing trauma through being moved and at times separated from siblings. A helpful illustration for the central role family plays in a child’s life is presented on the following page as the Circles of Care (Richter, Foster, & Sherr, 2006).

“A family is like a forest, when you are outside it is dense, when you are inside you see that each tree has its place.”

GHANAIAN PROVERB

Figure 2: The Circles of Care



The concept of the circles of care firmly places family and the child’s primary caregiver or guardian (mother, aunt, grandparent, foster parent etc) at the center of the child’s world. The primary caregiver is the main person to whom the child turns for safety, security, care and support. Beyond this one person is the extended family and wider community. Although not as central to the child’s early life they still surround and provide critical support to the development and socialization of the child. In addition, policies including child health and welfare legislation and programs also play important and interconnected roles in a child’s life.

Nurture Meaningful Participation of Children

Children’s participation in programs which affect them is essential. Active age-appropriate child participation ensures that children’s voices are heard and their felt needs expressed. Since children may express their needs, concerns and challenges differently than adults, adult driven programs run the risk of creating services which do not meet the true needs of the child. Decisions or judgments are based on what is assumed to be the problem or concern while a child’s need or priority may go unnoticed. Encourage all children to share their ideas, even from a young age. What is important is that children feel their ideas have

Child Participation

“The drive to participate is innate in every human being. Promoting meaningful and quality participation of children and adolescents is essential to ensuring their growth and development. Children have proved that when they are involved, they can make a difference in the world around them. They have ideas, experience and insights that enrich adult understanding and make a positive contribution to adult actions.”
(UNICEF – The State of the World’s Children 2003)

been heard, even though some input may be unrealistic. These ideas can be a point from which to teach and share.

Promote Action on Gender Disparities

OVC programs need to incorporate action which recognizes and responds to gender difference in all aspects of child care. Girls continue to attend school less frequently than boys even though school attendance is known to be a powerful HIV prevention intervention (Hargreaves & Boler, 2006). In sub-Saharan Africa, 40% of boys and 44% of girls are out of school (UNICEF, December 2004). Carol Bellamy, Executive Director of UNICEF (December 2004) explains, “Education is crucial to success against the pandemic. In fact, UNICEF remains convinced that until an effective remedy is found, education is one of the most effective tools for curbing HIV/AIDS”. In households affected by HIV, girls often take on caregiving roles for ill parents and siblings. In child-headed households, the girl child may be forced to drop out of school to become the surrogate parent to her siblings even if she is not the eldest child.

Adolescent girls need particular attention as they are at increased risk of HIV infection due to biological, economic and social factors (UNICEF December, 2004, AmfAR, n.d.). In sub-Saharan Africa, amongst 15-24 year olds, women account for 76% PLHIV (amfAR, n.d.). Stephen Lewis speaking at the XV international AIDS conference noted that young women and girls made up 75% of infected 15-24 year olds (Hargreaves & Boler). Orphaned girls, who lack the oversight of an adult protector, are susceptible to the whims and pressures of older men who can lure them with money, power and promises. Girls are also at increased risk due to myths such as having sex with a virgin can cure AIDS.

With the enticement of gifts comes the increased risk of sexual transmission of HIV infection, as well as pregnancy. Protecting the girl child from HIV infection, ensuring her access to education and an HIV free future should be fundamental aspects of programming. Adequate protection and oversight by a designated adult primary caregiver or female adult mentor will ensure vulnerable girls have the best chance of success and the protection needed to grow into healthy adulthood. To overcome gender disparities, gender equity needs to be mainstreamed into all aspects of programming.

Respond to the Specific Context and Remain Flexible

The diverse needs of OVC are not universal although the rights to food, clothing, shelter, care and protection are. Each community and country will present unique challenges and opportunities to children. No two children are the same, nor are any two communities. Each community has its unique assets, approaches to care and risks to a child’s wellbeing. A good practice is one that can be flexible and adaptable to the community context.

Strengthen Networks and Systems

As is shown in the Circles of Care diagram (Figure 2), the outer circles of support are also essential to a child’s wellbeing. Although the primary caregiver is paramount to an individual child’s wellbeing, the wider community can support or weaken the ability of this caregiver. Therefore, programs which focus support to vulnerable children and families, should also work to strengthen networks and systems at the village, district, regional and national level.

Developing parallel structures are inefficient and costly. Strengthening civil society's ability to respond to children's rights and developmental needs should be seen as a key part of OVC programs.

Referral systems for highly vulnerable children need to be developed. Child-headed households, abused children, children with disabilities and other children at increased risk require support from community based networks which are able to identify and refer children to appropriate services. The development of functional networks is important to improved access to care and treatment.

Link HIV Treatment, Prevention and Care Programs

Youth aged 15-24 are overrepresented in the numbers of new HIV infections. More than half of new infections occur in this age group and young people often lack essential knowledge about HIV and AIDS (UNFPA, 2003). For example, in Zambia only 50.4% of young women aged 15-24 with secondary education or higher had "comprehensive and correct knowledge of HIV" (UNICEF, December, 2004, p. 27).

Proven prevention efforts such as prevention of mother to child transmission (PMTCT) programs remain underutilized. In a recent survey in Nigeria, amongst pregnant women attending antenatal clinics, only 27% knew about mother to child transmission. (Adeneye et al., 2007). To increase basic knowledge of HIV as well as proven prevention programs such as PMTCT, services need to be integrated and community based (Bolu et al., 2007). Additionally, children living with HIV continue to have less access to ART than their adult counterparts. OVC programs need to prioritize prevention and treatment for children infected and risk of HIV infection. Programs which increase access to ARVs for adults or which focus prevention of vertical transmission in maternal health programs need to link to the continuum of care including basic education and prevention for all ages, pediatric ART and care programs including palliative care.

Chapter

3

"When I approach a child, he inspires in me two sentiments, tenderness for what he is, and respect for what he may become." —

Louis Pasteur

Child Development and the Vulnerable Child

Children's needs at different ages vary and so should the programs which provide them with support and protection. Effective programs will take into consideration physical, cognitive, emotional, psychological, social and behavioral differences based on stage of development. Children need to be supported in their successes and in obtaining the skills and experiences that are needed to live, work and go to school. Children of all ages need to know that the adults around them have confidence in their ability to become fully functioning members of society. While transition into adulthood is a slow process, the needs of youth ages 12 and older are of particular concern since they make up the majority of orphaned children in all countries (UNICEF, 2004). They are vulnerable to being launched prematurely into adulthood without the necessary skills to function most successfully. The next section details the goals of each developmental stage and strategies for optimally supporting children at each stage that lay the foundation for healthy, well-functioning adults. Special attention is given to identifying and addressing psychosocial needs for those children who are most distressed and having extraordinary difficulty coping with multiple losses and stressors. Further care will need to be taken when interpreting developmental stages in African countries or areas where traditional cultural values predominate, or resources are scarce, in order to design OVC programs with realistic expectations.

Child Development – Pregnancy through School Age

Mother's pregnancy

The growth of humans begins prior to birth. Many people do not consider the period when mothers are pregnant as important for a child's growth and development, but it is very critical considering that nutritional and health practices of pregnant mothers affect the physical wellbeing of their unborn babies. Poorly nourished women are more likely to deliver babies with low birth weights. Mothers under greater stress may also deliver premature, low birth weight infants. Exposure to alcohol and tobacco increases the danger of a child being born with a disability, deformity, or illness. Without intervention, babies of

mothers living with HIV may contract the virus at birth or while breastfeeding, which could lead to early death. Women who do not visit prenatal clinics risk experiencing birth complications that can threaten the survival of their babies.

Stages of Development after Birth

While it is very helpful to understand the broad stages of human development, it is important to keep in mind that children developing in different cultures may show various skills at different times. In some parts of the world, children may begin to speak at an earlier age, while in other parts of the world; children may begin to walk at an earlier age, and so on.

Table 3: Stages of Development

Stage	Goals	Physical, Intellectual, Social & Emotional Development and Support Strategies
<p>Infancy (Birth to 18 months)</p>	<p>Development of trust in the world</p>	<p>This is a critical period for brain development. By the end of this stage, the infant has control over her voice, with a vocabulary of 200 single words. She has gained control over her big motor movements – she can walk. She can hold small objects and feed herself. She will have gone through a phase of being fearful of strangers but by the end of this period she will be curious about other adults and children who are not in her family. Sleep will have started out as erratic and will progress to a pattern of short naps during the day and a full night’s sleep.</p> <p>For her to develop trust in the world, the infant needs to be cuddled. She needs to be fed when she is hungry and changed when her nappie or diaper is wet. She needs to know that her cries will be responded to by the adults in her life. She needs to have consistency in those who care for her, and ideally have a single primary caregiver. If caregiving is disrupted, the child could have trouble forming healthy attachments, she could become fearful and emotionally unstable. The health and life of mothers is so important in infancy that a marked increase in mortality for orphaned infants younger than two years of age and in the first six months after the mother's death has been found (Masma et al., 2004). The child’s lifelong ability to learn could be affected by these early assaults to optimal growth and development.</p>
<p>Toddlerhood (Two to four years)</p>	<p>Development of independence</p>	<p>By the end of this stage, toddlers can run, jump and stack blocks or other objects. They can toilet on their own and can speak in short sentences. They can use “I,” “me” and “you.” They copy adult actions and play alongside other children. They may begin to show their independence by doing the opposite of what they are told. They appreciate humor and can tell if another person is angry, sad or</p>

		<p>happy.</p> <p>For the toddler to develop independence, they need to know that there is an adult that they can come back to as they move about and explore the world. They need chances to do things their own way, like getting dressed and pouring their milk. They may need reassurance in response to loss or when their caregivers are feeling stressed.</p>
<p>Early Childhood (Four to six years)</p>	<p>Development of imagination</p>	<p>By the end of early childhood, the child can balance, jump up and down, and can kick and throw fairly precisely. She can copy simple shapes and print simple letters. She is independent in feeding and dressing herself, including tying shoes. She talks clearly, has mastered basic grammar, and can tell stories. She can read her name, count to 10, and knows her colors. Her vocabulary is about 2000 words. She can feel pride, responsibility and also guilt. She plays cooperatively, has special friends and begins to identify with gender roles. The foundation for curiosity and exploration is laid during this period.</p> <p>Adults can foster the development of imagination and creativity through story-telling, drawing and pretend games. Programs must integrate social, emotional and cognitive, including language, development of children since these areas are closely linked (Stock & Fisher, 2006). Adults must give children a sense of belonging and social and emotional support. This is important for orphaned children since a child's active imagination can contribute to fears that she or he is the cause of their current status or of the death of the parent.</p>
<p>School Age (Six to twelve years)</p>	<p>Development of competence and a sense of belonging</p>	<p>The child's work is to learn in school. Thinking becomes logical and organized and problem solving skills develop. Concepts of number and time become well established. The child learns to master the more formal skills of life, relating with other children according to rules, playing organized sports rather than just free playing, and the basic school subjects of social studies, reading and math. Children learn the values and attitudes that may become permanent as they grow older. They enjoy carrying out responsibilities and can feel guilty if their caregivers view them as irresponsible. They can express a full range of emotions.</p> <p>Caregivers must provide structure so that the child develops self-discipline. Learning problems should be identified and attended to. A child who has experienced loss can understand the finality of death and may have intense fears of being abandoned or of further loss. Regression to younger behaviors can occur under stress. Without proper structure, the child can have trouble</p>

	<p>developing a sense of empathy and morality. Without proper support, the orphaned child may become withdrawn, or may exhibit acting out behavior problems. It can be helpful to give children the chance to talk about death and loss while maintaining normal routines. Memory work and other rituals related to the deceased person may be valuable. Children need a sense of security, of belonging and a shared family identity.</p>
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Adapted from: Treadwell, 1994; Earles, Treadwell, et al., 2004

Temperament

In addition to thinking about what stage of development the child is in, it is important to remember that every child is born with a unique character. How that character fits in with his environment will determine the personality that the child develops. The characteristics that children are born with are neither good nor bad. Some children are more active than others. Some cry easily, while others are quieter. Some are more loving and others more reserved. These differences in children are called temperament traits. If the environment is a good match for the child’s temperament as he grows from infancy through early school age, he will learn how to be flexible, and yet feel good about himself in different settings that do not match his temperament as well. Temperament traits include activity, distractibility, intensity (energy level of responses), regularity, sensitivity, approach/withdrawal, persistence, mood and adaptability.

Adolescent Development

Adolescence marks the end of childhood. Most children reach and complete adolescence between their mid- and late teens (15 to 19 years). During this important transition period, youth must develop the skills that they will need to function as adults in the world. Yet it is important to acknowledge the difference between adolescence as a unique development stage of childhood with specific milestones to be achieved and “youth” which is socially defined. Youth in many cultures, does not necessarily track child development definitions of adolescence and, in some settings, the term “youth” is applied to young adults up to their 30s.

There are many tasks that the adolescent needs to work on as she prepares to enter adulthood. She should develop a comfortable body image, positive self-esteem and mature relationships. She will need to prepare for the future tasks of adulthood by gaining viable skills so that she can become a contributing member of society. During this time, cultural and individual identity will be strengthened.

Yet, while working towards maturity and mastery, there can be a great deal of confusion and turmoil as the young person challenges the adults in his life. This is an attempt to establish himself as an adult. This is the time when he must make his own decisions and must understand the consequences of his actions, but there are many times when he still needs guidance from adult role models. Adolescents know that they are entering the world of adulthood, which sometimes pushes them to “try on” their adult identity. Behaviors can be responsible, but also harmful, as in experimentation with sex, alcohol and drug use.

Adolescence has been called the age of “storm and stress” as it is a time of rapid changes, physically, sexually, emotionally and socially. To weather this “storm”, youth require the guidance and support of socially and culturally acceptable role models.

Life Skills

Communication

The adolescent must learn how to ask for help when he needs it. This requires that he has a realistic idea of what he can and cannot do. It also requires the skill to recognize what he is feeling. The youth must learn how to explain his feelings (where feelings are an important concept) and ideas clearly and to ask questions to make sure that he understands what someone else has said.

The youth must learn to resolve conflict, to sometimes find a middle ground when he disagrees with someone, or respectfully agree to disagree. The youth must learn how to respectfully interact with adults and negotiate with age-mates as he becomes more and more independent. He can accept compliments or praise without feeling embarrassed. It is more important to have at least one close friend that he can completely trust when he shares his feelings, than to have many friends if the relationships are shallow. It is also important for a youth to have at least one adult with whom he feels close.

Household Management

The youth should begin to be able to manage her money. She should be able to buy things on her own. She should be able to save money for larger things that she wants to buy. Males and females should know how to fix at least some meals and should know how to prevent food from spoiling. They should know how to wash and their clothes and mend them if needed. In southern Africa, even youth in urban settings may need to learn how to cultivate a piece of land or other livelihoods.

Self-Care

Males and females need to know how girls become pregnant. They should be able to explain how to prevent unintended pregnancy and STIs and have a full appreciation of the principles of abstinence, and later, being faithful in marriage. They should know where to go to get information on sex and pregnancy. Adolescent girls face a disproportionate risk of HIV in countries where the prevalence of HIV in the general population is high (UNICEF, 2004). They are vulnerable to coerced sex and to unsafe sex with older men. Orphaned adolescent girls are more likely to have begun sexual activity and to marry early, compared to adolescent girls who are not orphans (Gregson et al., 2005). Youth living on the streets are also disproportionately vulnerable to HIV. Youth, particularly young women, should be provided with the skills and information about how to protect themselves from becoming infected with HIV. It is important to teach youth basic first aid, safety and ways to take care of minor illnesses. The young person should have received education about the effects on the body of smoking, drinking alcohol or using illicit drugs.

Relationships

Youth must learn to show appreciation for things that others do for them. They must respect other people and other people's things. Caregivers must teach youth to avoid and resist relationships in which they are being hurt physically or emotionally or in which harmful or illegal activities are encouraged, which may pose a challenge in cultures in which adults' requests cannot be declined by children. The adolescent may become unsure about the social group to which he really belongs. He may become confused about how best to meet what other youth and adults expect from him. Sometimes the strong need to fit in with peers can result in the youth becoming unduly influenced by peers who encourage harmful or high-risk behaviors. Youth begin to develop the skills and interest to build intimate relationships. As they relate to other people, they learn more about themselves. The ability to develop intimate relationships and strong friendships in culturally acceptable and healthy ways is an important skill which youth begin to learn.

Work and Study Skills

The youth who is well on his way to being a productive adult knows how to use various resources (e.g. newspapers, libraries where they exist, etc.) to get information. He looks over his school work for mistakes before he turns it in. He manages his time and is not late to where he needs to be. He thinks about how the choices he makes now will affect him in the future. He can break down what steps it will take for him to reach his goals. He makes primary and alternate plans. When he is not sure about a choice, he asks trusted friends or adults for ideas. These skills may look different, however, across cultures.

Coping with Loss

Adolescents have the cognitive ability to understand loss, but may not always be in tune with their emotional responses, nor, in many African contexts, have they been encouraged to do so. They may not express their worries and fears directly and may feel angry about their losses. Adolescents are at risk for depression and feelings of hopelessness. Psychological and economic stress can lead to isolation and to engaging in high risk behaviors.

A specific risk in adolescence is becoming the head of the household if it means that it keeps siblings together or prevents the loss of an inheritance (Shetty & Powell, 2003; UNICEF, 2004). This may prevent school attendance and interfere with the ability to enter a career that will be productive over the long term. This may also interfere with age appropriate social and recreational activities.

In summary, children and adolescents living in the context of illness, loss, trauma, economic instability and stigma, especially in high HIV prevalence southern African countries, face many challenges to their optimal growth and development. Families and communities are challenged to meet their basic needs, food, shelter, safety, as well as needs for nurturing and socialization. Holistic programs look beyond the basics (Foster, 2002) to address children's essential psychological, social and behavioral needs.

Chapter

4

Psychosocial Support and the Vulnerable Child

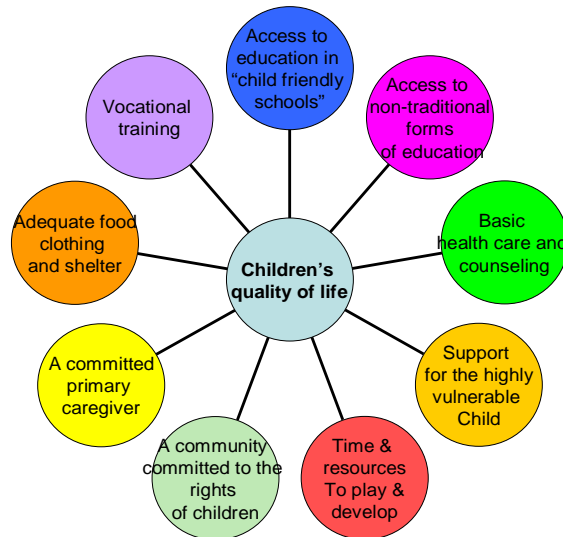
Psychosocial Support

Psychosocial support means many things to many people. Good practice requires a holistic yet unambiguous and measurable approach to psychosocial support. Figure 3 displays important elements which are needed when providing effective holistic care and support when working to improve children's quality of life which can integrate psychosocial support.

OVC require additional psychosocial support because of the accumulated experiences of trauma and stress. Parental illness and death are profound emotional traumas for children. For the vulnerable child, psychosocial support is needed to counterbalance harmful experiences such as neglect, abuse, extreme poverty and serious illness.

Trauma is an emotional shock that can lead to long-lasting, harmful effects. Orphaned children throughout Africa have reported anxiety, fear, stigmatization related to HIV, orphan status or poverty, depression and limited social support (Foster et al., 1997; Segendo & Nambi, 1997; Wild et al., 2007; Atwine et al., 2005; Shetty & Powell, 2003). Girls have been found to be more vulnerable than boys to distress caused by HIV-related stigma and discrimination (UNAIDS, 2004). Psychosocial support as described below can help children and young people cope with repeated emotional trauma and stress.

Figure 3: Nine Key Areas of Holistic Care and Support



Adapted from S. Strasser, 2007.

Nine Key Areas of Holistic Care and Support

1. Access to non-traditional forms of education, such as accelerated learning and numeracy education (ALNE), study circles, correspondence courses and radio based instruction.
2. Basic health care including integrated management of childhood illnesses, immunizations, growth monitoring and access to basic first aid, basic counseling including memory work, referral for individual counseling and trauma therapy as needed.
3. Highly vulnerable children may include the disabled, children living on the streets, the girl child and child-headed households.
4. Time and resources for play and (early childhood) development including preschools, after school programs, organized sports and playgrounds.
5. A community committed to children's rights including child protection committees (CPCs), paralegal training, child friendly police units, and children's centers or children's desks.
6. A committed primary caregiver who can access basic support and counseling.
7. Adequate food, clothing and shelter which can be strengthened through community led integrated savings and lending groups and small funds initiatives.
8. Vocational training which may be funded through block grants as well , mentoring and apprentices arrangements.
9. Access to education in "child friendly schools" where all children, including children living with HIV feel safe and challenged to learn.

Psychological, Social and Behavioral Needs of OVC

In a study using standardized psychological measurement, 73.3% of orphaned children fulfilled the criteria for suffering from post-traumatic stress disorder, on the short form Impact of Events Scale (Cluver & Gardner, 2006 – see Appendix A). Children in the same communities experienced equally high levels of peer problems, emotional problems and overall distress (Cluver & Gardner, 2006). OVC are thus likely to require more emotional support from the adults caring for them, yet these adults may be overwhelmed themselves by multiple losses and increased demands on their households (Freeman & Nkomo, 2007). Adults sometimes must also overcome strong cultural traditions in supporting vulnerable children, such as norms that shield children from talking about death and about the reason a loved one has died (Wood et al., 2006).

Provision of Psychosocial Support

Children need special help in dealing with the loss of a parent. Without this support, children may experience future difficulty in developing close relationships. Children may “protect” themselves by maintaining interpersonal distance from others for fear of further loss. Psychosocial support enables children to work through these fears so that they can continue to have meaningful and close relations with adults and peers.

Personal history is lost for a child whose parent dies when they are still young. They may grow lacking a sense of who they are and where they come from. This is especially true for families where the death or the imminent loss of a parent has been kept secret or denied. Stigma and fear of HIV disclosure keeps many from sharing their thoughts, worries and hopes for the future with their children. Children may not even know the parent is gravely ill or that the father or mother has died.

Yet children have the right to know the truth and to receive support to come through this profound loss, both healthier and stronger. A feeling of connectedness is important to children. Children can be assisted through counseling. Parents, other primary caregivers or guardians may need support in talking to the children in their care. This can be facilitated through simple drawing and play and through the development of memory books or compiling a family history.

Sadness and intense emotions are a normal part of grieving the loss of a parent. Children grieve in small doses and intersperse grief with periods of play. Children who get “stuck” in their grieving may end up having serious emotional and social problems. Children need space and time to grieve and need adults who will support them as they experience different emotions. Yet, children grieve differently than adults. Children may not sustain feelings of sadness and intense loss. This can be confusing to the adult caregiver who mistakenly believes the child is ok. Caregivers and children need to be supported and educated about grief, what is normal and expected, and practical tips for helping them through the transition to living without the parent.

Emotions associated with grieving may include:

- Disbelief that the loved one is really gone;
- Anger that the loss happened;

- Thinking “if only I had done something different, I would not have lost him/her;”
- Despair, “I can’t get over the loss;” and,
- Acceptance of the reality of the loss.

Acceptance of loss means that the child is able to “relocate” the deceased person in her life (Wild, 2001) - she can enjoy happy memories of her parent without becoming overwhelmed with the feelings. The child is able to find meaning in life, to live without the fear of future abandonment and to adjust to the changes in her environment. A child who has grieved in a healthy way will still feel bad at times, but is aware of the feelings and can talk about them. Some people live without this awareness; they have trouble getting close to people, and may appear “angry with the world.” It is important to consider the context of the loss that is, the quality and extent of family and community support in relation to the loss.

Specific Psychosocial Issues

Helping Children who Experience Severe Grief Responses - Depression and Anxiety

Depression is a sadness that does not just come and go, but is the child’s constant companion. Symptoms of depression include:

- Inability to have the normal range of emotions, constantly sad or “flat”;
- Thoughts about death;
- Thoughts about hurting self or trying to hurt self;
- Irritability;
- Withdrawal or isolation;
- Poor school performance, particularly after having done well in the past;
- Not sharing thoughts and feelings;
- Eating too much or too little;
- Sleeping too much or too little;
- Trouble making decisions, trouble concentrating;
- Feelings of guilt, hopelessness or poor self-worth.

By being loving, warm, and accepting, by providing structure in social, recreational and academic activities, and by supporting emotional expression, the caregiver can help the child to achieve the goal of experiencing greater enjoyment in life. This includes increased energy, participation in activities and healthy socialization. More importantly, the child would develop confidence in their abilities, a sense of belonging and security, and a confirmation of their worth that someone loves or cares for them. Adults can work with children to take life one step at a time, to take control where they can but not stress about things that they do not have control over. It is important to combat feelings of helplessness through minor steps of success and patience.

Succession planning programs (Gilborn et al., 2006) have been found to help parents living with HIV plan for their children's future by giving a structure for communicating openly with their children about HIV and AIDS, writing wills, doing memory work that captures

family customs, and providing children with a sense of family tradition rooted in their cultural heritage. These are important aspects of psychosocial support and increase children's sense of belonging (Foster & Williamson, 2000).

Helping Abused Children

In societies experiencing overwhelming illness, loss, as well as social upheaval, child abuse can become far too common. Signs of physical abuse include bruises, broken bones and burns. Signs of neglect include poor hygiene and delayed growth, although these can also be signs of poverty or HIV status, thus careful observation is warranted. Signs of sexual abuse include unusual sexual knowledge or behavior, STIs, pregnancy, and injury to the genitals. Unfortunately, abused children will often have been abused in more than one way. If a child tells or reports that he was or is being abused, this should always be investigated.

Children who have been abused may become fearful, withdrawn, watchful and easily startled. Conversely, they may become aggressive and irritable. The child may regress to earlier behaviors, such as daytime and nighttime wetting. A drop in school performance may be seen as well. Abused children may become overly compliant and passive and may endear themselves too quickly to many people, without discriminating who is trustworthy. They may have sleep disturbances, including nightmares and night terrors. Neglected children may beg, steal and/or hoard food.

Adults must be trained to identify an abuse child and to respond effectively. Adults need to assure children that they are in no way responsible for being abused. They must take care to keep the child safe and ensure the abuse is not repeated. Known perpetrators should be reported to the relevant authorities.

It may take time to build trust with the abused child so it is important to let her know that she is valued, safe and unconditionally loved. Encouraging expression of emotions through talking, drawing and/or writing is effective in decreasing mood disturbance and regression. Participation in positive activities can help increase feelings of self-worth.

Helping Children with Post-Traumatic Stress Disorder

There is a difference between being stressed, even severely, and suffering from Post-Traumatic Stress Disorder (PTSD). PTSD has been found in children who have been exposed to violence and natural disasters such as earthquakes, flood, and fires. It is important to recognize that the stress of many losses, exposure to illness and disruption of daily life can lead to PTSD. Children who experience PTSD need referral to trained counselors.

Children coping with anxiety, including PTSD, may appear fearful, restless and shaky, and may have such symptoms as a rapid heart beat, trouble sleeping, including nightmares, trouble paying attention, dizziness, trouble breathing, and irritability. Excessive worries or fears can interfere with the child's ability to concentrate and perform at school and to complete. It may not always be clear what the source of the anxiety. Sometimes the child will

show worries about something that has not happened or show worries that do not match the current stress.

In addition to external professional support, to help the child who is dealing with PTSD, the caregiver needs to build trust with the child. This is facilitated by being a good listener and by being warm and soothing and by establishing and maintaining routines. Structure and routine are important in assuring the child that the world is a safe, predictable place.

Adults need to talk to the child about what is real and not real, particularly if the child is experiencing worries out of proportion to current stress. These extreme worries may stem from not having resolved responses to previous, more severe stress. Children should be helped to identify and express these feelings and worries. They should be helped to increase their confidence by facing challenges and experiencing successes.

Helping Children with Behavior Problems

In coping with stress and trauma, some children turn their feelings inward and become depressed and anxious. Others turn the same feelings outward and act out with inappropriate behaviors. A child may become restless and distractible, with a short attention span, may not listen, may fail to finish chores and school work, and may become very disorganized, forgetting and losing things. They may have trouble getting along with others and may have poor self-esteem. These are signs of unmet emotional need and severe stress but are often misinterpreted and blamed entirely on the child as “naughty” or “bad”.

Adults can help children with behavior problems by increasing structure and routine and by providing natural, logical consequences for misbehavior. Children with behavior problems need positive feedback when they do well. Children can be taught strategies for stopping and thinking before acting. School work and chores may need to be broken down into smaller steps so that the child is successful in completing a simpler task. Another strategy for increasing success is to steer the child into activities in which he can excel.

Children with behavior problems often feel that they are being judged negatively and this can make the problem worse. As with other problems, encouraging children to name, then talk, draw or write about their feelings can channel those feelings more constructively. Children need to be taught conflict resolution skills and to think about how their behaviors affect other people. Children must know that expressing feelings, particularly of anger, should not violate another person. Both the caregiver and the child may need to become more aware of what leads up to or “triggers” the problem behaviors. By better understanding “triggers” such as common situations, feelings or events which lead to behavior problems, some problems can be avoided. Behavior problems can stifle a child’s development, getting to the root cause of the behavior and facilitating the child and caregiver to work through any stress and trauma are essential to healing.

Helping Children to Cope with a Significant Medical Condition

Like loss, trauma and abuse, dealing with a chronic or significant medical condition can, if handled poorly, negatively affect a child's development. If handled well, coping with and overcoming obstacles related to a medical condition can be empowering to a child.

Whatever condition a child is dealing with, whether it is a disability, a mild condition or something as significant as HIV, children need to have their questions and concerns answered honestly and at a level which is developmentally appropriate. A child needs to feel that his or her concerns are heard and to feel that their questions are answered.

Children need to know what they are facing so that they can appropriately care for themselves. This is very important for treatment adherence and for making informed life choices. For example, the adolescent living with HIV needs full understanding of sexuality and the impact of HIV on their decisions and choices. This is an important component of any adolescent's development and critically important for the young person living with HIV.

Emotional and psychological problems can be lessened if the child is told about their medical condition. This needs to be done in a way that she can understand and which is appropriate to their age and development. Yet, every child is different. Some will need support day-to-day in dealing with their diagnosis. Some will need support at important moments, such as at the time of the diagnosis or when there is an increase in symptoms or there is a setback. Open communication and keeping a child informed are important to emotional and psychological wellbeing and the general development of the child.

Having a serious medical condition is normally accompanied by fears. These fears can be rational, such as a fear of death, of the future, and of being ostracized. At times, these fears can be irrational. Living with a medical condition is usually accompanied by losses, such as a loss of freedom and feeling of invincibility. Children can feel that they have lost control of their life and of their health, that they have lost their future, that they have lost their family and relationships and that they have lost their self-esteem. Feeling different from other children can cause emotional problems, especially if the child looks different, is developing more slowly or is unable to keep up with his or her peers.

Yet, children living with chronic conditions should be encouraged to set goals and to achieve their potential. Goal setting and goal achievement are important to a child's sense of mastery and self esteem. All children need to pass through a series of milestones to come out as functional, happy adults. Children coping with illness are no different but face additional challenges. Table 2 reviews goals at different stages of development and how coping with a medical condition can be particularly challenging at each stage. As is shown in the table, a sense of trust and independence can be compromised, as can higher development stages such as feelings of belonging and competence when a child is busy coping with a serious illness.

Table 4: Developmental Challenges for an Ill Child

Stage	Goals	Challenges of a Medical Condition
Infancy (Birth to 18 months)	Development of trust in the world	Being separated from the main caregiver through repeated hospitalizations or having the caregiver pull back can affect trust.
Toddler hood (Two to four years)	Development of independence	Taking medicines and having activities limited can affect independence.
Early Childhood (Four to six years)	Development of imagination	The child might think that being sick is a punishment for something that she did or even just thought about doing.
School Age (Six to twelve years)	Development of competence and a sense of belonging	The child may feel different from other children, like she does not fit in. She may feel that she cannot do everything that she wants to do.
Adolescence (Twelve years and older)	Development of a comfortable body image, positive self-esteem and mature relationships. Prepare for the future tasks of adulthood that include developing self-awareness and self-acceptance, becoming a productive and contributing member of society, and discovering that life has meaning and value.	The adolescent may not feel comfortable with her body. She may worry about how her diagnosis will affect her ability to be in a relationship. She may not be able to accept herself or feel that her life is worth as much as other people's. This is particularly problematic if the condition is socially stigmatized and she is hearing negative messages about her condition.

Communication is essential to effective coping. Caregivers need to find out what the child thinks about his or her medical diagnosis. There can be misunderstandings and fears at different ages that adults can help a child work through. A child's understanding at 6 years will be very different than his or her understanding at 10 or 12 years. Therefore, education and open communication needs to be ongoing and adaptive to each child's stage of development.

Practical tips can include asking family members about the child's diagnosis, what they believe, their attitudes, fears, and concerns. Also, ask children about are their concerns and feelings. How is the extended family helping or hindering a child's coping ability? Children should also be encouraged to identify possible solutions and be given space to come up with effective coping strategies. This acknowledges the child's vital role in their own management of their condition while at the same time improving and supporting their problem solving skills.

Children can be helped to identify what methods have worked and not worked in the past. They can be encouraged to identify their strengths and where there may be opportunities for them. At a minimum, helping a child cope with illness includes taking their medicine and following their treatment regimen. In addition, emphasize good nutrition, proper sleep, exercise and spiritual practices. Children need to identify goals and work towards them. They need to develop good communication skills and healthy, trusting relationships with both adults and peers.

Helping Adolescents through the Transition to Adulthood

Since we all experience loss and change, transitions are part of our entire lives. However, the transition from adolescence to adulthood is one of the most critical in a person's life. Choices made in youth regarding education and sexuality set the stage for a young person's adulthood. For adolescents to transition well, they need to know that the adults around them have confidence in their ability to transition into the community as fully functioning adults. Children need to be supported to gain the skills and experiences that are needed to live healthily, work productively and develop meaningful relationships.

It can be helpful for youth, from about twelve years of age, to assess their life skills in the areas of career planning, communication, daily living, money management, self care, social relationships, work and study. They can be asked to reflect on what might hold them back from achieving their goals as well as what skills, strengths and resources they currently have to help them reach their ambitions. While many of these concepts may seem out of reach for adolescents in low-resourced countries, committed programming and policy change over time may broaden the scope of possibility in their context.

Helping Children and Youth Build Resilience

It is important for adults to support children to succeed and to develop confidence in their abilities to identify their strengths and to take advantage of opportunities to stay on track. For a vulnerable child whose life experience may be clouded by unpredictability, unmet need and loss, developing resilience is essential. Adult caregivers can help the child obtain and maintain a sense of mastery, a knowledge that they can cope with difficulties which come their way. A child, with adequate support and care, can see difficulties leading to new possibilities, a greater sense of personal strength and the helpful role of faith. When a person can acknowledge they are in a difficult circumstance and that they have the skills, support and attitude to deal with the adversity, this indicates healthy resilience.

Individual children and their communities can have a remarkable capacity for resilience in the face of adversity. Therefore, community involvement in the care and protection of vulnerable children should be encouraged. As vulnerable children are helped to "thrive, not just survive," the whole community is strengthened. Other elements of building resilience include raising community awareness about the rights and unique needs of children, the importance of childhood, child protection and the challenges children face today in their local community.

Family members and other caring community members such as teachers, religious leaders, and home based care volunteers can be taught basic communication skills which enable children to express their feelings, to share their challenges and to problem solve both in the home and psychosocial support settings. Developing the child's capacity for emotional expression, maintaining a family story, and fostering a sense of belonging within a caring community are all important to building resilience.

People who are resilient are able to triumph over life's challenges, and are able to envision a brighter future. Yet, we all need support to be able to do this. Children need guidance and encouragement to identify their strengths, whether those strengths are in education, arts, dance, music or sports or even in humor. Building on one's strengths can increase resilience.

Support groups can also be helpful to fostering resilience amongst people experiencing similar challenges and losses. Talking with people who have been through similar experiences allows children to learn they are "not the only one" and that others know what they are or have been through. Support groups allow children to share with each other what has worked for them and how they have overcome specific problems. Sometimes encouraging open communication between people who do not have the tools to communicate effectively can be detrimental, rather than helpful. Therefore, facilitators trained in psychosocial support may be necessary.

Children need to believe that they have a secure future. Warm and loving relationships with the primary caregiver, the broader family and wider community help to build up a child's resilience.



Chapter

5

Protecting Childhood

Child Rights

Childhood and child development are the embodiment of the common human experience. All children require certain conditions to grow and develop. Adopted by the General Assembly in December of 1948, the United Nations Universal Declaration of Human Rights (United Nations-Office of the High Commissioner for Human Rights, n.d.) began a process of enshrining a common understanding of human dignity within a framework of human rights which has consequently expanded into the development of specific rights for vulnerable groups. These vulnerable groups include children. “Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.” (Article 25)

In 1990, member states of the United Nations adopted the Convention on the Rights of the Child (CRC). Adopted by 191 countries, the CRC’s legally binding principles are almost universally accepted. The rights declared in the CRC recognize the specific development needs and distinct vulnerabilities of children. It is an instrument of legal guidance for countries to introduce the necessary laws and systems to ensure the basic human dignity of children. Therefore, child rights serve to lead those responsible in providing for children’s needs and protecting them from abuse and harm.

- **General principles:** These rights refer to the general dignity of a child, having an inherent right to life and development with respect for their views, decisions made in their best interest and to be protected from discrimination.
- **Civil rights and freedoms:** These define the age and nature of a child with a right to name, nationality, identity and privacy. These rights also protect the freedoms of expression and association.
- **Family environment and alternative care:** These highlight the responsibilities of parents and wider society in ensuring the rights of children. It also provides for the protection of family and children without families.
- **Education, leisure and cultural activities:** These rights hold a special place in ensuring healthy childhood development.
- **Special protection:** There are numerous articles in the CRC which provide protection for groups which are particularly vulnerable to abuse and other severe violations of

their rights. Some specify the illegality of certain forms of exploitation like child labor, sexual abuse and trafficking.

- Basic health and welfare: These rights expand on the right to life in reference to health care, social security and standard of living.

Legal Protection

There are three specific legal issues that affect vulnerable children in southern Africa, including birth registration, inheritance and maintenance.

Based on the above right to name, nationality and identity, children have the right to have their births registered with the government. Birth registration can often be required for children to access their basic rights like education and health care.

Children that lose one or both parents are often in danger of losing access to the assets that once belonged to the family. Special services are needed to assist children in gaining access to their inheritance rights. This can often be accomplished when a parent is sick through succession planning.

Succession planning can also facilitate protection of a child’s right to maintenance and guardianship. The legal responsibilities of a parent to maintain and provide the basic needs for their child need to be transferred to new guardians taking over these responsibilities once the parent(s) have died.

“Everyone has a right to a nationality.”

Article 15
1948 Universal Declaration of Human Rights

In addition to fundamental legal rights, children require social protection. Social protection safeguards the chances to a healthy and productive childhood. In a recent review of social protection in an era of HIV, Greenblott (2007) explains that social protection can take many forms, from legislating, providing pensions, giving grants to orphan caregivers, feeding programs at school, and a “a litany of other interventions” (p. 6). Below three important child social protection emphases on child labor, sexual abuse, and children living on the street are discussed.

Protection from Harmful Child Labor

The poverty in which some southern African vulnerable children and their families live can result in the child becoming involved in work which is inappropriate to their age and development. The CRC recognizes the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child’s education or to be harmful to the child’s wellbeing. Good practices in OVC support should, therefore, ensure that involvement in work does not constitute exploitation, does not cause the child harm or compromise his childhood.

Supporting the caregivers’ ability to improve and sustain their livelihood will relieve vulnerable children from unnecessary economic burdens and enable him or her to engage appropriately in education, household and recreational activities.

Protection from Sexual Abuse, Commercial Sexual Exploitation and Trafficking

Vulnerable children and youth, especially girls, in southern Africa are increasingly exposed to the dangers of sexual abuse in the home, their community or through the illicit sale of children into sex work, known as human trafficking. Not only does sexual abuse and exploitation have a disastrous impact on the psychosocial wellbeing of a child, but these practices also increase their vulnerability to disease, especially HIV. Some children are abused or exploited without their consent while others enter sex work in exchange for money and goods for survival. Vulnerability to sexual abuse in all forms can be reduced when there is one, dedicated primary adult caregiver in a child's life. A responsible caregiver can ensure the child's safety and can be trusted by the child.

Protecting Children Living on the Street

There are a number of reasons why children move to the street. Usually, children are led to the streets through a combination of problems at home and the lure of perceived opportunities. A rapid assessment of street children in Lusaka, Zambia (Lemba 2001) found that a majority of children mentioned poverty or financial needs as the main reason they were on the streets, with a significant number also mentioning being mistreated or other family problems.

Life on the street for a child, without the care and protection of a responsible adult, is filled with danger. Children lack basic protection including adequate clothing and shelter, food, and are at immense risk of being abused by others. Children living on the street are highly vulnerable and need to be prioritized within programs.

Protection through Improved Livelihoods

Current thinking on social protection moves beyond the "humanitarian imperative" to simply protect. Social protection, when used to describe activities aimed at improving livelihoods, includes initiatives that provide cash or asset transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized. Social protection should aim to reduce the use of negative coping strategies and to move beyond protecting to promoting livelihoods (Greenblott 2007). As economic need is so often the driver of danger for vulnerable children in the southern African context, much can be done to protect children by improving the family's livelihood.

The Interagency Task Team (IATT) on Children and HIV and AIDS has a special working group on social protection. They recently published a paper on the benefits of cash transfers for children affected by HIV. This report shows that "cash transfers can be financially feasible, even in the poorest, most severely AIDS-affected countries," and argues that, "social protection, including cash transfers, must be prioritized as an essential basic service alongside investments in healthcare, education, water and sanitation, to make a difference for the most vulnerable children" (d'Allesandro 2007, pp.1,3).

The Role of Government in Protection

The role of national governments as the ultimate duty bearers in the protection of rights cannot be overlooked. While this paper emphasizes the importance of direct care and support to children and families, good practices also inform and advocate on behalf of children in need. Civil society has a central role to play in ensuring governments are promoting and protecting children's rights.

There are existing policy instruments at the international and national level that provide a foundation for the promotion and protection of children's rights. To increase government effectiveness, policies must be translated into practices at the local level. This requires national leadership and coordination amongst all agencies involved in supporting and implementing programming on behalf of vulnerable children.

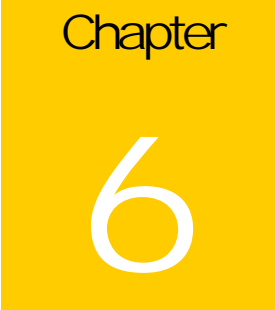
Building on the Framework for the Protection, Care and Support of Orphans and Vulnerable Children, a decision was taken to initiate the interagency (UNICEF, UNAIDS, USAID and WFP) rapid assessment, analysis and action planning process (RAAAP) in highly affected countries in sub-Saharan Africa (Webb et al., 2006). The RAAAP intended to confirm baseline data, assess critical gaps and constraints to scale-up, identify actions and resources required to address them, and mobilize stakeholders at the country, regional and global level. At the start of the process, sixteen countries were chosen.³ Later another 10 countries joined the initiative.⁴ After the data collection was completed, each country developed five year national plans, including costing and budgeting information, with some including a monitoring and evaluation plan. Key areas of the plans included government commitments to guarantee access to education, nutrition and health care, HIV-related care and treatment, psychosocial support and legislative reform/legal protection. As the process continues, the international community continues to support the RAAAP initiative, identify weaknesses or challenges and recommend improvements based on the lessons learned. Some of the key recommendations include:

- Improve national ownership and integration with on-going national processes, like the Poverty Reduction Strategy Process;
- Balance macro and micro level responses emphasizing decentralization, so that capacity at the district level is strengthened; and
- Improve engagement with and support of civil society, especially in efforts to scale-up effective programs.

Based on these efforts and processes at the national government level, it is imperative that all groups and communities working with vulnerable children are aware and to the extent possible, engaged with the national action plans and those members of the government charged to implement them. This can improve access to essential services and protection of rights for children. Knowledge of these national action plans can provide civil society, communities and families with a tool for advocacy on behalf of children as well as a framework for monitoring government response and progress.

³ Central African Republic, Cote d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Rwanda, Swaziland, Tanzania, Uganda, Zimbabwe and Zambia

⁴ Angola, Burkina Faso, Burundi, Democratic Republic of Congo, Djibouti, Eritrea, Ghana, Madagascar, Somalia and Southern Sudan.



Chapter
6

“Bitter are the tears of a child: Sweeten them. Deep are the thoughts of a child: Quiet them. Sharp is the grief of a child: Take it from him. Soft is the heart of a child: Do not harden it.”

--Pamela Glenconner

Good Practices in Support of Vulnerable Children

The chapter is a review of good practices submitted by each SARO country program during 2007 which, using a standardized scoring tool, received the highest scores in key areas of quality programming. Each good practice was evaluated using a scoring tool developed by four regional technical advisors in SARO (Appendix B). These technical advisors shared from their experience and expertise in child health and child survival programs, HIV home-based care, ART and OVC programming, justice and peace as well as monitoring and evaluation (M&E).

The purpose of the scoring tool was to provide a standardized way of assessing each good practice submission. First, each submission was categorized into one of the three following categories of good practice:

- Innovative Practice
- Successfully Demonstrated Practice
- Replicated Good Practice.

Once categorized, each practice was scored, based on the following five-point Likert scale:

- 1: not at all/no demonstration
- 2: a little/minimal demonstration
- 3: somewhat/some demonstration
- 4: good/much demonstration
- 5: excellent/a great deal of demonstration.

This was followed by a second scoring (using the same 5 point scale) against six program quality criteria: sustainability, efficiency, ethics, partnership, assets, and structures/processes. The full scoring tool is found in Appendix B.

Results

SARO received nine submissions from six CRS country programs: Lesotho, Madagascar, Malawi, South Africa, Zambia and Zimbabwe. Four programs were categorized as innovative, four were seen as successfully demonstrated, and only one seen as replicated good practice.

The scores across these three categories ranged from some demonstration (3) to excellent demonstration (5). The average score and range for each quality program area is presented below.

Table 5: Average Score and Range for Six Aspects of Program Quality

	Average Score	Range
Sustainability	3.55	{2-5}
Efficiency	4.05	{2-5}
Ethics	4.05	{2-5}
Partnership	4.33	{3.5-5}
Assets	3.77	{2.5-5}
Structures and Processes	3.72	{2-5}

Four programs were chosen for field visits one from Zambia, two from Zimbabwe and one from South Africa. These programs received high scores in both the category of good practice (innovation or successful demonstration or replication) as well as high average scores across the 6 quality criteria. The next section presents the four programs which were seen to be models of good practice. An overall description of each good practice and a table of program fast facts are presented followed by a discussion on challenges and opportunities within each practice or program.

Good Practice Sites

1. The Integrated AIDS Project (IAP) of Ndola Diocese, Ndola, Zambia



Home-based care volunteers dancing and singing. Trained and highly motivated volunteers are the backbone of community based care and support to people living with HIV as well as vulnerable children. (Zambia)

It is a clinic day in the high density suburb of Nkwazi, one of many such compounds in the copper mining town of Ndola, Zambia. Two dozen community volunteer caregivers for the Home-based Care (HBC) program are gathered at the Chishilano multifunction center in the heart of the compound as community members begin to arrive for their clinic visits. The volunteers sing, dance, joke and show appreciation to one another and to the community members that they serve. The volunteers wear distinctive green chitenge (cloth skirts) imprinted with red ribbons of hope in the face of the HIV pandemic. The chitenge is a symbol of pride, respect and responsibility in this vibrant community that has

successfully implemented a unique household targeting program for the most vulnerable. The support and care services offered by IAP are designed to address effects and causes in relation to the HIV pandemic in a holistic and integrated manner. A wide array of linkages, referrals and services are offered to families by caregivers skilled in multiple disciplines. The IAP focus on building household capacity is designed to provide for a more sustainable approach to responding to the effects of the HIV pandemic.

The Ndola Diocese's Integrated AIDS Program informally began to serve PLHIV in 1991. Where the initial goal was to support people with AIDS to die with dignity at home, today the program offers screening for tuberculosis and HIV, with follow up home care for community members diagnosed with those conditions. This includes medication management. Participants are also able to access advice from paralegals, psychosocial counseling and food assistance. The program has evolved with the changing needs of its participants. As more people on ART look ahead to longer life spans, they are eligible to gain specific work skills through multifunctional centers and to apply for loans to start their own businesses.

IAP programming for vulnerable children began in 1995 as the needs of the children whose parents were sick, dying or deceased became apparent. These children very often need food,

support to enter or to remain in school, psychosocial support following abuse and trauma, and protection of their rights to their parents’ property.

IAP Fast Facts	
Year Program Commenced	1991 – AIDS Programming 1995 – Vulnerable Children Programming 2004 –RAPIDS Program (PEPFAR funded)
Population Served	12,000 Adults at 11 sites in 5 towns; 3500 on ART
Number of Children Served	31,000; 100 on ART
Personnel	43 Nurses, 11 OVC Field Supervisors, 13 Drivers, 14 Technical Staff and 4 Support Staff
Assistance Provided	School Support: fees, uniforms, books, supplies Food and Other Basic Material Support Income Generating Activities Home-based Care Psychosocial Support

IAP provides a truly integrated approach, with each aspect of the UNICEF Framework for the Protection, Care and Support of Orphans and Vulnerable Children (2004) addressed. First is a focus on health, with the HBC volunteers receiving training in TB and HIV screening and counseling. The nurses and volunteers also receive training to recognize the need for and provide psychosocial support. An additional psychosocial support service is the Life Skills Camp that children attend once per year. The children receive support from counselors and from one another at the camp to strengthen coping and decrease feelings of isolation.

Another major focus of the program is to ensure school success for children whose parents are supported by the HBC program. The nurses and HBC volunteers work closely with the schools to monitor children’s progress and attendance. Children are provided with books, pens, bags and school fees. Five mentoring groups have been set up in which older children tutor and encourage younger ones. Children are provided with material support to help them to have a life similar to those who have parents.

Livelihoods strategies are based in the multifunction centers. The program, Twatasha, supports businesses that include making high energy protein supplements (HEPS, a ground corn - soy blend), chicken rearing for eggs or broiling, and tailoring. Future plans are to begin operation of a maize grinding mill. There is a focus on sustainable local solutions. For example, Ndola Diocese has donated land for farming and the food will go to beneficiaries and for money.

IAP utilizes a number of strategies to address stigma. Some people who have been served by the program are now volunteers. Volunteers and community members are able to acknowledge publicly that they are living with HIV. Ndola Diocese has a radio station that airs programs about HIV prevention, AIDS treatment and the rights and needs of children. The support groups have been given one radio each so that those without radios can hear the programs. Food assistance goes to a whole household, without singling out a recipient.

When stigma is observed, volunteers gather everyone to discuss the incident and reinforce the need for community members to support one another.

IAP is exceptional in recruiting and retaining volunteers, with over 745 volunteers. Some have been with the program since 1993. The drop out rate is lower than 5% and usually happens at the training and practical stages. The volunteers spend many hours with families, increasingly providing basic care as the sick become incapacitated. The volunteers receive very little material support, but express gratitude for what receive (protective clothing for handling body fluids, “uniforms” – chitenge for women and shirts for men, and bicycles). RAPIDS staff note that there are very few child headed households in the compound because other community members and volunteers become quickly aware of the potential for a child headed household and locate the next of kin when necessary. The HBC volunteers comment that there are no orphans in Nkwazi saying “these are our children now.” Interventions and support are infused with humor and tradition. The volunteers have an extensive repertoire of songs and dances, which include messages about HIV prevention and the importance of solidarity within the community in the face of the pandemic.

IAP is also known for creating and sustaining strong partnerships. Linkages are made with schools, for example, as the nurses provide workshops to teachers on stigma reduction and ART. Staff members have found that some teachers will supplement the HBC home visits with their own follow up with the home. Headmasters allow the late payment of school fees while RAPIDS is awaiting fund disbursements. The nurses and volunteers work hand in hand with joint home visits and with nurses sharing their trainings with the volunteers. A paralegal is on-site at the multifunction center on Wednesdays. Paralegal training on child rights has resulted in increased sensitivity to child abuse in the community with appropriate referrals to social welfare or to the police victims support unit being made.

Program monitoring is well incorporated into IAP’s day to day functioning. For example, assessments and follow up are documented by the volunteers on user-friendly pictorial assessment forms (Figure 4). When the social welfare coordinator is quickly able to enumerate the latest figures in relation to beneficiaries served, it is apparent that she “owns” the monitoring process.

khina	section	house No.
1.		2.
3.		
4.		

Figure 4: An example of user friendly M&E tools.

Challenges

The IAP program faces a number of challenges. First is the scale of the need. While every effort is made to meet the needs of children whose parents are or have been in the HBC program, not every child in need of school support can receive it immediately. There are 2,820 IAP children beneficiaries in school, but full financial support is available for only 1,332. More importantly, program personnel estimate that there are as many as over 10,000 children who may need assistance. This is based on the statistic that the typical Zambian family has 6 children. Staff are sometimes faced with the difficult situation in which one child in a household whose parent has been a RAPIDS client receives support, while several of her relatives, cousins, in need in the same household are not eligible to receive support.

A second challenge is meeting the basic need of adequate nutrition. With so many adults out of work because of illness and so many households with many dependents, many children are going hungry or underfed. It is difficult for a child to concentrate on school work when hungry. Many food sources are only seasonally available. CRS can quickly scale up once a need for food assistance is identified in relation to drought or other natural disaster. However, many relief agencies, CRS chief among them, understandably prefer to support efforts to create sustainable food sources rather than dependency on handouts. Children may be left hungry for long periods during these transitions to more sustainable food security interventions.

Programming for older adolescents presents IAP with a third challenge. Concerted efforts to improve school outcomes began in 2004 and have resulted in a high rate of secondary school graduation. Unfortunately, there are no funding sources available to support youth in pursuit of higher education. Ready access to vocational training and employment is limited. IAP staff report that adolescent females in particular perceive they have no other choice but to marry and start a family. The hard won victories in decreased rates of HIV transmission may be short lived if young men and women are not gainfully employed and have the positive self-esteem that comes with living to their full potential.

The HBC volunteers and nurses have received some training in providing psychosocial support, but more is needed. Costs limit the number of children who can attend the Life Skills camp and once yearly attendance is not enough to support optimal coping skills. A closely linked issue is the failure to recognize the rights of children. Some men still operate under the myth that having sex with a virgin will cure them of HIV. Some children are not identified as victims of abuse until they present with a STI or pregnancy.

The most important psychosocial support strategy for children, protecting the lives and health of their parents, is still difficult. ARV cost, even when costs are shared, is often prohibitive. It can go as high as K200,000 per month (50-60USD). The nurses and volunteers have noted that some people, once they feel physically better, will begin to neglect their health. Some may even revert to promiscuous behaviors.

Funding for children on ARVs is not subsidized, nor is the cost of necessary monitoring, e.g. CD4 cell counts. Children's access to adequate health care is limited given that there are many fewer health care professionals with expertise in pediatrics. There is only one specialized pediatric hospital in the region. Pediatric medications may



Staff of the Catholic Diocese of Ndola Integrated AIDS Program and field staff of the Twatasha multifunctional centre where gardening, small animal husbandry, tailoring, knitting, and HEPS production occur. (Zambia) *Left to right: Mr. Raymond Mwamba (Twatasha Ctr Coordinator); Ms. Lomantzi Mazyopa (Social Welfare Officer); Mr. Gabriel Zulu (HBC Field Support Officer).*

include syrups that need to be kept cool, but typically refrigeration is unavailable in the compounds.

Opportunities

Psychosocial screening can be made user friendly, such as by using pictorials similar to those used for HIV and TB screening. Volunteers and nurses should be taught that screening for psychological distress is as important as screening for physical illnesses. Funding is needed to increase the number of children who can attend the Life Skills camps. Volunteers and parents need training so that lessons learned in the camps can be reinforced daily.

A national plan is needed to insure that all children are able to access primary and secondary education, regardless of ability to pay fees. Partnerships must focus on providing all of the necessities for children to attend school including books, uniforms, and at least one daily meal. Public-private partnerships with the local mines, a major industry, should be investigated. Their financial support for education scholarships for students to go on to post-secondary and vocational training would strengthen the existing successes achieved. Finally, youth could be apprentices to the HBC volunteers and this could provide a foundation for entry into the health care field.

Employment opportunities must be strengthened so that youth and adults see options in life and a positive source of self-esteem. The cycle of poverty can be ended, but will require a concerted effort to implement sustainable solutions that are based within the community.

There is a need for creative strategies to provide for food security while avoiding fostering reliance on handouts. At the same time, hungry children need to be identified and their needs addressed quickly. Cost share for medications should be eliminated and medications provided free of charge in resource constrained settings.

The IAP approach can be strengthened with components of other successful programs. Some universities in southern Africa sponsor business students in consulting on marketing, creating a business plan, and accounting to create and sustain small businesses in urban and rural areas. Such student consultants could be utilized to strengthen the initiatives of the multifunctional centers and to identify market opportunities for vulnerable youth. Conservation farming and high-yield farming strategies in areas where farming land is limited can be expanded. Keyhole gardens could be created throughout compounds and small animal husbandry activities exploited for out of school youth.

2. Tsungirirai Station Days, Norton, Zimbabwe



Norton is a town in the Mashonaland West Province of Zimbabwe. It is located about 40 km west of Harare on the main road and railway line connecting Harare and Bulawayo. The population of Norton is supported by the Tsungirirai Private Voluntary Organization (PVO). Tsungirirai provides support for children orphaned or made vulnerable by HIV and AIDS, a community preschool, home-based care for PLHIV, a voluntary HIV counseling and testing site, and community education for HIV prevention. Tsungirirai started in 1994

with HBC linked to Norton Hospital. Programming for vulnerable children began in 1998 as staff and volunteers encountered the range of needs of children whose parents had died. In 2000, Tsungirirai expanded its programming for vulnerable children to the rural areas outside the town of Norton.

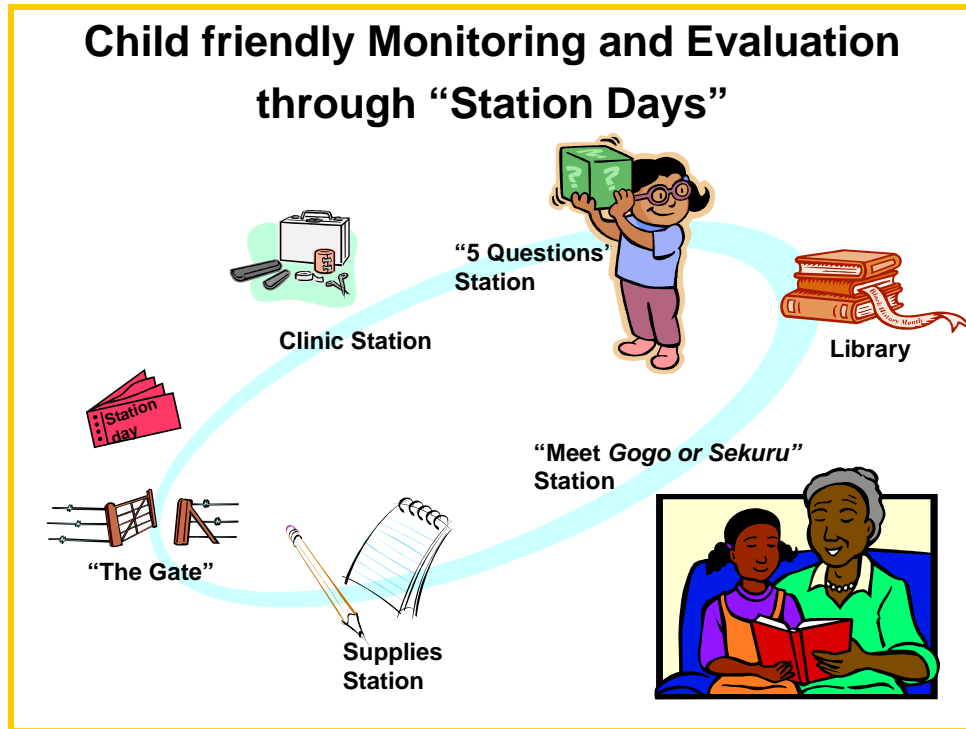
Tsungirirai Fast Facts	
Year Program commenced	1994 – HBC linked to Norton Hospital 1998 – Vulnerable Children Programming
Population Reached through Station Days	150-180 Children per Station Day at Tsungirirai center (Norton). 30-40 Children per Station Day in Rural Outreach Centers.
Number on ART	72 Adults on ART, 9 Children on ART.
Personnel	26 Staff
Assistance Provided	School Support – fees, uniforms, books, supplies Food, daily meal served on site Other Basic Material Support Home-based Care Psychosocial Support Community Education

In 2003, volunteer input led to the development of Station Days, a M&E activity that allows for the regular and accurate collection of data on children’s health and psychosocial status. Given that M&E activities often involve collecting information from children without children immediate gain, Station Days is designed to benefit children by disseminating material goods and information as they pass through “stations” in which psychological, physical and social functioning are assessed. Importantly, Station Days are enjoyable and fun for the children who are allowed to express themselves and to be heard.

All of the Tsungirirai staff and volunteers participate in Station Days and begin preparing for the event three weeks in advance. Strategies for collecting information from the children are

designed to meet the developmental capacities of children in the 6 to 12 years and older than 12 years age groups.

Station One is the Gate. Each child is given a ticket and a vitamin tablet or a sweet, if the latter is available. The ticket has the child's name and the number of stations the child has to pass through. From there, the child does the stations in any order, but ends at the supply station. At each station, the staff or volunteer staffing the station signs the ticket to acknowledge passage through the station at the final station, the completed ticket is traded for a token.

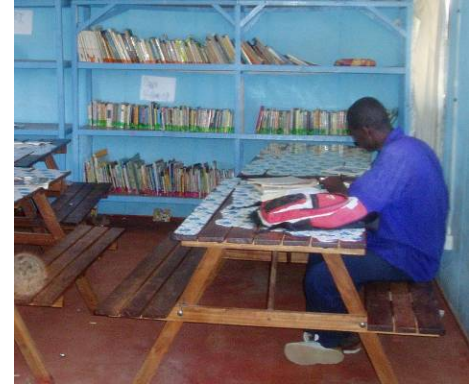


At the Clinic Station, the child's height, weight and general health status are recorded by a nurse. This allows for an assessment of the effectiveness of nutritional support. Minor ailments are monitored, wounds are dressed and children needing medical attention are recorded for referral to the hospital. Communicable diseases such as scabies are also monitored and treated. Ears are cleaned as needed, nails cut and collars checked. Children on ART are monitored without the stigma of having health checks at different times than their peers.

The counseling station is a private station where five standard questions are asked of each child. The questions focus on life at home, at school, and at the Tsungirirai center. The staff draft questions based on the last station day or what transpired since the last station day. For example, if the paralegal staff provided training about child rights at the next Station Days children are asked about child rights to determine what has been retained. If there was training about HIV prevention, general knowledge about HIV is assessed. Questions are seasonal to allow for the annual assessment of proper clothing particularly in the winter season.

At the “Meet Gogo or Sekuru” station, children meet with volunteers who are their elders. The elders give advice about manners, health and hygiene. Children are grouped by age and gender so that girls aged between 11 and 13 are given a talk about puberty and preparing for menarche. Older girls and boys receive information about sexual and reproductive health, and HIV prevention. The children are helped to prioritize problems and create solutions with the goal of improving overall coping. The volunteers maintain the cultural tradition of advice from trusted elders, particularly helpful if the child’s parent is deceased, guardian is ill or generally overwhelmed.

Children’s academic performance is assessed at the Library station. Children bring in their school exercise and homework books to be reviewed by the staff or volunteer staffing this station. School attendance is monitored and an action plan developed if problems are uncovered. The youngest children may participate in this station by simply drawing. Teachers are invited to be a part of the Library station so that children can pose any problems that they might have. Children may receive pens at this station and textbooks are available to borrow.



A young man making use of the library facilities at Tsungirirai

The last station is the Supplies/Token station. Children completed all of the stations receive tokens for attending Station Day. Tokens are usually basic necessities and include soap, toothpaste, hats, petroleum jelly, blankets and jerseys. Children may also receive oranges or toys. Children in rural areas are also offered a meal, given that they may have traveled some distance to participate in the station Day activities.

Station Days were initially conducted on a monthly basis, but are quarterly because they are both in Norton and at the rural sites. 150-180 children per Station Day participate in Norton while 30-40 children attend rural Station Days usually conducted at one school. Each child’s information from all but the clinic station, which maintains its own records, is filed in a book that follows the child over time. Child are encourage to decorate the cover in his own design. Immediately after Station Days, staff must review all books to count responses for monitoring purposes and to note any concerns or trends that have developed for individual children since the previous Station Day. Tsungirirai has strong partnerships with social welfare and other community organizations so that referrals can be made as needed.



Joyce Chitemere, one of the founders of “Station Days”, seated in front of children’s Station Days record books.

Station Days was initiated to provide for one-on-one support to large numbers of vulnerable children. Tsungirirai staff expresses great pride in the improvement they have seen in the psychosocial support to beneficiaries through the Station Days mechanism. The benefits that are apparent to staff and beneficiaries ensure that the M&E component of programming

for vulnerable children at Tsungirirai is owned by all.

A major strength of Station Days is its flexible design. Information gathered at each station is consistent, yet geared towards different age groups, seasons of the year and changes based on events that may have occurred since the previous Station Day. Tsungirirai staff emphasize that stations can be added to the core stations to accommodate program and community needs. Another important strength of Station Days is that information that Tsungirirai staff gather informs future programming. For example, staff noticed that some children, particularly those in rural areas, were not aware of career options open to them. Nor did the children understand the steps and planning necessary to pursue a given career. At the next Station Day, one of the standard questions focused on the child's ambitions. Staff and volunteers then were able to guide the child through thinking about the steps needed to pursue that career. A child expressing a desire to be a doctor is encouraged to excel in math and science. The child's changing goals or progress in meeting her goals is assessed on subsequent Station Days. Staff also invite professionals to do presentations about their careers.

The structure of Station Days creates a friendly environment between adults and children. Children are encouraged to talk and adults really listen. Staff and volunteers are careful not to promise anything that may lead the child to feel disappointed. Even at the advice giving stations, Tsungirirai staff and volunteers actively focus on helping the children come to their own solutions when faced with a problem.

Station Days is an intervention in that psychosocial support and a great deal of life skills education is provided. Each week, 200 OVC come to Tsungirirai's drop-in centre for meals, psychosocial support and library activities. Station Days serve as a way of monitoring and evaluating the drop-in centre's effectiveness in meeting OVC care and support needs. Counselors are nurses who have received training in the provision of psychosocial support. The drop-in center offers legal assistance weekly through the Zimbabwean Women Lawyers Association mobile legal center.

The program for older youth ages 18-24 is Young People We Care. The program focuses on involving youth to prevent HIV. Participating youth are linked with HBC by assisting with tasks given them by staff and volunteers, including cleaning and organizing educational campaigns.

Challenges

Tsungirirai staff note that supplies pose Station Days the biggest challenge. Often there is not enough food for every participant in the rural Station Days, despite the limited focus on direct beneficiaries. Staff wonder if children will be as eager to participate in Station Days if they do not receive tokens and the ability to provide tokens relies entirely on donations.

Tsungirirai acknowledges that it can be a challenge to retain volunteers, but note there are benefits to volunteers. Benefits include recognition and respect in the community and more concrete benefits including groceries, uniforms, medications and trainings. Volunteers undergo an initial comprehensive training followed by two annual refreshers on such topics as herbal therapy and psychosocial support.

Opportunities

Both potential HBC and Young People We Care volunteers are identified by the community elders, teachers and other village leaders. The volunteers are selected from the submitted roster and trained at Tsungirirai. Specific volunteer responsibilities are outlined by the communities. Many youth become members of the local AIDS Action committees, thereby increasing child and youth input into programming. Documenting this process would be informative to programs which struggle with improving community involvement and volunteer retention.

The Station Days model has been adopted by two other CRS Zimbabwe partners, an indicator of its effectiveness and replicability. The model is also spreading through national and international conference presentations, journal articles, and exchange visits in the Southern African region.



Tsungirirai's Staff (L to R) Joyce Tamuka Chitemere (OVC Coordinator), Chiedza Chinembiri Mutandira (Programmes Manager), Constance P Chasi-Chifamba (OVC Officer), Happiness Muchongwe-Mungvari (OVC Officer), Marsha Treadwell (Consultant and co-author).

Station Days is an M&E tool that can be highly effective in informing programs and policy over the short and long term. Information of consistently high quality has been obtained from the Tsungirirai Station Days. Tsungirirai staff have been exceptional at incorporating the input to create programming that most effectively addresses the needs of their beneficiaries. Tsungirirai staff are developing a training manual based on their experience and expertise so that the processes of Station Days are well documented. This training manual will allow for more effective replication and follow up evaluation at other sites. The most important aspect of Station Days is its flexibility, a wide variety of community projects could make effective use of Station Days to evaluate and adapt programming. The community contributes to the decision on which stations are included in addition to the gate and final station.

Station Days offers the opportunity for children's issues and concerns to be consistently documented and followed over time. This information can be used to address the immediate needs of individual children as well as to inform future direction of programs. Formal strategies to screen for psychological, social and behavioral distress, and overall wellbeing could be added to the Station Days model. Such screening would allow for timelier problem identification and intervention.

Tsungirirai staff advises that the most effective Station Days seamlessly integrate the community in which it is conducted. Community stakeholders including teachers, children, parents, and social welfare workers should be involved in planning from the very beginning. This will allow for the collection of information that is of most importance to the community and will insure that even if an agency like Tsungirirai or an outside funder is not available, Station Days will continue in that community.

The provision of community education could be enhanced in relation to the conduct of Station Days. Guardians and parents could participate in a separate but nearby station where they receive training in everyday strategies to support problem solving, coping and improved communication with their children. A group discussion at Station Days could focus on child rights and the ethics of supporting children and childhood. In this way, the psychosocial support provided directly to the children can be reinforced on a daily basis within their homes and communities.

Provisions of Station Days tokens should be balanced with the ability to sustain the program. Showing appreciation with material things, particularly food, is a common strategy. However, staff should not underestimate the importance of the psychosocial support that they give. Careful planning could result in a pattern in which some Station Days are conducted without tokens, but that the “gift” for participating is some sort of entertainment at the end of the day such as a play or a no-cost excursion. Each program and community should decide how often Station Days should occur to provide quality psychosocial support, inform programming and collect M&E data. The number of Station Days should not depend on access to food or tokens to be given.

While Station Days is a model for other programs, Tsungirirai faces the same challenges that other programs face. These include: protecting the health and wellbeing of parents given the costs of accessing treatment for HIV and AIDS, barriers to starting and maintaining children living with HIV on ARVs, security of food and other basic commodities, consistent programming for youth over the age of 18.

3. Mavambo Accelerated Learning Center, Mavvuku, Zimbabwe

Harare’s high density suburb of Mavvuku, located 17 km east of the city center, is unusual in its high concentration of people of Malawian, Mozambican and Zambian origin. These groups migrated to Zimbabwe to seek work, primarily in the years before independence. Mavvuku’s population of 400,000 is characterized by a high prevalence of HIV infection and difficult economic circumstances. Many children have lost their parents and live with elderly grandparents. These children often lack the funds to attend school, as well as birth registration papers that are essential to allow entry and eventual graduation from the educational system. The Mavambo Trust works with the children and families of Mavvuku to increase access to formal education. Children participate in the Mavambo Learning Centre (MLC) that is embedded within a highly developed system of care and protection including nutritional, psychosocial, health, legal and community support. Mavambo’s dedicated staff of teachers, social workers and volunteers work to ensure that their beneficiaries receive the foundation necessary to become well-adjusted, productive and socially responsible adults.



Photo credit: Mark W. Adams for CRS Zimbabwe

Mavambo Trust Fast Facts	
Year Program Commenced	2001 – Accelerated Literacy and Numeracy Education Program
Population Served	4,500 children
Number of Children Served	48 per year, more than 200 since program inception
Personnel	26 Staff, 100 Volunteers
Assistance Provided	Intensive academic instruction School Support – fees, uniforms, books, supplies Nutrition Comprehensive Psychosocial Support Community Education and Awareness Raising

Children ages 8 to 12 who have never been to school are prioritized for enrollment in the learning center’s Accelerated Literacy and Numeracy Education (ALNE) program. They are initially identified by other children or volunteers within the community and referred to the MLC. Social workers conduct a psychosocial assessment of the children and their families and followed by an assessment of the child’s reading, math and language skills conducted by a learning center teacher. The children who perform poorest on the educational assessment



Mr. Banti (above and right) hard at work with his students

are selected for entry into ALNE because they are in most need. At any given time, there are 48 children enrolled in ALNE, allowing for individualized instruction.

Children in the ALNE program are separated by approximate age into three classrooms, with 16 children per class. In the absence of birth registrations, Mavambo staff count the children’s teeth to estimate age. Eight and nine year olds are in the “green” room, 9 and 10 year olds in the “red” room, and 11 to 12 year olds are in the “yellow” room. Each class is instructed in English, Shona, and math each day. The teachers are assisted by tutors who are youth volunteers from the community.

Mavambo’s three teachers are very experienced and highly motivated. One teacher retired from the formal school system after a number of decades to teach full-time at MLC. Their teaching approach is integrative and experiential, whereby children use more than one sensory modality to learn. For example, math exercises are reinforced by counting stones or sticks. In English class, children learn prepositions by acting out sitting on their

chairs or putting their book in their bag. They summarize what they have read in Shona or English and practice telling stories about their experiences. Another important teaching principal is “going from the known to the unknown.” Every child knows

some English words on entry to the program, such as sugar, milk, bus, a starting point for the English teacher.

Yet, Mavambo’s remarkable success, where the drop out rate from the program is zero, where every child is placed in formal school and where most excel, is not just due to technique. None of the teachers see a classroom of students; instead they see each child as an individual. The children are observed to be very restless in the classroom when they begin in January, but they quickly become attentive and focused. Ms. Gibson, the English teacher, believes this is because she does not impose rules, but rather works out what the classroom rules should be with the children. In this participatory way, they have ownership of the process within their classrooms. In keeping with a broad focus on what it means to really learn, Mavambo sponsors excursions every term such as visits to the airport, to local game parks or to factories.

The Mavambo Learning Centre is much more than its ALNE program of 48 students. Current enrollees and graduates of the ALNE program who are placed in one of the 12 local primary schools are provided with hot lunches that provide them with the energy to learn. Psychosocial programming is offered each afternoon. Tutors assist MLC and other



community children with coursework and in preparing for the exams that will allow them to enter secondary school. The volunteer tutors, in turn, are assisted with employment in school uniform shops during the peak season when not tutoring, so that they gain employment as well as teaching experience. A block grant system provides the local schools with material resources in exchange for fee waivers for some students.

Psychosocial programming for Mavambo's students and other vulnerable children in the community includes life skills, games, peer counseling and HIV and AIDS education. Mavambo social workers offer special programs of drama, dance and sports on Saturdays and have conducted a week long "Who Am I?" workshop. Psychosocial programming is designed to increase critical thinking, problem solving capabilities and to boost self-esteem. Children are provided with the opportunity to find what they can excel in and to experience the freedom of creative expression. A full-time counselor is available for scheduled or drop-in appointments. Parents and guardians are brought in once monthly for group support, and for education on such topics as HIV and AIDS and children's rights. The social workers articulate the need to empower the children's caregivers as an essential element of psychosocial programming, with a focus on rights. Social workers have provided education about Zimbabwe's "National Action Plan for Orphans and Other Vulnerable Children", on the legalities of wills and the importance of inheritance planning.

Mavambo M&E activities now include the Gathering Place, an adaptation of Station Days conducted each term. Mavambo teachers, volunteers, students, parents, guardians and other community members determined the information to gathered at each station and have modified the Station Days model to meet the needs of the Mavambo programs. Information from Gathering Place has identified children in need of counseling and medical attention. Programmatically, the Gathering Place informed an increased focus on memory work, children's rights and strategies to improve nutrition within community households, such as low input gardening.

Mavambo social service staff work closely with children and families. Their first goal is to help families obtain the needed birth registration papers. Although the task is arduous, they have eventually been successful in obtaining the papers for all of the ALNE program students. Mavambo social service staff assist in the active monitoring children's school progress.



*Tabitha Gibson-
English Literacy Teacher
(Mavambo Trust-Zimbabwe)*

One key to the MLC's success is that the children know that there are adults genuinely interested in their wellbeing. Once a child has become a part of Mavambo, his academic progress and school attendance is monitored. When he begins school, he knows that the expectation is either that he is at home, at school, or at Mavambo. Strong relationships cultivated with school headmasters are a key to success. Five months after the ALNE program began, Mavambo held an open house for headmasters and has held one annually since. The headmasters now welcome MLC graduates into their schools and show a keen interest in the teaching methods used at Mavambo.

Mavambo staff are flexible, closely monitoring children's needs and adjusting programming accordingly. For example, the ALNE program was designed to be a three year program but most students complete it in 9 months. Mavambo staff initially placed children into formal educational programs throughout the academic year, but found it is best to place them only in January or May and not in the last term. M&E activities informed the need for a greater focus on basic health support. Memory work activities were also added when M&E uncovered that existing psychosocial support had not addressed children's bereavement issues as effectively as previously thought.

One of Mavambo's greatest strengths lies in the close collaborations with families and community. Social workers meet with the primary caregivers, usually *Ambuya* or grandmother, at least monthly. An annual open house is held for families in addition to being welcome to visit the social services offices at any time. Children, caregivers and other community members are actively involved in all aspects of programming including strategic planning. Mavambo community volunteers are available 24 hours per day, every day of the year. They are the "eyes and ears" in the community referring the children most in need, discouraging families who are not as much in need from attempting to access services, and following up with child rights and protection issues. Volunteers may conduct home visits when the social workers are overwhelmed. Volunteers are well-respected in the communities and proudly wear their badges or distinctive *chitenges* (traditional fabric wraps). Volunteers are provided cooking oil or ground maize when available and value the trainings and monthly refreshers.

Challenges

Obtaining birth registration is often labor intensive and expensive, as social workers attempt to track down birth registrations not only of the child but often of the deceased parents, who also may not have been registered. These problems are compounded within an immigrant population.

In a patrilineal society, cultural issues include mothers' fears of registering children without the father's permission. Maternal uncles might disapprove of registering the child within the mother's family in the father absence. To overcome these challenges, Mavambo social workers work closely with the Registration Office supervisors and educate the community about the importance of birth registration, which is free within the first 6 weeks after the birth. The social workers also give workshops on the issue at local birthing centers.

The ALNE program, while extremely successful, reaches far fewer children than could benefit from such educational opportunities. High quality and extremely committed teachers, as well as intense personal involvement with each child, appear to be key ingredients of ALNE's overwhelming success. Whether such a model can be brought to scale or replicated remains to be seen.

Opportunities

Mavambo's success student retention and placement in formal schools lends enthusiasm to program replication in other areas, given the difficult family and economic scenarios that sustain barriers to school attendance throughout Africa's southern region. Mavambo staff sought to replicate the project in Tafara, Mabvuku's next adjacent suburb that is equal to it

in size, as a next step and recognizing that a contained geographic catchment area allows for greater success in such a holistic approach. However, the intangibles that underlie Mavambo's success are more difficult to replicate. Teachers of similar commitment and caliber are essential. Mavambo's teachers have been with the program since its inception and have been willing to function as mentors, social workers, community advocates, home visitors and program evaluators as the needed.

Under the leadership of founder and project coordinator Sr. Kathleen Barbee, Mavambo staff have learned and practice working with children rather than for them. Children are well integrated into every aspect of the program, from the peer counselors, to the child care team that meets each term to review program progress.

Physically, a learning center such as Mavambo only needs a block for classrooms, a cooking area, a source of educational materials and administrative offices. It is critical to create strong community ties from the start and to make a concerted effort to link with the schools. The networks include, but are not limited to older youth in programs such as Young People We Care, zonal child protection committees, and HIV prevention committees. Mr. Gomwe and Sister Kathleen (assistant coordinator and coordinator, respectively) state "we believe in networking – alone we cannot do much."

Mavambo staff have the capacity to train others in their teaching methods. They have received funding to formalize their curriculum in a training manual. Teachers from Eastern and Southern Africa have come to observe the Mavambo's day-to-day functioning. Complementing rote learning methods with experiential learning strategies is highly innovative and effective to accelerate learning.

Mavambo's psychosocial programming is also worthy of replication. Staff perceptively state that "Psychosocial support is absolutely necessary to keep the children in school. It is not something on the side." While some might argue that Mavambo is expensive to implement, the costs of a truly individualized, holistic approach that results in effective learning and achievement, cannot be underestimated. A successful program replicating the MLC must by nature be small, individualized and geographically contained. Other programs may provide a larger number of children with school fees, but if the child is not supported and guided, interacting daily with an adult who knows his strengths and challenges, and he ends up dropping out of school, the program was not cost effective nor efficient.

Policy must focus on removing barriers to birth registration. The United Nations Convention on the Rights of the Child states that children have a right to an identity. If a destitute mother cannot get her baby registered until her hospital bills are cleared then her child's rights are fundamentally being denied. It behooves her community to advocate for change that protects the rights of its most vulnerable citizens.

4. Community Outreach Center, Marianhill, South Africa

Nestled amidst alphabet cards and children’s drawings on the wall in a front room is one committed volunteer’s certificate of congratulations for the establishment of her home as a Drop-In Center in KwaNdengenzi. The Drop-In Centers (DIC), school groups and home based support are three elements of the Community Outreach Centre (COC) serving vulnerable children in KwaNdengenzi and 12 other townships and villages near Marianhill on the East Coast of South Africa.

The COC was established in 1997 as a department of St. Mary’s Hospital Marianhill. The COC began training HBC caregivers for the care of patients with chronic illness, HIV included, in 1998. The program later expanded to include care and support of children orphaned and made vulnerable largely by AIDS in 2003 with specialized training offered to the volunteer caregivers. One of these volunteers began a psychosocial support group for school children at her church, and this gave birth to similar such groups in both primary and secondary school. Two of the children who were participants in that first group are now leaders in the school group program and were instrumental in the establishment of the Drop-In Centers in 2005. The COC has since employed them as Peer Educators and they are tasked with the facilitation of the school support groups. Thus, the COC powerfully embodies the principles of community and child participation.

Community Outreach Centre Marianhill Fast Facts	
Year Program Commenced	1997 – Department of St. Mary’s Hospital 1998 – HBC for PLHIV 2003 – Vulnerable Children Programming
Number of Children Served	1,900 467 in School Groups 146 in Drop-in Centers
Personnel	20 Staff 373 Volunteer HBC Caregivers
Assistance Provided	School support – fees, uniforms, books, supplies Food and other basic material support Stimulating activities for preschoolers Income generating activities HBC Psychosocial support
Funding support	Significant support from local businesses and donor organizations; Caritas Germany and Caritas Austria; CRS - support for Home Based Carers

No more than 25 children are assigned to any given DIC to maintain, as much as possible, a feeling of family. The DICs operate 5 days per week, beginning at 7:00 a.m. On a typical day, school-aged children bring their 3 to 5 year old siblings to the DIC on the way to school.

Both receive porridge at the center and the older child continues on to school. Play is a cornerstone of the preschooler's day in the DIC. The "mother" of the home and her two volunteer assistants have been trained in strategies to stimulate early childhood development. The children receive bread with perhaps peanut butter or margarine at tea time and have a nap. After school, the preschoolers and their older siblings who have returned from school eat a cooked lunch together at the center. Washing and brushing teeth after meals is stressed. The older children rotate doing light chores such as washing dishes and sweeping. They also receive homework supervision before returning home with their young siblings at 4:00 p.m. Presently, 35 child headed households are supported through the DICs. Other especially vulnerable children, those who have been abused or neglected, are extremely poor, or are orphans, are identified by volunteer caregivers and referred to the DICs.

The homes that will potential serve as DICs are assessed by the OVC coordinator. The home's security is of primary importance. Physically, the home can be upgraded, such as with fence repairs, however, care is taken that the home does not stand out from the homes surrounding it. COC delivers food to the home twice weekly and is kept in a locked cupboard, to ensure that it is used for the drop-in children. Refrigerators have been purchased for each DIC. The "mother" receives a small stipend, as well as assistance to pay for rent and electricity. The DIC program is relatively low cost at 6000R per DIC monthly. Further, the "mothers" and volunteers do not receiving undue financial incentives that might detract from their main focus of caring for the children.

Play is also a fundamental element of the school groups, in which children learn life lessons while having fun. Weekly, 35 to 40 children ages 13 to 18 gather at their primary or secondary school sites. The children begin a round of songs and games of their choosing. COC staff have mastered supporting the children without hampering their process. For example, the youth leaders requested funds for a play day, planned and executed an exciting program that went in a direction that the adults never envisioned. Groups from three schools gathered at one site on a Saturday and competed in debate, drama and music activities. The groups decided to invite other community children to the event, stating that they wanted to help other children in need. With the successful implementation of four play days to date, the youth have gained practice in the skills of organization, delegation and



leadership. The area coordinators note that when the youth see a need or have an idea, they have complete confidence that they can move their vision forward. They do not give up until their goal is achieved.

Each school group has names itself and group membership is a source of pride, rather than stigma, throughout the school. The children are referred for the group by their teachers, other students or volunteer caregivers based on their vulnerability. Once referred, final selection for group membership is made by the group itself. To keep the group size low, new members enter only when another leaves. Hundreds of children are waiting for a group opening. COC staff

experimented with larger groups to meet the tremendous needs, however, they found that the sense of connection felt by the children and the psychosocial support received from staff and other children suffered.

A close partnership with each school is essential to the success of the school groups. The COC is part of a broad network of community support that does what it can to meet the needs of the very poor. The volunteer caregivers and teachers exchange information to insure that the most destitute families are identified and assisted. Schools with the largest number of needy children are priorities in which to start the groups but school personnel must also demonstrate the motivation to work closely with the COC.

Communication between the schools and the COC is facilitated by a yearly “open house.” Given that the COC volunteers are members of the communities, they can “tell (the schools) things that they did not know.” They may identify children who have not been in school for a number of years or note a change in circumstance that may necessitate greater school support for the child. As much as possible, the COC connects both the school and community with information and resources, such as government assistance, rather than being a primary provider of material assistance. They also provide information, particularly in relation to the implementation of initiatives designed to protect children’s rights.

The children can count on the meal that they receive once weekly in their group and are monitored regularly by nurses from St. Mary’s with regard to growth, development and physical health. The neediest children receive 100% school support (uniforms, books, fees). The COC negotiates with other families to pay 50% of the school fees at the beginning of the year, with the expectation that the family will come up with the remainder by the end of the academic year. A goal of the COC is to foster empowerment rather than dependency.

The COC facilitator training is intensive and the necessary dedication level emphasized. The training consists of one month of instruction and 6 months of practicum, including conducting school groups. Two facilitators staff each DIC and each school group together with COC staff. The five field workers have come from the ranks of the volunteer corps, including the two former school group participants who were nominated and selected for the position by other volunteers. The field workers in turn train the volunteers and set up and monitor the DICs. The 120 OVC volunteer facilitators receive a small stipend for travel. The drop out rate for nearly 400 volunteers is virtually non-existent, with the exception of volunteers who have gone on to higher education or employment opportunities. The volunteers have a high standing in the community and recognize the opportunities that the comprehensive training affords. They are proud



A Dream Team for Kids

A caring health worker- Ms Frida Mncwabe, a committed mentor – Mr. Michael Teufel (OVC coordinator) and a Principal with high expectations - Ms. Majola (Dassenboek High School)

to display their certificates and wear the tee shirts that identify them to community members. They receive a small gift of food or toiletries at the end of the year. Interdependency among staff and volunteers is crucial because the small, funded staff cannot see all program beneficiaries. The volunteers are skilled at assessing needs and making appropriate social welfare, paralegal or health referrals.

Many checks and balances are in place to ensure child protection and program quality. Volunteers meet monthly to share issues, problems and concerns and to receive ongoing support and education from the facilitators. The facilitators are appointed into their positions for one year and must perform satisfactorily in order to continue. They have been carefully selected by the community and COC staff and receive routine monitoring. The OVC coordinator calls on each DIC once weekly and the facilitators visit the DICs even more often. If problems with a DIC or a child in the DIC arise, the coordinator or facilitators will visit as frequently as needed to provide support. Child-headed households must be visited once per month. Random site visits are done by the coordinator and facilitators in the community at which they ask the beneficiaries about the support they receive from the volunteers.

Challenges

The volunteers know all of their clients by name and know the details of their lives. They are there to serve the people who are not just statistics to them. The volunteers are well versed on the ins and outs of the grant and social welfare systems, however, they can only provide linkages to the system, as the government requires that only governmental staff do actual investigations to determine the extent of needed services which can prolong the process.

Staff safety and the threat of violence challenge the program. This area, like many areas of South Africa, experience high rates of crime and gun related violence. While this program is able to be community-owned and community-based, the threat of violence remains a concern.

Opportunities

The COC staff articulate that their goal is for older children from the school groups to lead the younger groups. The younger groups are still adult-led although with a strong child participation focus. Staff note that their experiences have strengthened their ability to support child and community participation. However, volunteers and staff from other programs, particularly those with more traditional views, may be more challenged to embrace the fundamentals of child participation. COC staff identify the need to provide intensive training on this issue as their program expands. Similarly, the focus on play does not always come naturally to some of the “mothers” who may more easily grasp the importance of feeding the children in their care.

Maintaining transparency can be challenging but is essential to preserving community relations. COC staff take care to increase give-aways if they receive anything extra from donors, but sometimes have to also be careful to demonstrate that one DIC did not get more than another.

The COC staff have identified unmet needs related to programming for older children and for very young heads of households. They may be 19 or 20 years old, but were children

when they began caring for their siblings. They may have gaps in their education that the system, where age is tied to grade level, does not have the flexibility to meet. The policy that the schools must now take in all children, regardless of their ability to pay the fees, is not realistic as the schools become overburdened. The COC's partnership with the schools is critical whereby they are able to provide some help with fees, uniforms, and books. However, increased funding to meet the educational needs of children of all ages is sorely needed as are income generating activities. Another major need is food security that could be addressed in part by the resources to create more high-yield gardens in the community.

The COC staff aren't afraid of making mistakes and energetically pursue creative solutions as challenges arise. They note, for example, that the DICs are so cost effective that an individual donor or small business could sustain the funding for one center. A campaign to link donors with the community surrounding Marianhill could result in more safe and secure places to send their young children during the day, freeing PLHIV to focus on their own health or income generation. More DICs would support the children in their important task of playing, and thereby thriving.



Fresh vegetables for the children's meals are cultivated adjacent to the drop in center.

Chapter

7

“No matter how long the night, the day is sure to come”

Congolese Proverb

Conclusions and Recommendations

Conducting this good practices exercise has allowed the chance to step back from the day to day work to reflect on the current strengths and limitations in programs for vulnerable children. It has provided an opportunity to be inspired by the creative and innovative work that is being done by many of our imaginative and resourceful CRS partners in southern Africa. Often such creativity occurs despite limited resources, new challenges and increasing numbers of children presenting with vulnerabilities and unmet basic needs.

As has been shown through this exercise, many individuals and organizations rise to the challenges they face and are able to provide high quality responses to improve children’s chances of emerging as functional, capable and caring adults. This time of reflection has shown that many people embrace the guiding principles of programming for children, from prioritizing child participation to ensuring that children’s obvious and less obvious psychosocial needs are met. A number of common themes were noted amongst the identified good practices, shown below.

Aspects of Good Practices in OVC Programs

- ✓ Community-based
- ✓ Community Owned
- ✓ Well-trained, valued and recognized volunteers
- ✓ Child participation expected and encouraged
- ✓ High expectations for all children
- ✓ Willingness to make mistakes and learn from them
- ✓ Flexibility and adaptability
- ✓ Responsive to changing needs of children as they grow and develop
- ✓ Strong M&E systems which are up-to-date and are “user friendly”

Overall Program Recommendations

1. **Encourage broad participation by adults and children**--Regardless of how an assessment is conducted, information about children's needs should be gathered from more than one source: from the children, from parents, from teachers, etc. When assessing need and designing programs, the voices of children, including highly vulnerable children, need to be included.
2. **Community ownership**--A community based model responds to the needs of vulnerable children, encourages community ownership and enhances sustainability. By being community based, community assets are exploited to their full potential. Each of the good practices discussed in this paper are entrenched in and owned by communities and benefit largely from the existing assets which already exist there.
3. **Basic training for working with children**--A common understanding of the fundamental role of childhood, child rights and basic child development are critical to good programs and should not be assumed. Basic education and training on these should be a standard part of any OVC program. Teachers, parents and volunteers can be trained to recognize and respond supportively when children show warning signs, such as becoming withdrawn, disruptive, or when academic performance declines. Basic training can help to increase the chance that children who are compromised do not go unnoticed and receive the care and attention they need.
4. **Do No Harm**--As discussed throughout the paper, the best interests of each child should guide our actions. For example, we recommend the targeting of beneficiaries to be based on need and not on potentially stigmatizing labels such as children orphaned by AIDS or living with HIV. Multidimensional targeting criteria, with an emphasis on reaching the most vulnerable regardless of HIV or orphan status is encouraged.
5. **Ensure a holistic response**--Community based child care programs that provide food, access to health care, and a safe place to learn and play are critical to the development of vulnerable children. Such programs should also include play, art, music, cultural and sports activities that allow vulnerable children to integrate socially and to experience healthy childhood, as resources permit. These programs are best run by trained and consistent caregivers who children can come to know and trust. All of the programs reviewed here showed a deep appreciation for individual children and the need to look at a child holistically and not simply as a beneficiary of specific inputs. All people interviewed were passionate about protecting children and childhood.
6. **Encourage routine, child friendly monitoring**--Programs should be routinely monitored and periodically evaluated. Using standardized measurements improves the comparability of results across sites. Rigorous analysis informs policy better than impressions and anecdotal information and is worth the time and cost. The Station Days is an excellent monitoring tool which allows projects to identify unmet needs, monitor for higher level indicators, including outcomes and possibly impacts. The development of a training manual and scale up of the Station Days methodology is encouraged.

7. **Engage with National Action Plans for Orphaned and Vulnerable Children--** Programs for vulnerable children should be guided by national action plans for children and the global strategic framework (2004) that builds on the United Nations Convention on the Rights of the Child (1990).
8. **Foster learning and sharing of best practices--**This document is an early effort at documenting and sharing good practices and encouraging learning amongst partner organizations working with children. The program is encouraging this amongst local partners as well as regionally in sub-Saharan Africa through cross visits and success stories. When people can share what has worked well for them with others, it is motivating to all involved and promotes improved programs using approaches which have proven results. It is hoped that such efforts, as documented here, will continue and expand the knowledge base of successful programs for vulnerable children.

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APPENDICES

Appendix A: Impact of Events Scale

Appendix A⁵ Impact of Events Scale	
Intrusive	Avoidance
I thought about it when I didn't mean to.	I avoided letting myself get upset when I thought about it or was reminded of it.
I had trouble falling asleep or staying asleep, because of pictures or thoughts about it that came into my mind.	I tried to remove it from memory.
I had waves of strong feelings about it.	I stayed away from reminders of it.
I had dreams about it.	I felt as if it hadn't happened or wasn't real.
Pictures of it popped into my mind.	I tried not to talk about it.
Other things kept making me think about it.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.
Any reminder brought back feelings about it.	I tried not to think about it.
	My feelings about it were kind of numb.

⁵ Cluver L, Gardner F. The psychological wellbeing of children orphaned by AIDS in Cape Town, South Africa. *Annals of General Psychiatry*. 2006 Jul, 5:8.

Appendix B: Good Practices Scoring Matrix

APPENDIX A

STEP 1: Each practice is categorized into one of the three levels of good practice.

STEP 2: Each practice once categorized, is rated using the definition in *italics* by means of a 5 point scale: 1(not at all/no demonstration) 2 (a little/minimal demonstration) 3 (somewhat/some demonstration) 4 (good/much demonstration) 5 (excellent/a great deal of demonstration)

Levels of Good Practice

Level One: Innovative Practice

1 2 3 4 5

A novel practice which shows promise to improve OVC programming such as a new approach, method or device.

or

Level Two: Successfully Demonstrated Practice

1 2 3 4 5

A practice which has demonstrated a concrete positive result through formal review or preliminary findings (e.g. OVC targeting criteria)

or

Level Three: Replicated Good Practice

1 2 3 4 5

A practice which has been successfully demonstrated and expanded to other projects, partners or countries.

STEP 2: Each good practice is then rated on the following criteria using the same five point scale defined above:

Sustainability- A practice which meets an immediate need of OVC while also demonstrating that it can continue as a practice without external support 1 2 3 4 5

Efficiency- The estimated cost, in time or money, corresponds well with the results of the practice 1 2 3 4 5

Ethics- A practice which in addition to doing good, has also shown it acknowledges and limits the possibility of inadvertently doing harm 1 2 3 4 5

Partnership- A practice which demonstrates a shared vision as well as strong cooperation between partners 1 2 3 4 5

Assets- A practice which incorporates the assets (social, human, natural, physical, financial and/or political), of communities or improves such community assets. 1 2 3 4 5

Structures/Processes- A practice which addresses the structures (e.g. political, economic, social) or processes (policies) 1 2 3 4 5



Every child deserves a childhood



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