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PEPFAR HKID PORTFOLIO REVIEW CHILDREN IN THE HIV/AIDS EPIDEMIC

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
ARV	Antiretrovirals
AU	African Union
CBO	Community-based organization
CBCC	Community-based child care center
CDC	Center for Disease Control (U.S.)
COP	Country Operational Plan
CPC	Child Protection in Crises
CCT	Conditional cash transfer
DCOF	Displaced Children and Orphan's Fund
DFID	Department for International Development (U.K.)
DHS	Demographic and Health Survey
DSW	Department of Social Welfare, Swaziland and Tanzania
ECD	Early childhood development
FBO	Faith-based organization
FY	Financial year
GBV	Gender-based violence
GDP	Gross domestic product
GHI	Global Health Initiative
GH Tech	Global Health Technical Assistance Project
HES	Household economic strengthening
HIV	Human immunodeficiency virus
HKID	PEFPAR budget code for funding to programs supporting orphans and vulnerable children affected by HIV/AIDS
HRIS	Human resource information system
HRSA	Health Resources and Services Administration (US Dept of Health and Human Services)
HSS	Health systems strengthening
IATT	Inter-agency Task Team
ILO	International Labor Organization
INGO	International non-governmental organization
JLI	Joint Learning Initiative
M&E	Monitoring and evaluation

MICS	Multiple Indicator Cluster Survey
MVC	Most vulnerable children
MVCC	Most Vulnerable Children Committee
NACCW	National Association of Child Care Workers
NCPA	National Costed Plan of Action, Tanzania
NGO	Non-governmental organization
NIH	National Institutes of Health
NICHD	National Institute of Child Health & Human Development
NIMH	National Institute of Mental Health
NPA	National Plans of Action
OGAC	Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS (USAID)
OVC	Orphans and vulnerable children
PC3	Positive Change: Children, Care, and Communities Project
PEPFAR	President's Emergency Plan for AIDS Relief
PMO-RALG	Prime Minister's Office— Regional Administration and Local Government, Tanzania
PMTCT	Prevention of mother-to-child transmission
PSS	Psycho-social support
QDDR	Quadrennial Diplomacy & Development Review
QI	Quality improvement
RFA	Request for application
SAHDC	Southern African Human Development Coalition
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	U.S. Government

PREAMBLE

PEPFAR is playing a critical leading role in responding to children affected by AIDS and is the single largest source of support for children affected by HIV and AIDS in the world. With a cumulative disbursement of close to \$2 billion since 2004, PEPFAR funding is estimated to be six times the allocation of the Global Fund to Fight AIDS, Tuberculosis and Malaria for orphans and vulnerable children over the same time period.

PEPFAR is positioned to provide leadership for a concerted focus on children in the HIV/AIDS epidemic.

PEPFAR is also positioned to harvest the capacity and penetration achieved by two decades of community effort to care for and support children affected by HIV and AIDS.

As such, PEPFAR has the capacity and is obliged to provide global leadership to this field in two areas:

FOCUS ON CHILDREN IN THE HIV/AIDS EPIDEMIC

PEPFAR must ensure a concerted and continuing focus on children in the HIV/AIDS epidemic. Since the start of the epidemic, two to three generations of adults and children have been infected and affected by HIV and AIDS. The risk of HIV, and vulnerability to the impacts of the disease, operate across the lifecycle. Children and youth offer unique opportunities for intervention, as is currently done through the global effort to ensure HIV-free survival for children. By improving the protection of children and youth across all aspects of the epidemic—from prevention, on through treatment and care support— infections can be halted, treatment ensured, and impacts attenuated.

HARVEST AND USE THE GROUNDSWELL OF SUPPORT BY FAMILIES AND COMMUNITIES

Over the last 30 years, a unique groundswell of support has emerged from families and communities to protect and support children affected by HIV and AIDS. Children constitute a profound motivation to act against the epidemic at the community level. Millions of relatives, friends, and neighbors— men and women, young and old— have offered their love, home, time, and financial resources to look after affected children.

With the funding and technical support of PEPFAR and others, this groundswell has developed into massive capacity, with widespread and deep community penetration by community-based organizations. Both this capacity and the motivation to care for and protect children can be used to advance along all fronts of the epidemic— knowledge of HIV status, the prevention of vertical transmission and HIV prevention among young people, and expanded treatment and care and support for families.

Paradigm Shift toward Systemic Outcomes

The order of magnitude of PEPFAR funds available at country level propels the various PEPFAR agencies into leadership roles. PEPFAR is able to leverage partners, interest, funds, and energy to do more for children. It is the opinion of the review team that given its size, strength,

experience, and expertise, PEPFAR can and should provide leadership by setting strategic focus, addressing the critical issues in a systemic manner, providing an evidence base for practice, scaling up sound practices, and maintaining an operational research agenda to guide future developments.

EXECUTIVE SUMMARY

INTRODUCTION

The 10% budgetary earmark in PEPFAR, at approximately \$350 million per annum, is the largest single allocation for orphans and vulnerable children (OVCs) from any funding source. The Office of the Global AIDS Coordinator (OGAC) has requested an external review of the results and progress to date. Specifically, the team was tasked to:

- Assess the strengths and weakness of current strategies and approaches as defined at headquarters and implemented in the field with respect to children in the epidemic
- Recommend strategies and priorities for the future direction of the PEPFAR HKID portfolio (see Appendices A and B. Scope of Work and Methodology)

The focus of the review is thus forward-looking, rather than a detailed assessment of program practice or results to date. The main body of the report is kept as short as possible, with evidence and examples provided in the appendices. Each section looks at the strengths of the current portfolio through its achievements. Perceived weaknesses are addressed in the discussion of opportunities and in the recommendations.

SUMMARY OF FINDINGS

PEPFAR is Making a Unique Contribution to the Response to Children

The PEPFAR HKID Portfolio has enabled the current breadth and depth of the response to children in the epidemic by virtue of:

- The magnitude of the financing provided by PEPFAR
- The institutional and organizational capacity that has been developed at all levels— from headquarters through to communities that have been sensitized to respond to children affected by HIV and AIDS
- The human resource deployment and development at an international, national, and local level, ranging from highly skilled professionals, to local government officials, to the colossal numbers of volunteers providing care and support to children

Greater Benefits for Children and Families Will Be Achieved by More Focus and by More Efficient Mechanisms for Delivering Services and Support

- The very substantial resources of PEPFAR must be focused in areas where evidence for impact has been established and where scale-up is feasible. These areas are early child development, keeping children and young people in school, and family strengthening through social benefits and services, and other inputs.¹
- The concept that a project must provide all seven services— or even three or five of them— to a child in order to be comprehensive and of good quality is somewhat misguided. A child in a stable family receives many of these “services” at home and at school, through clinics and churches, and via other social networks.
- Providing resources closer to children, families, and communities, and focusing these resources on the support systems around children (from families to policies), will help

¹ As defined by OGAC, the 6 + 1 services are food and nutrition; shelter and care; protection; health; psychosocial support; and education, and economic and family strengthening.

reduce the current disparity between the amount of funds allocated to intermediaries and the modest benefits reaped by children and families on the ground.

- There is a continuum of service provision from the current delivery of material and other benefits to children by local community-based organizations (CBOs) and non-governmental organizations (NGOs) to the implementation of government-led systems in collaboration with civil society.
- PEPFAR funding should reflect the needed complementarity between government and civil society, each with comparative advantages and distinct but important roles and responsibilities. Governments have political and legal authority, can operate at scale, are able to make provisions that solve systemic problems, and can provide infrastructure and essential services. Civil society often carries moral authority, especially among the most affected and disadvantaged groups; it can also move quickly and flexibly, and is able to address the unique problems of individual people.

Forward Movement is Already Evident: Building on Strengths

While the move from an emergency-style to a sustainable development program has already begun, much more action is needed to continue this shift. Signs of forward movement include the following:

- Increased partnering with local NGOs in line with the USAID Forward initiative and the strategy for PEPFAR's second phase
- Increased technical assistance for governments at the national and subnational levels to coordinate the response to children in the epidemic through appropriate legislation, standards, financing, and workforce development and deployment
- A focus on outcomes in quality improvement initiatives
- A call from the field for more implementation research to provide evidence and guidance to ensure the most effective responses
- Increased interest in and funding for a variety of forms of economic strengthening for families to enable them to care for and support their own children

The External Portfolio Review team noted a number of successful models for providing economic support to households, including village- and community-based savings and loans, health insurance cards for families, school block grants to reduce the burden of school fees, agricultural interventions (linked to early childhood development, nutrition interventions), and skills training for caregivers and young people.

These changes— which can galvanize key, systemic change and result in major improvements in the well-being of children— are already under way and are propelling the current portfolio forward. At the same time, PEPFAR must move swiftly to address those issues that are holding the program back from achieving its full potential.

Incentives Must Work to Achieve Desired Goals: Addressing Weaknesses

It is the opinion of the Review Team that weaknesses in the program stem in large part from unintended incentives that counter sustainable, positive outcomes for children. These perverse incentives need to be addressed to achieve a more sustainable and systematic approach that helps strengthen families, local civil societies, and all levels of government.

Incentives around Targets, Indicators, and Definitions

- The high targets set and agreed upon by implementing partners have created an incentive for partners to focus on delivering less expensive goods and services to individual children in order to meet targets and accurately monitor the number of children reached.
- Similarly, partners have little incentive to stop serving a child, or get them “off the list,” as this would bring their numbers down.
- Partners have had little incentive to work with older children. Due to the definition of a child as 0-17, partners have not addressed the needs of adolescents close to the limit, as they would not be counted toward a target after the cut-off age.
- There has been inadequate incentive to work with families, as partners are unclear on how to count the children served; at the same time, strengthening families is a key PEPFAR OVC Guidance point
- With the dropping of “caregivers trained” from the new generation of indicators, there is possibly even less incentive for programs to try to reach primary caregivers.
- There has been little incentive to wrap around and integrate services, given that the issue of double counting could affect reaching targets.
- Partners have had little incentive to focus on systems or capacity building beyond the minimum needed to deliver a service and account for it.

Incentives to Partner for Sustainability

Large amounts of money are needed to fund the current tier/cascade model of service delivery in which resources are passed from international NGOs (INGOs) out of country, to in-country NGOs, to local NGOs, to local community-based groups, and eventually to recipient children and families.

- INGOs should be incentivized to build the capacity of local institutions and communities, leading to demand-driven technical assistance.
- Partners need an incentive to share their materials, best practices, and innovations within a competitive bidding process.

Incentives to Focus on Services

The 6 + 1 services outlined in the OVC Guidance 2006 introduced implementers and partners to the holistic and multisectoral nature of care for children. However, it also created an impression that organizations should address all the needs of children themselves or through referrals:

- Partners were incentivized to over-extend themselves beyond their areas of expertise to offer an extra service and count a child as a primary direct beneficiary. This indicator has changed but the mentality remains, along with a fear of non-compliance due to the fact that the Guidance has not been revised.
- Programs were incentivized to offer the most affordable service rather than the most needed. Most reviews show psycho-social support (PSS) to be the least costly and more frequently provided option.
- Partners have little incentive to focus on the quality and impact of the services they delivered or to prioritize needs.
- Partners were incentivized to bypass families and parents to ensure that an identifiable child who had received a service could later be tracked and counted.

KEY RECOMMENDATIONS

Leadership

- Provide leadership for a concerted focus on children in the HIV/AIDS epidemic and to capitalize on the capacity and penetration achieved by two decades of community efforts to care for and support children affected by HIV and AIDS

Sustainability

- Prioritize strengthening family capacity as the primary means of supporting children
- Strengthen government systems for policy, financing, and regulations that enable national and subnational systems of care and that, in turn, underpin the contribution of civil society.
- Continue to shift support away:
 - From assisting individual children to empowering families to care for and protect children in a sustainable way
 - From providing emergency commodities to assisting national partners in providing constitutive benefits such as education, protection, and health
 - From mitigation of adverse effects of exposure to the prevention of vulnerability
- Continue to build capacity in and use community networks to:
 - Play their complementary roles with government and others in supporting prevention, treatment, care and support for children
 - To take on more of the financial, training, technical and monitoring functions currently performed by INGOs (once capacity is confirmed)
 - To free up financial resources for use at the community and family level
 - To increase advocacy and accountability

Country Leadership

It is the Review Team's observation that there is an urgent need to brief and sensitize country programs, missions, implementing partners, and everyone within the ambit of the PEPFAR program on the five-year strategy. It is evident from responses at country level that there is little understanding of the new five-year vision, particularly in the area of country ownership.

Provide technical assistance to help governments fulfill their obligation to citizens through the following actions:

- Implement broad social policy initiatives that improve care and protection of children in the epidemic on a national level and contribute to both the prevention and mitigation of HIV and AIDS, including:
 - Free or subsidized schooling
 - Free or subsidized health care for children
 - Child protection
 - Social benefits and social services
- Promote country-specific workforce development in support of children in the epidemic

Integration

Integrate and coordinate the “HKID Portfolio” with:

- U.S. Government HIV/AIDS programs (prevention, prevention of mother-to-child transmission, treatment, care and support, gender)
- Other U.S. Government-funded initiatives (Global Health Initiative, Feed the Future)
- Key gender initiatives
- Country-level HIV/AIDS programs
- Broader health and development initiatives, social benefits, etc.
- Business coalitions and other private-public partnerships
- UN agencies, multilaterals, and the Global Fund to Fight AIDS, Tuberculosis and Malaria

Knowledge and Evidence Base

Improve the knowledge base for the provision of effective care and support for children in the HIV/AIDS epidemic.

- Expand scientifically based intervention research
- Include child development expertise in the PEPFAR scientific advisory board
- Step up investment in rigorous evaluations of overall effectiveness and cost-effectiveness

Strategic and Technical Direction— Muscle behind the Message

These recommendations are aimed at U.S. Government Agency Headquarters:

- Ensure the HKID portfolio has proportional levels of staff to budget, and staff to support contracts or agreements, at the headquarters and country level, to provide adequate technical support and quality assurance.
- Increase technical and management capacity, including staffing levels at headquarters, regionally, and in country, in proportion to the size of the HKID allocation and the importance of issues affecting children and families in the HIV/AIDS epidemic.
- Ensure country-level capacity in U.S. Government country teams and in host governments “to know their epidemic, know their country, and know their children” so that they can customize local interventions and focus on “hot spots.” This would entail using existing local data from sources such as national demographic and health surveys, household income and expenditure surveys, and national HIV strategic frameworks for planning and impact monitoring purposes.
- Update the 2006 Guidance to take into account the goals of the second phase of PEPFAR, the Global Health Initiative, and the paradigm shift required to address children in the epidemic. This will help give clear and unambiguous direction to countries on issues related to targeting, provision of family-centered services, systems strengthening, and social protection. It will also ensure that children in families benefitting from U.S. Government support can be counted.
- Develop and disseminate a robust method for counting children benefiting from various forms of systems strengthening to encourage greater investment in this area.
- Establish a cross-cutting Technical Working Group on children at headquarters, with representation from all relevant technical areas, including pediatrics and prevention, to promote the integration of issues relating to children at risk and those affected by HIV/AIDS throughout the work of PEPFAR and its implementing partners.

- Change the terminology from “orphans and vulnerable children” to *children in the HIV/AIDS epidemic* to promote integration across prevention, treatment, care, and support and to respond to the wider ambit of the re-authorization²

Focus: Do More of What Works

Consistent with the goals of the Global Health Initiative, PEPFAR should “do more of what works” to create the momentum for greater impact and coverage. Areas where the evidence of impact is strong, and scale is feasible, are: early childhood development, keeping children in school for as long as possible, and strengthening families. These can be implemented through multiple strategies that include the following:

- Using community networks more efficiently and comprehensively
- Supporting workforce development for quality and sustainability
- Assisting host governments in strengthening social service and child protection systems
- Integrating with government plans, other U.S. Government initiatives, development partners, and the private and philanthropic sectors
- Promoting evidence-led implementation

² Tom Lantos and Henry J. Hyde. “Orphans and Children Who Are Vulnerable to, or Affected by, HIV/AIDS.” United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

I. INTRODUCTION

At approximately \$350 million per annum, the 10% budgetary earmark in the President's Emergency Plan for AIDS Relief (PEPFAR) is the largest single allocation for orphans and vulnerable children from any funding source. For the first time in the history of the HIV/AIDS epidemic, a substantial sum of money provided a material demonstration of the world's commitment to the well-being of children affected by the HIV/AIDS epidemic, leading the way for other bilateral and multilateral investments to assist these children.

Through its partner agencies— USAID, State, Peace Corps, Centers for Disease Control, Health Resources and Services Administration, Defense, and Labor— PEPFAR has disbursed close to U.S. \$2 billion for HIV/AIDS-affected children in 26 countries since 2004. This amount is over and above support to the Global Fund to Fight AIDS, Tuberculosis and Malaria, to which the United States is the single largest contributor; it is also in addition to U.S. Government funding for prevention of mother-to-child transmission (PMTCT), pediatric HIV treatment, treatment for adults (many of whom are parents), and HIV prevention for young people, all of which also benefits children.

THE OPPORTUNE MOMENT

The Office of the Global AIDS Coordinator (OGAC) has requested an external review of the results and progress to date under PEPFAR in responding to children affected by AIDS, including strategic recommendations, to ensure a state-of-the-art response to children in the epidemic.

The review comes at an opportune moment— mid-way into the implementation of the Reauthorization Act of 2008,³ which granted \$48 billion for efforts to fight HIV/AIDS, TB, and malaria globally from 2009 to 2013. The Act also secured the 10% budgetary requirement for care and support for “children affected by, and made vulnerable to, HIV and AIDS.” This earmark recognizes that the vulnerability of children and youth is both a consequence and a driver of the epidemic.

PEPFAR AND GLOBAL HEALTH INITIATIVE

In the context of expanded treatment, prevention (including PMTCT), care, and support, the second phase of PEPFAR aims to move from an emergency to a sustainable response. PEPFAR is the largest part of the Global Health Initiative (GHI), which was launched in 2009.⁴ GHI aims to foster sustainable effective, efficient, country-led public health programs that deliver essential health care.

PEPFAR aligns itself with GHI through:

- Ensuring a woman- and girl-centered approach to health and gender equity
- Increasing impact by strategic integration and coordination
- Strengthening and leveraging key multilateral institutions
- Encouraging country ownership
- Building sustainability through health systems strengthening

³ Tom Lantos and Henry J. Hyde. *United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria*.

⁴ <http://www.ghi.gov/>

- Improving metrics, monitoring, and evaluation
- Promoting research, development, and innovation

Under the GHI, PEPFAR aims to:

- Support the prevention of more than 12 million new HIV infections
- Provide direct support for more than 4 million people on treatment
- Provide care and support for more than 12 million people, including 5 million orphans and vulnerable children

Additional targets for GHI across assisted countries include: reducing under-5 mortality rates by 35%; lowering child under-nutrition by 30% across insecure countries in conjunction with the President’s Feed the Future Initiative; and reducing to 20% the number of first births by women under 18. A focus on vulnerable children and their families under PEPFAR will help contribute to these targets.

EXTERNAL PORTFOLIO REVIEW

The key question addressed in the review is whether the HKID Portfolio is maximizing its opportunity to make a difference in the lives of orphans and vulnerable children and their families and communities. The team was tasked to:

- Assess the strengths and weakness of current strategies and approaches, as defined at headquarters and as implemented in the field with respect to children in the epidemic
- Recommend strategies and priorities for the future direction of the PEPFAR HKID portfolio (see Appendices A and B. Scope of Work and Methodology)

The focus of the review is forward-looking rather than a detailed assessment of results to date. The main body of the report is kept as short as possible, with evidence and examples provided in the appendices.

The review considers how the HKID Portfolio is responding to PEPFAR II and GHI goals, as well as current approaches to the three main objectives for children in PEPFAR’s Five Year Strategy:⁵

- Building national systems of care
- Strengthening the capacity of families and communities to care for vulnerable children
- “Developing and targeting need-based OVC responses that are sensitive to the diversity of sub-populations within the larger OVC population”
- For coherence, the review was structured around the PEPFAR Five-Year Strategic Goals:
 - Transition from an emergency response to promotion of sustainable country programs
 - Strengthening of partner governments’ capacity to lead the response to the epidemic
 - Expansion of prevention, care, and treatment in both concentrated and generalized epidemics
 - Integration and coordination of HIV/AIDS programs with broader health and development programs to maximize benefit
 - Investment in innovation and operations research to evaluate impact, improve service delivery, and maximize outcomes⁶

⁵ Appendix: PEPFAR Prevention, Care, and Treatment.

⁶ The U.S. President’s Emergency Plan for AIDS Relief, Five Year Strategy, p. 6.

II. TRANSITION FROM AN EMERGENCY RESPONSE TO THE PROMOTION OF SUSTAINABLE COUNTRY PROGRAMS

RECOMMENDATIONS

- Prioritize strengthening families as the primary means of supporting children affected by and vulnerable to HIV and AIDS through household economic strengthening, social protection, and social services.
- Strengthen government systems for policy, finance, and regulation to support sustained national programs. This will underpin and help maximize the contribution of civil society.
- Continue to build capacity in and use community organizations and networks to:
 - Play their complementary roles with government and others in supporting HIV/AIDS prevention, treatment, and care and support.
 - Increase advocacy and accountability.
 - Take on more of the financial, training, technical, and monitoring functions currently performed by international nongovernmental organizations (INGOs). This will help free up additional financial resources for use at the community and family level.

ACHIEVEMENTS

The change from an emergency to a sustainable development approach has begun. This is evident from meetings with U.S. Government teams as well as with implementing partners and government officials at the country level. There are robust discussions around the issues of sustainable quality programs and country ownership.

- PEPFAR implementing partners have reached close to 3.6 million children affected by HIV/AIDS, up from 630,200 in 2004. These children received at least one of the following 6 + 1 services, as defined by OGAC: food and nutrition; shelter and care; protection; health; psycho-social support (PSS); education; or economic and family strengthening. Increasingly, families and households were reached with economic strengthening interventions. PEPFAR is one of few global initiatives with this level of systematic investment in the protection, care, and support of children.
- A huge number of international and local non-governmental organizations, community-based organizations, and local institutions including schools, committees, churches, and traditional authorities have been enabled to identify, assist, and refer children and families affected by the HIV/AIDS epidemic. NGOs and CBOs report increased management, financial, governance, and monitoring and reporting skills as a result of capacity development provided by PEPFAR prime and subpartners. PEPFAR partners are enlisting more local NGOs both as subpartners and as prime partners.
- Capacity development of local NGOs and CBOs and strengthening of country health and social systems are key strategies for sustainability. Capacity building for NGOs/CBOs in organizational development and technical training has increased community engagement in health and social care, child protection, advocacy, and health promotion and health literacy. Partnerships with governments to strengthen and improve social and health services have helped expand access to services for children. Such strategies enable large numbers of children to be reached while simultaneously building up safety nets for families and children.

Although there is no aggregated figure of the number of community organizations that have received capacity-building support as sub-subgrantees of PEPFAR-funded projects, the illustrative examples provided below from actual programs illustrate this achievement:

- In South Africa, over 1,000 sites are engaged with PEPFAR-funded activities in support of children
- In Ethiopia, more than 500 local institutions have been supported in offering services to children and families through the Positive Change: Children, Care, and Communities (PC3) Project
- In Namibia, one prime partner, a local faith-based organization (FBO), funds close to 90 congregations and community projects

Voices from the Field:

“In terms of capacity building, our program has gone from 0-60% in five years” (local FBO leader in Tanzania).

“There was a great paradigm shift, from ‘distributing commodities’ to understanding social work practices and moving towards social work programs, which includes as a foundation identifying children and family needs and assets, and providing services based on needs.”

OPPORTUNITIES

The second phase of PEPFAR has shown the potential to shift:

- From assisting individual children, to empowering families to care for and protect children
- From providing emergency commodities, to assisting national partners in providing constitutive benefits such as education, protection, and health
- From mitigation of the effects of exposure, to the prevention of vulnerability

Local and International NGOs

There are challenges to sustaining the current prototypical U.S. Government partner program. The partner agency may have anywhere from 1 to 20 prime international or local NGO partners, each of which could have 1-40 subpartners. These, in turn, may have multiple sub-subpartners or community sites where they operate.

The dominance of INGOs—initially needed to provide accountable funding conduits and technical assistance for service delivery in the emergency response—will wane as local capacity for direct service delivery increases and systems for inclusive education, health, and protection evolve.

Contracts and agreements with INGOs require performance criteria to ensure they play a balanced role in a sustainable, country-led response. Such a response has to be based on strong existing or emerging local civil society organizations and community networks that are increasingly capable and have relationships with local and district government.

Providing resources closer to children and families and for the support systems that surround children will help reduce the current disparity between the funds allocated to intermediaries and the modest benefits received by children and families on the ground. This disconnect is clearly noticeable when conducting field visits in rural and poverty-stricken communities. More strategic partnerships with the local business sector, which we have reason to believe has unrealized potential, are also needed to ensure successful continuation of programs.

Moving forward requires the pendulum to swing from an elaborate and, at times, inefficient INGO structure that both supports local capacity and delivers services, to one in which local community networks are properly resourced and used.

This shift should be gradual and the U.S. Government will need to staff up to accommodate the possible added management burden. There are alternative management models— such as the civil society fund approach in Uganda and the umbrella grant management model in South Africa— which could be further developed and explored.

Government and Civil Society

PEPFAR funding should reflect the complementarity between government and civil society, each with its comparative advantages and distinct but important roles and responsibilities. Governments have political and legal authority, can operate at scale, are able to take steps to solve systemic problems, and can provide infrastructure and essential services. Civil society has moral authority, especially among the most marginalized populations, can move quickly and flexibly, and are able to address the unique problems of individual people. There are examples in sub-Saharan Africa of vibrant and symbiotic relationships between government and civil society. For example, in South Africa, government has an emerging system for paying local CBOs to provide services to children and families.

Quality government services need to form the warp through which vibrant civil society initiatives can be woven to ensure that resources reach vulnerable families and communities.

Communities and Families⁷

Stable, strong families are the best providers of care for children over time. Strengthening families is essential for children’s development and wellbeing; the protection of children from suffering, disadvantage, abuse, and isolation; and the preservation of human and family capital. Stable families also play an essential part in HIV prevention into the next generation. Yet some programs continue to bypass parents or marginalize them by delivering material goods and services, including psycho-social interventions, directly to children, rather than through the family network.

Strengthening families involves four major sets of actions.

- Putting families at the centre— recognizing and acknowledging the importance of families in the lives of children in all policies, programs, and services.
- Ensuring through economic strengthening and other measures that families have sufficient resources to provide adequate care for children.
- Assisting families in accessing services that enable children to thrive and have opportunities to realize their human potential.
- Providing supportive services for children’s care in ways that sustain and reinforce family relationships and mutual commitments to build long-term, sustainable protection for children. In this way, parents feel empowered and children are grateful to parents, not to NGOs, for the help they receive.

There is insufficient recognition of the role played by parents, intimate caregivers, and other family members, or the value of assisting families in supporting children. Interventions to ensure psycho-social support for children should be directed at families, schools, peer groups, and other everyday social systems from which children ongoing derive reassurance and security. There is an urgent need in this field to clarify the children that need additional outside psycho-social assistance at an individual level, as well as information to pinpoint when assistance should be delivered, by whom and for how long, and which interventions of proven effectiveness should be employed (see Figure 1 below).

⁷ See Appendices C and D: Family Strengthening and Psycho-social Support.

Figure 1. Interventions to Assist HIV/AIDS-affected Children and Families

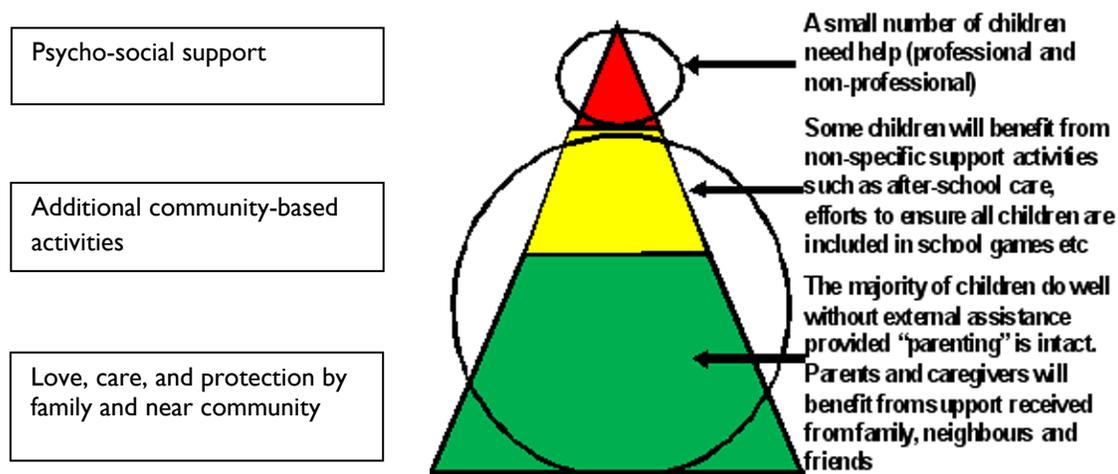


Table 1 illustrates the current direct delivery of material and other services to children by local CBOs and NGOs and the continuum along which PEPFAR needs to move to support government-led systems in collaboration with civil society.

The concept that a project must provide all of the 6 + 1 services described in Table 1 to a child in order to be comprehensive and of good quality— or even three or five services— is misguided. A child in a stable family receives many of these services at home and at school, at clinics and churches, and through other social networks. While families affected by HIV and AIDS are under stress, the vast majority have not disintegrated. Assistance for children affected by HIV/AIDS supplements, but does not replace, the care provided by families.

Table 1. Continuum of Service Delivery from Individuals to Systems Strengthening: Illustrative Examples			
	Individual Services	To	Systems
	Best provided by families, those closest to the home, local CBOs and NGOs		Best provided by a broad government- led and coordinated initiatives
Education	Provision of uniforms, textbooks, and stationery; individual school bursaries	⇒	School board training; block grants; school aids; free schooling/fee waivers; child grants to help pay for education; school feeding; after-school care; inclusive education; provision of hostels; school health services; community-based early childhood development (ECD)
Child Protection	Assisting individual children to get birth certificates; succession planning; identifying and referring maltreatment and sexual abuse cases; foster parenting;	⇒	Institutionalization of documentation (birth, death, inheritance); legislative frameworks; budget support for prevention and response to maltreatment; permanency for children living outside of family care; work force strengthening; social services; police and legal, health; implementation of laws and policies that are protective for girls like age of marriage.

Table 1. Continuum of Service Delivery from Individuals to Systems Strengthening: Illustrative Examples

	Individual Services	To	Systems
	Best provided by families, those closest to the home, local CBOs and NGOs		Best provided by a broad government- led and coordinated initiatives
Health	Referrals of individual children to health facilities; health screening; HIV prevention education	⇒	Family health insurance; health-promoting schools; system linkages with malaria, TB, HIV care, ART; improved life skills at schools and other institutions
Nutrition	Nutrition guidance and behavior change; provision of soup kitchens; food parcels; nutrition supplements	⇒	Agricultural support; economic strengthening for families; village cooperatives; food fortification
Psycho-social Support	Group and individual counseling; prayers; recreational activities; memory books; home visits	⇒	Policy development for inclusivity in all organizations and institutions; leadership from FBOs; child-friendly and gender sensitive schools
Shelter and Care	Provision of blankets and clothes	⇒	Household economic strengthening; social protection; assistance from village committees; standards and legislation for alternative care

III. STRENGTHEN PARTNER GOVERNMENT CAPACITY TO LEAD THE RESPONSE TO THIS EPIDEMIC

RECOMMENDATIONS

Provide technical assistance to governments to:

- Implement broad social policy initiatives that improve the care and protection of children in the epidemic at the national level and contribute to both the prevention and mitigation of HIV and AIDS, including:
 - Free or subsidized schooling
 - Free or subsidized health care
 - Child protection and
 - Social benefits and social services
- Promote country-specific workforce development in support of children and families affected by the epidemic.

ACHIEVEMENTS

The review team noted a strong intention by the Office of the Global AIDS Coordinator (OGAC) and its partners to move from an emergency response for children affected by HIV to a response that requires partner government capacity to lead and coordinate. This is manifest in PEPFAR's country-level support for:

- Partnership Frameworks
- Country Operational Plans (COPs) that show where investments are taking place, a strategy that allows all development partners to see the level of U.S. Government investment in various activities
- Incorporating the work of Track I implementing partners and, in some cases, the partners themselves, into USAID country portfolios. This has eased many of the anomalies found in the Track I OVC Evaluation, including duplication of services in certain regions
- Providing technical assistance and other support to departments and ministries at the national and subnational level to support a coordinated response to children affected by HIV/AIDS
- In collaboration with host governments, the development of:
 - Monitoring and evaluation frameworks at national and community levels
 - Regulatory frameworks, including minimum standards for quality control of services for children
 - Development and implementation of National Plans of Action for vulnerable children
 - The functionality of national coordination structures for children
 - Decentralization of child services to district and local level through national planning, finance or other ministries
- Countries have been assisted in analyzing workforce gaps and develop action plans in response.

Social Service Systems Strengthening for Prevention, Care, and Protection

A clear indication of a more developmental and sustainable approach has been PEPFAR's increased focus on systems strengthening, in particular, social service systems strengthening and supporting human resource development in relevant ministries. The ministries responsible for children often lack adequate capacity in developing policies and legislation and in regulating, delivering, and monitoring services for children. Often responsible for women in addition to children, these ministries may also lack the capacity to respond to the gender inequalities that make women and girls more vulnerable in a variety of areas.

The PEPFAR/USAID meeting on social service workforce systems strengthening held in Cape Town in November 2010 illustrated the potential returns from investing in these systems—for example, expansion of the number and quality of social workers (Malawi), regulation of children living in alternative care (Namibia), and improved monitoring and evaluation of the national OVC response (Côte d'Ivoire, Swaziland).

HKID has supported policy, management, and information systems within governments to conduct child abuse investigations, establish appropriate alternative care placements for children outside of family care, and monitor vulnerable children and families. HKID has collaborated at the country level to complement other U.S. Government efforts, including PEPFAR Sexual and Gender-based Violence (SGBV), U.S. Department of Justice and USAID Democracy and Governance programs (including the Displaced Children and Orphan's Fund [DCOF]).

Tanzania: Strengthening District Government Capacity in Children's Services

In Tanzania, the Review Team heard of the capacity development efforts of an implementing partner working with the department in charge of financing sub-national government. This support was complemented by technical assistance for district government, enabling it to request and utilize funds that were available from central government for children's services. This systems strengthening approach seemed to offer a range of potential benefits to children in the epidemic, including the recruitment of more social welfare workers in the district and greater availability of services.

South Africa: Investing in Community-centered Care for OVC Households

In South Africa, the Isibindi program, funded by PEPFAR/USAID and other partners, is a good example of how investment in community child protection systems can help vulnerable children and their parents gain access to child support grants as well as to ART. The Isibindi model of care mobilizes and trains child and youth-care workers from the local community to respond comprehensively to the needs of vulnerable children and their families, many affected by AIDS. Through regular, often daily, informal home visits, the care workers ensure that children remain in their communities and live with their families. This family-based care and support provided within the context of the life-world of the child can help link vulnerable households and children to a range of services and ensure national social security, free education, and other provisions are inclusive of poor HIV-affected households.

UNICEF is in a unique position in countries to lead the child protection agenda. UNICEF and PEPFAR have collaboratively supported legislative frameworks and standards that promote permanency-based alternative care, improved surveillance of violence against children, and strengthened prevention and management of child maltreatment. It is envisioned that this positive child protection partnership will continue between PEPFAR, as a funder, and UNICEF, as the technical agency for implementation. A promising step forward was the Violence Against Children household survey, undertaken through the Together for Girls partnership. These surveys are providing a strong evidence base to direct national child protection efforts in several countries.

Child protection activities must be mainstreamed at:

- All points of contact with children and families
- Within all organizations that work with children
- Within the national frameworks for children

At the same time, the External Review Team felt the basic safety and well being of children was not being sufficiently safeguarded at some sites. This is of special concern when INGOs are implementing or overseeing projects. For example, children wait in the sun for long periods of time to greet visitors, presumably without refreshment; play by open fires; and are unsupervised on busy roads. These basic practices need be addressed as well as more complex issues involving national systems of child protection.

Voices from the Field:

“Millions of volunteers have been providing services to vulnerable children without receiving any remuneration or formal training. Civil society has effectively lobbied the South African government to provide funding to career path and remunerate the volunteer work force. Training will be done through the local NGO, NACCW (National Association of Child Care Workers) Thogomelo Project, and will be funded by government.”

Quality Improvement: Care that Counts

In 2007, PEPFAR/USAID supported a quality improvement project, Care that Counts, which has now reached 12 countries. With the emergency nature of PEPFAR’s first phase leading to a rapid roll out of commodities and basic services for children, there were concerns that these programs may have overlooked quality and impact in favor of rapid expansion. Given the under-development of the social service sector, coordination among services and standardization is often lacking. Care that Counts’ quality improvement work on standards development created the space for policy makers and implementing partners to work together to improve programs for children affected by HIV/AIDS.

Partner agencies and implementing partners reported that the resulting quality standards were helpful in defining services by providing a minimum standard. Some countries saw the concepts of frequency, duration, and amount or intensity of services as most useful, while others concentrated on dimensions of service quality. The focus on outcomes as the ultimate test of quality was highly appreciated. This project is an example of a systemic approach to improving systems of care for children involving leadership from government and contributions from civil society.

OPPORTUNITIES

From Volunteers to a Workforce: Professionalization of Social and Health Care at the Community Level.⁸

Current social welfare workforce development plans may lack clearly defined strategies and realistic implementation mechanisms. This is partly due to the absence of accurate human resources data and cost projections and undeveloped systems for recruiting, hiring, accrediting, and promoting workers. In addition, education opportunities are inadequate to meet the demand for social welfare workers due to inappropriate learning and teaching methods and curricula, and the absence of mechanisms for recognizing prior learning. Little consideration has been given to experiences in other countries, including the fact that the social welfare workforce tends to aggregate in urban offices rather than where services are needed, and to move out of government service quickly due to poor workplace conditions, low salaries and lack of other incentives, unrealistic expectations, and lack of recognition and appreciation.

⁸ See Appendix E. Social Workforce Development.

Over the last three decades, millions of men and women, young and old, have volunteered their time, energy, and often their own money and resources (e.g., food) to assist others in their community. Many have undergone training on some aspect of their work in community health or home and child care, or received basic legal, development, agriculture and other forms of assistance. Most of these people move from project to project, during which time they may receive a stipend, lunch, a bicycle, or the like. When the project ends, they might leave with a certificate or a testimonial, but with no formal qualifications or evidence of advancement.

Voices from the Field

“We need a greater focus on systems strengthening. There is a need to start focusing more on the OVC supporting systems. These include social welfare workforce both pre- service and in-service as well as trainings for local government etc.”

“What we really need to focus on is how do we promote and build the capacity of local government entities (at district and village levels) and civil society to develop a culture that promotes quality improvement.”

A major contribution to workforce development and professionalization, as well as to human and social development at the country level, would be to strengthen and formalize systems for training, work experience, qualifications, and advancement for this extremely large and motivated cadre of volunteers that provide a wide variety of community-based services. Women often represent the majority of unpaid volunteers, leading to further gender inequality. Doing means building a workforce system from the bottom up, as well as re-enforcing the system top down through expanded social worker training and service provision.

UNAIDS, Press Release from the General Assembly, March 28, 2011

To strengthen the safety net for children affected by the epidemic, several countries have taken steps to implement social cash transfer programmes for vulnerable households. Countries that have expanded access to cash assistance for households with vulnerable children include Gabon, Malawi, Namibia, and Zambia.

This approach will improve the quality of community services at the point of delivery. Just as important, it will enable individuals to move up the rungs of learning and experience and begin to enjoy differentiated employment prospects, pay levels, and advancement possibilities that respond to their personal capacity, efforts, and initiative. It will also help meet halfway the top-down development of the social welfare workforce as well as ensure a strong cadre of people working at the grassroots.

There are good opportunities to learn from the health sector, not only about increasing the number of trained professionals and non-professionals, but also on ways to retain them in low-resource contexts and ensure they are deployed in remote and under-served areas.

Other recommendations arising from the previously noted conference in Cape Town include:

- Supporting the establishment of country-level as well as global Social Service Workforce Strengthening Alliances to support coordination, unified leadership, and the development of shared learning, goals, benchmarks, and strategic plans
- Developing related strategies and plans for country regulatory mechanisms, advocacy, and identification of critical resources, tools, and sources of support for social welfare workforce strengthening initiatives

- Continuing to support the sharing of best practices and technical assistance through the publication of key documents, OVCSupport.net, study tours, webinars, and new targeted technical assistance mechanisms
- Contributing to the growing body of knowledge regarding components of a functioning social welfare system and workforce through establishment of a forum for coordinating and vetting research and targeted research on key topics

Strengthening Social Protection

Social protection refers to government-supported mechanisms to protect society’s most vulnerable groups.⁹ It includes a variety of tools such as social security payments (cash transfers); food vouchers; subsidies for schooling, health care, fuel, or transport; public works programs; livelihood training; and others. Each mechanism has to be matched to the capacity of recipients: For example, the aged or disabled benefit more from social security payments and subsidies than employment or micro-lending. Social protection mechanisms help strengthen families economically, producing savings families can use for essentials like food and hygiene.

That said, the evidence is now clear that economic strengthening— especially direct social cash transfers for the poorest families— should be the lead program upon which services are built to address the needs of children affected by HIV and AIDS. This is not what is currently in place. Instead, there is a smattering of project-based services offered to children and, in some cases, families who may be too poor to benefit from them. For example, a family that has no money for food or hygiene will be unable to reap an advantage from counseling and advice.

Families affected by HIV/AIDS, whether under high- or low-prevalence conditions, become poorer as incomes and livelihoods decline and expenditures related to HIV and AIDS increase. Already poor families have few if any assets or savings to cushion the impact of HIV and AIDS. Affected families cut consumption— they buy less food, and they have less to spend on schooling, hygiene, and transport. These reductions have their greatest negative effect on children, girls in particular. For these reasons, as well as the fact that poverty limits uptake of HIV/AIDS prevention and treatment, there is broad agreement on the need to economically strengthen households affected by HIV and AIDS (JLICA, 2009).

The External Portfolio Review team noted a number of successful models to provide economic support to households, including village- and community-based savings and loans, health insurance cards for families, school block grants to reduce school fees, agricultural interventions (linked to ECD nutrition interventions), and skills training for caregivers and young people.

The appropriateness of an intervention depends on the capacity of the household to make use of the assistance provided. A labor-constrained or ill caregiver, for example, will benefit more from direct cash transfers than on interventions that rely on repayment or labor. For this reason, direct, regular income transfers— even if small— have emerged as the preferred policy option for HIV- and AIDS-affected families.

⁹ See Appendix F: Social Protection and Economic Strengthening.

A comprehensive review of the potential of income transfers, both conditional and unconditional, to protect children affected by HIV and AIDS was undertaken for the Joint Learning Initiative on Children and AIDS. This review concluded: “Cash transfers appear to offer the best strategy for reaching families who are the very poorest, most capacity-constrained and at-risk, in large numbers, relatively quickly, in a well-targeted and systematic manner, compared to alternative approaches”¹⁰

African countries have themselves indicated a readiness to adopt national social security mechanisms, albeit in stages, with such schemes now in place in 26 countries. What should not be done is for income transfers to be implemented within projects in an ad hoc, uncoordinated manner, and for transfers to target so-called “AIDS orphans.” Targeting data from Malawi, Mozambique, Uganda, and Zambia shows that the proportional gain in per capita consumption and schooling is maximized when social cash

transfers are directed to the poorest households with children rather than to orphan households, not all of whom are vulnerable. This is because it is the very poorest families with children who lack the resources and assets needed to absorb the shocks associated with HIV/AIDS, while orphans may be, and in some countries are, incorporated into better-off families

On-the-ground experience has shown that state and civil society need to be in partnership at a national level in implementing social transfers to ensure they include marginalized families, including those affected by HIV and AIDS.

There is a unique opportunity for PEPFAR to take the lead:

First, by building support for a concerted effort to enable more countries hard-hit by HIV and AIDS to implement social protection mechanisms appropriate for their country context, including income transfers, subsidies, and insurance schemes, to provide a fundamental safety net for children and families affected by the epidemic

Second, by consolidating the technical evidence regarding implementation and monitoring and evaluation

Third, by directly providing technical support, with built-in high quality evaluations, to a selected group of countries

¹⁰ Adato, M., and L. Bassett (2009). Social protection to support vulnerable children and families: The potential of cash transfers to protect education, health and nutrition. *AIDS Care*.

OVC Registers: Avoiding a Vulnerability Conundrum

As has been painfully learned in the fight against child abuse, low- and middle-income countries lack the resources to use registers as the basis for service delivery. Useful registers are expensive, as they are initiated to trigger effective services and must be regularly updated.

Registers can result in energy going into getting a child onto a list of vulnerable children or orphans, with little consideration as to what will be done to address the child's situation once on the list, or how and when to take the child off the list. Lists also generate expectations among families that are seldom met by a commensurate level of services.

The OVC field needs to avoid making the same mistake. For example, in Tanzania as a result of prompting by international agencies, enormous efforts have been made by government, NGOs, and communities to register over 785,000 most vulnerable children (MVC). Over several years, and at a cost close to USD \$800,000, the list is only 65% complete, with 1/3 of the country's districts yet to be surveyed. In South Africa, a maternal orphan register started as a pilot has proved unworkable because it cannot be maintained and the infrastructure and services to respond to children put on the register are not in place.

A conundrum with respect to OVC registers is that they only list children who are overtly vulnerable at the time of registration. Children who become vulnerable after the registration team leaves the house—when their parent falls ill or has to stop work—do not receive services until the list is updated, if it ever is.

Further, lists encourage agencies to identify children, but do not incentivize the graduation of children off lists. Lists may suggest that a child remains forever vulnerable until he or she is 18 and then becomes a vulnerable adult. Project- or program-level indicators such as number of children and families no longer requiring external support for schooling, or numbers of children with three essential basic needs met, would help incentivize amelioration and graduation off such lists.

IV. INTEGRATE AND COORDINATE HIV/AIDS PROGRAMS WITH BROADER GLOBAL HEALTH AND DEVELOPMENT PROGRAMS TO MAXIMIZE IMPACT

RECOMMENDATION

Integrate and coordinate the HKID Portfolio with U.S. Government HIV/AIDS programs (prevention, treatment, care, and support), other country-level HIV/AIDS programs, and broader health and development initiatives in-country.

ACHIEVEMENTS

The review team identified benefits and challenges relating to integration and coordination through country visits and questionnaires. Evidence shows that several country programs are moving in the right direction. While the potential benefits of integration are clear, implementers are still wary of possible challenges and pitfalls, as detailed in Table 2. In general, many of the perceived difficulties with integration and wrap-around stem from the HKID portfolio’s isolation from other HIV/AIDS service delivery platforms.

Benefits of Integration	Challenges to Integration
<ul style="list-style-type: none"> • Comprehensive services for households and improved quality of life for families • Increased efficiencies and impact— cost-saving by reaching affected children through an existing network or structure • Early identification of children affected by HIV and AIDS • All sectors become more sensitive to children’s needs and there is cross-learning • Promotes a holistic approach to clients’ needs • Allows smooth transition in services for older adolescents • More robust care programs for children • Fewer providers going to each household • Reinforces partnerships and supports family-centered approaches • Leveraging resources for more services • Robust and specialized technical and resources are leveraged from other programs to support OVC 	<ul style="list-style-type: none"> • Fear of double counting— “We were told that a child in a PMTCT program cannot be counted in the OVC program” • Anxiety about reaching targets for numbers of children served • Possible overload on service providers • The long lead time and effort required to build linkages and systems for integration • Provision of cross-training among providers and other program staff required • Each initiative has its own targets, time frame, and geographic limits • Concern that HKID funding will be diverted to cover rising treatment costs rather than less understood interventions such as family strengthening • Different cultures and networks— for example there is a strong shared agenda between gender programs and child protection efforts but gender-based violence programs were slow to incorporate interventions for minors

The Portfolio Review team gained the strong impression that, although a few country programs are moving in the right direction, there has been little integration of the largely stand-alone OVC program into broader HIV and AIDS platforms, and even less integration with other USAID programs in areas such as nutrition or education.

OPPORTUNITIES

Based on budgetary requirements, the HKID Portfolio comprises 10% of PEPFAR implementation monies. In FY2011, prevention receives 28% of PEPFAR funding, treatment 27%, care and support (other than OVC) 10%, and health systems strengthening 8%.¹¹ In FY2009 the U.S. Government as a whole provided more than \$2.6 billion in assistance for highly vulnerable children,¹² of which over \$513 million came from PEPFAR (HKID and pediatric care/treatment).

The greatest benefit for children affected by HIV and AIDS will be achieved through integration and coordination with broader HIV/AIDS efforts as well as with programs for vulnerable children. To do this, several things must occur:

- Different funding allocations and U.S. Government agencies must work toward the same goal at the country level—the health and well-being of vulnerable children, including those affected by the HIV/AIDS epidemic (for example, Feed the Future and PEPFAR).
- Maximum efficiency must be achieved through the combined use of available human and operational resources and services (for example, in remote areas, vehicles and personnel needed to deliver bed nets, counseling and testing, ARVs, and support for families must be coordinated to the greatest extent possible).
- Services must be linked whenever possible. PMTCT programs must link to or incorporate nutrition and treatment literacy, as well as community-based care and support for children and families. Counseling and testing must be used to reach families and link them to HIV/AIDS services as well as nutrition, immunization, and care and support. Gender-based violence programming can link to economic strengthening activities to address issues that make girls more vulnerable.

Voices from the Field

“The USG CountryTeam takes a multisectoral approach to HIV with regards to OVC. Throughout PEPFAR I OVC education activities were primarily implemented out of USAID’s Education Office. This allowed OVC education intervention to be integrated with wider country education activities as a whole. Resources allocated were based on expected levels of beneficiaries and an estimation of need. This approach builds on the comparative advantage of USAID education work and does not create unnecessary additional mechanisms and structures.”

In the Health at Home program in Kenya, family members are tested together and immediate links made to treatment, care, and prevention.

¹¹ The amounts reflect Country and Regional Operational Plans (B, Nyberg, February 2011).

¹² Fourth Annual Report to Congress (2010). A Whole-of-Government Approach to Child Welfare and Protection. PL109-95, p. 39.

Continuous Care of Children

One of the best predictors of child survival and health is maternal survival; clearly, keeping parents alive is key to maintaining strong families and protecting children. Yet despite strong evidence on the benefits of prevention, treatment, and care for the whole family, HIV-related services continue to target individuals. A package of HIV-related services for the entire family within a continuum of care needs to be developed and tested. In particular, at-risk and infected children identified through PMTCT services must be linked to nutrition, early child development programs, and community-based efforts to support children and families affected by HIV and AIDS.

V. INVEST IN INNOVATION AND OPERATIONS RESEARCH TO EVALUATE IMPACT, IMPROVE SERVICE DELIVERY, AND MAXIMIZE OUTCOMES

RECOMMENDATIONS

Improve the knowledge base for the provision of effective care and support for children in the HIV/AIDS epidemic:

- Improve scientifically tested intervention research
- Expand child development expertise on the PEPFAR scientific advisory board
- Step up investment in rigorous evaluations of effectiveness and cost-effectiveness

ACHIEVEMENTS

- The development of *www.ovcsupport.net* to distribute much-needed program information to the field
- The commissioning of evaluations of programs with potential to be scaled
- The employment of a staff member dedicated to evaluation
- The effort and consensus building that went into the development of a holistic framework for assessing child well-being, the Child Status Index

OPPORTUNITIES

All sources of information consulted indicate a serious shortage of relevant applied science about children affected by HIV and AIDS, policy research, tests of effectiveness, rigorous program evaluation, and costing. This includes the very large “grey literature” in the field, comprehensive reviews of interventions, a scan of the published literature, evaluations funded by PEPFAR, and research, currently under way, supported through the National Institutes of Health (see Appendix G. Knowledge Underpinning Programs).

In general, there is more evidence available on the situation of children affected by AIDS and the content of NPAs than there is on program coverage, the effectiveness of various interventions, or the process of developing national responses (IATT, Working Group on National Plans of Action, 2008).

Science in the field of HIV and AIDS prevention and treatment is generally very strong. Unfortunately, the evidence, scientific capacity, funding, and innovation manifest in these fields has not been extended to improved responses for children affected by HIV and AIDS. In fact, the absence of intervention research to advance this field parallels the neglect of children in the epidemic, a fact also seen in the area of prevention and treatment.

Based on these findings, the Portfolio Review Team strongly urges that research and evaluation receive the highest priority from PEPFAR leadership to ensure development of a strong understanding of how best to assist children and families affected by HIV/AIDS and to mitigate the impacts of HIV/AIDS on families and communities.

Our recommendation is to strengthen monitoring and evaluation by establishing new requirements for performance evaluations, design rigorous impact evaluations, and link evaluations to future funding decisions. (QDDR Executive Summary) This requires that the

Scientific Advisory Board pay attention to children in the epidemic, including leveraging the work of respected U.S. and international researchers and scientists from a range of disciplines that bear on children affected by the epidemic, including child development, child protection, and social service delivery.

To launch effective leadership in this field, the Board should undertake a “knowledge project” to bring together existing theory and evidence drawn from child development interventions, pediatrics, child psychiatry, GBV, education, and related disciplines to identify gaps and improve existing practices supporting children affected by HIV/AIDS.

The Board should also advocate for scientifically robust, community-based trials of interventions with the potential for large-scale application. These trials need to examine a number of important components, including the nature of interventions, staff training, and the length and intensity of interventions needed to achieve benefits and costing.

There is also an urgent need to disseminate relevant research findings from related fields, country reports with household survey data, and other data to national authorities responsible for taking the lead with regard to children in the epidemic. This is needed to strengthen the policy and planning functions of the lead agencies and ministries so they can use nationally generated data on children as well as learn from and apply international evidence. This is critical for ensuring that scarce national and external resources are targeting the children in the greatest need and investments are linked to evidence of program impact.

Voices from the Field

“The sheer complexity and volume of activities often do not provide technical teams with enough time to reflect on how they could work differently, and to stay abreast of emerging developments in the field.”

This information must also be accessible to PEPFAR OVC Focal Points as well as to PEPFAR Mission staff in related programs. While www.ovcsupport.net lists a number of publications, most are unpublished program reports related to practice in the narrow field of OVC. The format of the UNAIDS email publication HIV This Week (see Appendix H. Research Dissemination) is a good model. In this communication, the Chief Scientific Advisor to UNAIDS calls attention to new publications, providing both a published abstract and a short evaluation of the scientific merit and program significance of the paper (see below). A similar notification service would greatly enhance knowledge of scientific advances and program innovations in the OVC field.

VI. STRATEGIC TECHNICAL LEADERSHIP AND DIRECTION

RECOMMENDATIONS

- Ensure the HKID portfolio has proportional levels of staff to budget, and staff to contracts or agreements, at the headquarters and country level to provide adequate technical support and quality assurance.
- Increase technical and management capacity, including staffing levels at headquarters, regional and in-country in proportion to the size of the allocation and the importance of the issues affecting children and families in the HIV/AIDS epidemic.
- Ensure country-level capacity in U.S. Government country teams and in host governments “to know their epidemic, know their country, and know their children” so that they can develop interventions addressing local needs and can focus on “hot spots.” This would entail using existing local data from sources such as national demographic and health surveys, household income and expenditure surveys, and national HIV strategic frameworks for planning and impact monitoring purposes.
- Update the 2006 Guidance to take into account the goals of the second phase of PEPFAR, the GHI, and the paradigm shift required to address children in the epidemic. This will help give clear and unambiguous direction to countries on issues related to targeting, family-centered services, systems strengthening, and social protection. It will also ensure that children in families benefitting from USG support can be counted.
- Develop and disseminate a robust method for counting children, based on the strengthening of various systems to encourage greater investment in this area.
- Establish a cross-cutting Technical Working Group on children at headquarters, with representation from all relevant technical areas, including pediatrics and prevention. The working group should be tasked with promoting the integration of issues related to children at risk for and affected by HIV throughout the work of PEPFAR and its implementing partners.
- Change the terminology from “orphans and vulnerable children” to *children in the HIV/AIDS epidemic* to respond to the wider ambit of the Reauthorization¹³ and promote integration.

ACHIEVEMENTS

- Despite the limited number of headquarters staff working on HKID issues, these staff provide much appreciated technical support to the field through working group meetings, country visits, and biannual forums for sharing lessons learned.
- The Regional Advisors have provided regular mentoring and assistance to in-country staff.
- PEPFAR successfully placed advisors in 25 of the 26 countries with COPs for children. These individuals have been able to provide country-level leadership for the OVC portfolio and have engaged actively and directly with government and other donor partners and counterparts. The advisors are ideally placed to lead the country ownership strategy.

¹³ Tom Lantos and Henry J. Hyde. “Orphans and Children Who Are Vulnerable to, or Affected by, HIV/AIDS.” United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

- The annual COP Guidance and technical considerations provide PEPFAR’s latest thinking regarding children affected by HIV and AIDS.
- Evaluations have been commissioned to review the effectiveness of various OVC responses, including the best ways to support children in school and a comparison of block grants versus bursaries.

OPPORTUNITIES

Exercising Technical Leadership

The HKID Portfolio’s stature within PEPFAR is not commensurate with the size of its funding nor the portfolio’s breadth and reach. The OVC Advisors in place in-country are requesting greater leadership and guidance from PEPFAR and its headquarters implementing agencies.

Exercising technical leadership could include the following steps:

- Urgently revising the current 2006 Guidance to take into account the goals of the second phase of PEPFAR, GHI, and the paradigm shift required to address children in the epidemic. This will help give clear, unambiguous direction to countries on issues related to targeting, family-centered services, systems strengthening and social protection.
- Developing a communication strategy, including regional training, to accompany the new guidance.
- Developing strengthening mechanisms for mutual guidance and learning from field and headquarters, including invigorating the PEPFAR-wide OVC Community of Practice on children (the headquarters OVC Technical Working Group and OVC focal points and technical working groups in the field) through more frequent, regular meetings (biannual OVC Forums and monthly phone calls), driven by a progressive agenda.
- Ensuring the HKID portfolio at the headquarters and country levels has proportional levels of staff to budget, and staff to contracts or agreements, to provide adequate technical support and quality assurance. The current limited Headquarters Operational Plan budget in FY 2010 –around 1% of the annual HKID contribution— may be hindering the consistent provision of assistance and communications between headquarters and the field.

Voices from the Field

“There are gaps between some of U.S. Government field offices and the overall U.S. Government guidance. OGAC and USAID should take a leading role in sharing/promoting technical guidance documents, and in promoting evidence based, effective OVC programs (such as a monthly conference call to discuss one program and why it works, challenges, etc)”.

“What is important is that there is a systematic way to promote effective models that need to be scaled up. It is important that OGAC, along with USAID/Washington play a more active role in the field to promote harmonization of programs.”

“Build the understanding at the field level of the PEPFAR strategic vision and goals.”

The Terminology

The “OVC” label is no longer useful in describing or addressing the plight of children in the HIV epidemic for a number of reasons.

- Orphanhood is not the only— or even the major— cause of adversity stemming from HIV/AIDS.
- The word orphan was never a commonly used word in sub-Saharan Africa. Translated into vernacular, it frequently has connotations of neglect, ostracism, and rejection.
- Children are openly referred to as “OVCs,” which is offensive and exacerbates discrimination.
- The terminology has siloed the portfolio and allowed programs that are not “OVC” to disregard or not prioritize the needs of children affected by the epidemic. This has become a barrier to the inclusion of children across prevention, treatment, and care and support.

The 10% budgetary requirement should be considered as a call for the proper care and support of children and youth in all areas— in PMTCT, pediatric ART, life skills prevention, prevention with adolescent girls, and care and support— and not as a parking place for children’s issues. The earmark should be viewed as a call for the support of all children affected by the HIV/AIDS epidemic, from pregnancy to those transitioning to adulthood. The Reauthorization Bill includes children who are vulnerable to, as well as those affected by, HIV/AIDS. This allows greater flexibility in providing services to at-risk children, especially in communities with high HIV prevalence rates. It also makes clear the necessity for a continuum from prevention, to treatment, to care and support.

Speaking of “children in the epidemic” is less stigmatizing, more inclusive, and more descriptive. This fosters integration of children’s issues in prevention, treatment, care, and support.

“I guess I’m an orphan but I never knew it because my uncle always introduced me as his child”

Indicator

The mandatory PEPFAR indicator— number of children receiving at least one care and support service— is currently widely interpreted as requiring direct service provision to individual children. Although family members can be counted when services are directed to the household, this is not widely understood and therefore not always implemented.

This misinterpretation has the unfortunate unintended consequences of:

- Encouraging programs to bypass parents and primary caregivers to ensure that an individual child receives a service or commodity that can be counted. This risks marginalizing and disempowering parents and parental figures as decision-makers and primary caregivers of their children.
- Discouraging much-needed and important integration. In some cases care and support is not currently being provided to children out of fear of double counting when a child is involved in another PEPFAR program— for example, a child born in a PMTCT program or a child

Voices from the Field

“The current indicators are not sufficient to report on impact and quality, nor do they track where OVC funds are being spent”

“We need to focus on high impact interventions where we are going to get the greatest outcomes/impact to reduce vulnerability of children and their households.”

whose parent or primary caregiver is receiving antiretroviral (ARV) treatment. Such children are obvious targets for care and support.

- Keeping children in OVC programs over long periods of time to maintain and to increase the number of children counted. The aim of programs must be to *reduce* child vulnerability, not to maintain or encourage it. The practice of long-term support over several years is creating anxiety about “graduating OVC” to early adult programs. It is neither necessary nor sustainable for programs to provide support for individual children throughout childhood and adolescence and into adulthood. Such funding practices pose an opportunity cost that discourages more sustainable and empowering investment to strengthen family economic and social security.
- Rendering invisible or at least inconsequential (by not counting and thus not recognizing) the excellent work that is being done to strengthen families, enhance government services, and improve local institutions, including schools and community committees.

What is required is a consistent, easily communicated, defensible method for responsibly reporting to Congress on the numbers of children served by PEPFAR through systems strengthening on the family, community, and national levels. The current indicator allows for counting both adults and children addressed by interventions to strengthen family security, but more guidance on this point is required. There is currently no mechanism for reporting community and national systems strengthening. The use of locally available and relevant monitoring data from the DHS and other surveys could be considered.

Such an approach would incentivize partners— local and international, civil and governmental—to plan for impact and sustainability. It could also encourage an approach that builds on strengths and resources instead of focusing on needs and deficits. And it may encourage investments in more systemic and integrated approaches to strengthening families and local communities to respond to the needs of children, including adolescents transitioning to adulthood.

VII. DO MORE OF WHAT WORKS

RECOMMENDATION

A focused approach is key: Programs cannot and should not try to do everything. Consistent with the goals of the Global Health Initiative, PEPFAR should “do more of what works” to create the momentum needed for greater impact and coverage. Areas where the evidence of impact is strong and scale is feasible are early childhood development, keeping children in school, and strengthening families. A focused approach is key: Programs cannot and should not try to do everything.

FOCUS

To achieve impact and create coverage for the greatest number of children, PEPFAR should do more of what works. There are three areas in which the evidence of impact is strong and where large scale implementation is feasible.

When It Matters Most: Services for the Youngest Children and Their Parents¹⁴

Good maternal health and adequate early care and nutrition for young children are the first and most important steps in providing children with a good start in life and preventing vulnerability to poor health, education, social relationships, and life prospects.¹⁵

Available indicators reflect the slow rate of change in key infant and child health outcomes, such as under-5 mortality.

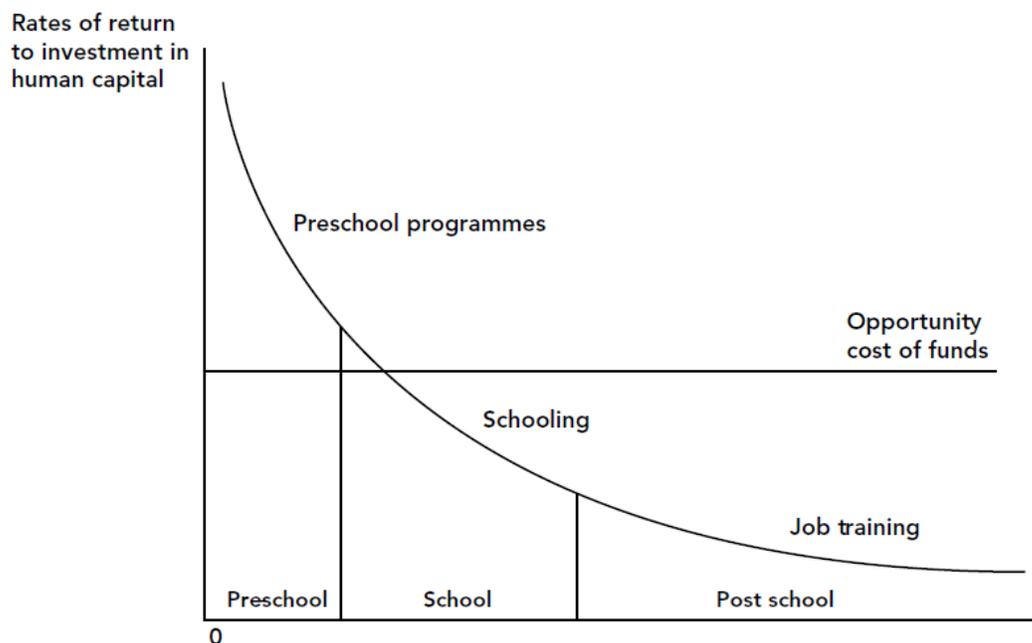
Early childhood development interventions are effective, targeting children at an age when the foundations for later health, learning, and behavior are laid. They are efficient, using relatively low-cost methodologies with long-term effects; equitable in that they can improve learning outcomes for girls and other vulnerable groups; and sustainable, relying as they do on existing community and family structures. For these reasons, early child development programs are agreed to provide the highest returns on human capital investment (see Figure 2).¹⁶

¹⁴ See Appendix I: Early Childhood Development.

¹⁵ Grantham-Mcgregor, S., Y. Cheung, S. Cueto, P. Glewwe, L. Richter, and L. Strup (2007). Developmental potential in the first five years for children in developing countries. *The Lancet*, 369, 60-70; Victoria, C., L. Adair, C. Fall, P. Hallal, R. Martorell, L. Richter, and H. Sachdev (2008). Maternal and child undernutrition: Consequences for adult health and human capital. *The Lancet*, 17, 23-40; Martorell, R., B. Horta, L. Adair, A. Stein, L. Richter, C. Fall, S. Bhargava, S. Dey Biswas, L. Perez, F. Barros, C. Victora, and COHORTS Group (2010). Weight gain in the first two years of life is an important predictor of schooling outcomes in pooled analyses from five birth cohorts from low- and middle-income countries.” *Journal of Nutrition*, 140, 348-354.

¹⁶ World Health Organization (2008). Commission on the Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva: World Health Organization ; Chandan, U., and L. Richter (2009). Strengthening families through early intervention in high prevalence countries. *AIDS Care*, 21, 76-82.

Figure 2. Rates of Return of ECD



PEPFAR partners in many countries are exploring ways to increase access to and improve the quality of early childhood development interventions.

Infant and young child health and development—especially in the first 1,000 days, i.e., pregnancy and the first two years of life—are critical and fundamental to child and adult outcomes. Interventions during this important window need to be scaled up through the following actions:

- Working with government departments on the necessary policies, legislation, strategies, work force development, and financing options for speedy implementation together with civil society organizations and international partners
- Building closer links with PMTCT to ensure pregnancy choice, good maternal and infant nutrition, and child care and stimulation in the first two years of life
- Building closer links with gender, to ensure male involvement and participation and reduce gender-based violence
- Building private sector partnerships, and leveraging and integrating with other initiatives such as the Global Health Initiative and Feed the Future

Improving ECD in Malawi

In Malawi, the Review Team observed an ECD program where NGOs and CBOs were assisting a community in becoming independent in running its center while supporting the community in food and livelihoods security and referring children to health services. At the best of these centers, the growth of young children is monitored, children receive a nutritious meal and the attention of a trained adult, and they have a safe space to play when their mothers are working. These benefits are offered to all children in highly HIV-affected communities, with orphans and vulnerable children specifically included. An approach that is more likely to generate broader community ownership is one of inclusivity rather than one that only targets orphans. The Government of Malawi is considering the provision of salaries for some of the caregivers.

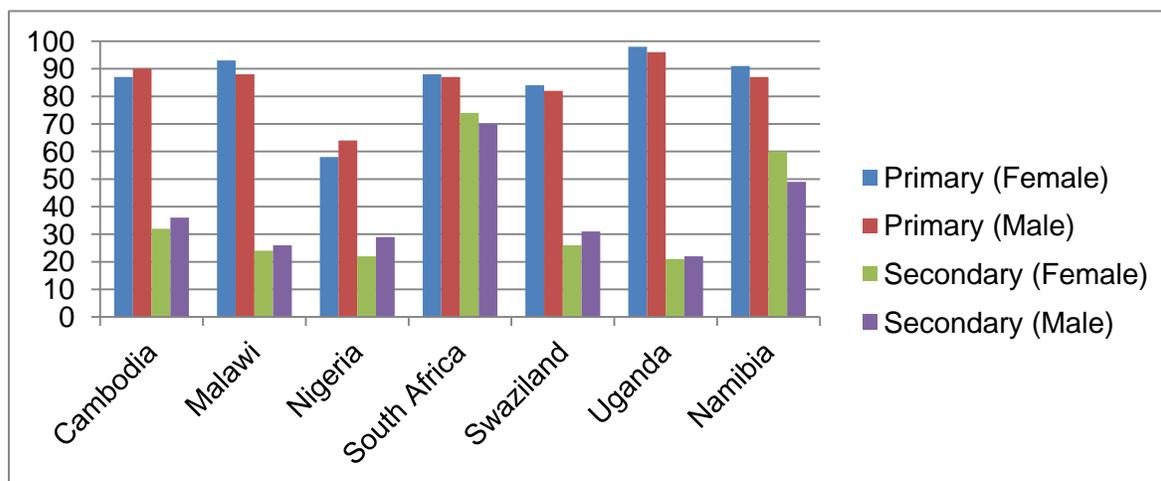
- Expanding financial support to government and civil society efforts to promote early childhood development, with attention to the transition to pre-school and primary school

“Recent reviews of ECD programs demonstrate that the benefits of early intervention for vulnerable children are far-reaching and lead to reduced instances of stunting, heart disease, and mental illness; increased school attendance; improved social and gender equality; and enhanced prospects for income generation throughout life. Highly effective programs prioritize integrated interventions that secure children’s human capital—in particular, nutrition, early childhood development (ECD), and education services” (Joint Learning Initiative on Children and AIDS, 2008).

Why It Matters: Education for Protection and Prevention¹⁷

Education is a prime HIV prevention strategy, a means for empowering girls and a tool for human development.¹⁸ While many countries are getting closer to universal access to primary education, net secondary enrollment is still low (see Figure 3). Every effort must be made to keep children in school for as long as possible, but not in ways that favor AIDS-affected households above national or provincial norms, as this is likely to lead to perverse incentives, including corruption and fraudulent use of funds; discrimination against those receiving benefits by those who are not; fostering of AIDS-affected individuals in households to get benefits; reporting children as orphans to get benefits, etc. PEPFAR can encourage governments to expand educational provision and can work with USAID to realize this goal. This could be a joint activity using HKID and PEPFAR Prevention funds.

Figure 3. Net Primary versus Secondary School Enrollment by Gender in Selected Countries (2005-2009)¹⁹



¹⁷ See Appendix J: Education.

¹⁸ Pettifor, A. et al. (2008). Keep them in school. *International Journal of Epidemiology*, 37, 1266–1273; Gupta, G. (2002). How men’s power over women fuels the HIV epidemic. *BMJ*, 324, 183-184.

¹⁹ UNICEF 2010 State of the World’s Children.

Keeping children in school for as long as possible is critical. Strategies that have been used to keep children in school longer include:

- Policy development, leverage, and assistance at the national level for expanding secondary schooling and improving the quality of primary schooling
- Increasing provision, especially in rural and under-served areas
- Lowering costs to families associated with education, and providing block grants to schools instead of bursaries to individual children
- Use of school aides/assistants and after-school activities to improve learning outcomes and decrease victimization and school violence
- Promoting school feeding to improve attendance and learning
- Sensitizing school management, including School Boards, to the needs of vulnerable children
- Creating child-friendly schools that respond to gender needs (e.g., Circles of Support)
- Responding to gender inequality in access to education

PEPFAR has provided support through initiatives to ensure children affected by HIV and AIDS stay in school. In some countries there is a shift away from individual bursaries to provision of grants to schools that agree to exempt children from paying school costs or that undertake other initiatives to support inclusivity and quality for all children. These have the added advantage of improving the quality of the learning environment (which benefits all children) as well as overcoming barriers to access faced by the most vulnerable children.

In Malawi, the team observed a good model of how the needs of children affected by HIV and AIDS were better integrated in school development plans developed by management and parent-teacher associations. The schools were then supported in implementing aspects of their plans. This appears to be a more sustainable and scalable approach to supporting vulnerable children than the provision of individual bursaries which the team observed in other contexts. The review team welcomes the analysis commissioned by the PEPFAR OVC Technical Working Group through USAID that is currently being undertaken by Boston University to review the impact of different forms of educational support. This could feed into new country-level guidance in relation to educational support for children in the HIV/AIDS epidemic.

A gender lens needs to be applied to educational initiatives to respond to the heightened susceptibility of girls to HIV infection. The prevalence rate for HIV in the 15-24 age group in sub-Saharan Africa is estimated at 3.4 for women and 1.4 for men (see Table 3).²⁰

Table 3. HIV Prevalence among Young Men and Women in Selected Countries		
Selected Countries	Women 15-24	Men 15-24
Malawi	6.8	3.1
South Africa	13.6	4.5
Tanzania	3.9	1.7
Sub-Saharan Africa	3.4	1.4

²⁰ UNAIDS Report on the Global AIDS Epidemic, 2010.

Structural interventions targeted at adolescent girls (especially economic strengthening) have been shown to have an impact on young women’s risk in relationships, particularly with older men. In Malawi, for example, conditional and non-conditional cash transfers to adolescent girls attending school increased school attendance and decreased child marriage, early pregnancy, and self-reported sexual activity.²¹

Where It Matters Most: Strengthening Vulnerable Families to Care for Children

Economic Strengthening

Families affected by AIDS get poorer by virtue of loss of income, reduction of livelihood activities, and increased expenditure on illness and death. Many families deplete their reserves, sell their assets, and slip into destitution. For these families and other poor families in high prevalence countries, economic strengthening is a necessity to assist them in 1) covering their families’ medical and transport costs, including those associated with continued access treatment, 2) covering costs associated with the protection and well-being of children such as education, food, clothing, and safe shelter, and 3) preventing children’s vulnerability to infection in the next generation by limiting engagement in hazardous and exploitative activities, e.g., child labor, commercial sex, and illicit activities.

It is essential that economic assistance is targeted at families and not individual children, so that it does not bypass or undermine existing household coping strategies and acknowledges the needs and stresses faced by other family members.

PEPFAR is among the major funders contributing to efforts to mitigate the economic impact of the HIV epidemic on households. PEPFAR can lead the way in demonstrating innovative approaches to support children affected by HIV and AIDS by ensuring the economic, social security, and stability of families.

PEPFAR has supported partners in strengthening household capacity in a number of ways:

- Health and nutritional support for primary caregivers
- Home visits to provide child care support
- Business and vocational skills training for primary caregivers and older youth
- Internal savings and loans
- Facilitation of access to government grants or services and other social protection mechanisms such as health insurance cards
- Provision of material and food support

The External Portfolio Review team noted a number of successful models for providing economic support to households, including village- and community-based savings and loans, health insurance cards for families, school block grants to reduce school fees, agricultural interventions (linked to ECD nutrition interventions), and skills training for caregivers and young people.

However, there are few strategies currently in place for reaching the poorest and most labor-constrained households, many of whom are HIV-affected. These very vulnerable families are not

²¹ Baird, S., et al., *The Short-Term Impacts of a Schooling Conditional Cash Transfer Program on the Sexual Behaviour of Young Women*. Policy Research Working Paper 5089, Impact Evaluation Series no. 40, World Bank, Washington, D.C., October 2009, pp. 16–19; Baird, S., C. McIntosh, and B. Ozler, *Cash or Condition? Evidence from a Randomized Cash Transfer Program*. Policy Research Working Paper, Impact Evaluation Series no. 45, World Bank, Washington, D.C., March 2010, pp. 34–36

able to participate in income-generating projects, take on the risk of loans, or respond to market opportunities.

There is growing in-country political support for social security-based income transfers, together with evidence of their positive impacts on households in high-prevalence, low-income countries. As shown in Appendix E. Social Welfare Services Systems and Workforce Development, there is robust evidence that predictable social transfers help improve household food security as well as children's nutrition and education. In many countries, such transfers are now part of nationally owned and -led social protection strategies. PEPFAR can play a strong role in supporting the administrative and social systems underpinning implementation as well as in monitoring and evaluation.

With the emergence of the Feed the Future initiative, there are good opportunities to ensure that the needs of HIV-affected households and children are mainstreamed into national food security plans.

PEPFAR is playing a key role in the economic empowerment of youth, as part of its assistance to affected children in transitioning into adulthood and independence. This helps reduce vulnerabilities that increase susceptibility to HIV infection. A number of PEPFAR initiatives are helping youth— including adolescent girls, older siblings who head households, and single female-headed households— to increase their earning capacity and care for themselves and for children in their households. These initiatives include vocational and business skills training, business start-up training, apprenticeships, cooperatives, and life skills training. This range of initiatives needs to be evaluated, with those that are shown to be effective systematized and scaled up.

RECOMMENDED STRATEGIES

The focus areas discussed above can be addressed by tapping into emerging strategies in the HKID portfolio and building on their strengths:

- Working with and through community networks
- Supporting well-planned and articulated workforce development for quality and sustainability
- Analyzing social welfare, educational, financial, and other national and sub-national systems and providing the necessary technical assistance to improve their ability to ensure care and protection for children and families in the epidemic
- Integrating with U.S. Government and other partners and programs
- Building a strong body of evidence through robust research to guide programming

VIII. NEXT STEPS

A paradigm shift is required that incentivizes the following:

- An intentional, practical, and visible focus on strengthening families, rather than providing services directly to individual children.
- Provision of targeted support for key government interventions that support a continuum of care incorporating government responsibilities and community networks that provide services to children and families. Consideration could be given to interventions where there is an opportunity to model and evaluate innovative solutions.
- Integration with all available resources across U.S. Government and host government and multilateral /donor platforms for children in the epidemic.

A number of specific steps can be taken to begin to address the recommendations in this report:

- Spearhead the launch of a new focus on children in the epidemic, to create integration across efforts supporting prevention, treatment, and care and support for children
- Complete and disseminate Guidance for a new approach to HKID
- Develop a communication strategy for the Guidance and an on-going communication campaign to reinforce the paradigm shift
- Provide more training at the Mission, host government, and implementing partner level to ensure that the PEPFAR five-year strategy and Moving Forward documents and concepts are fully understood and implemented
- Signal the paradigm shift by establishing a cross-cutting Technical Working Group on children at headquarters, with representation from all relevant technical areas, including pediatrics and prevention, to promote the integration of children at risk for/affected by HIV throughout the work of PEPFAR and its implementing partners
- Launch the new vision to garner widespread endorsement for the approach
- Ensure the Scientific Advisory Board gives attention to the research required for leadership in HKID implementation
- Provide global leadership for children in the epidemic to match the magnitude of HKID

These shifts must build and expand linkages between health systems and non-health community-based interventions. The PEPFAR OVC response has made large investments in community-level capacity, with good returns. This capacity can be harnessed to better link children in the epidemic with prevention, care, and support and treatment to achieve better protection for families and children.

APPENDIX A. SCOPE OF WORK

**Global Health Technical Assistance Project
Contract No. GHS-I-00-05-00005-00**

I. TITLE

Activity: GH/OHA: Review of the PEPFAR Orphans and Vulnerable Children (OVC) Portfolio

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

Begin as soon as possible, to be completed by April 2011.

III. FUNDING SOURCE

GH/OHA

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

This request sets forth a statement of work for an external review of the PEPFAR Orphans and Vulnerable Children (OVC) portfolio. PEPFAR investments comprise the largest donor funds targeted to orphans and vulnerable children. Therefore the Office of Global AIDS Coordinator has requested an external review of the results and progress to date of the PEPFAR OVC portfolio and specifically for key strategic recommendations that will ensure a state of the art OVC portfolio. The review will reference and articulate the current OVC strategy, policies and guidance, program interventions and populations addressed. The review will provide the basis for any reformulation of the PEPFAR strategy and approaches for programs for orphans and vulnerable children and its support of the Global Health Initiative. In sum, the team will:

- 1) Assess the strengths and weakness of the current strategies and approaches as defined at head quarters and as implemented in the field with respect to OVC.
- 2) Recommend strategies and priorities for the future direction of the PEPFAR OVC portfolio.

V. BACKGROUND ON PEPFAR OVC PROGRAMS

The goals of the President's Emergency Plan for AIDS Relief (PEPFAR) include care for 12 million HIV/AIDS affected individuals, including 5 million orphans and vulnerable children (OVC). The key objectives of the program as defined in the 5 year strategy are to:

Build National Systems of Care

The needs of orphans and vulnerable children demand a multisectoral approach. PEPFAR, therefore, seeks to contribute to partner country government leadership which includes support to coordinate and strengthen various ministries, including those overseeing education, food and nutrition, social welfare, and health, which support children, families, and communities affected by HIV/AIDS. This support includes the training of professional and paraprofessional staff as well as the development of national standards for quality services provided to OVC by both the public and the private sector. PEPFAR also works to ensure that its OVC programs are integrated with other U.S. Government programs targeting children and vulnerable populations and with other PEPFAR prevention, treatment, and care programs.

Strengthen the Capacity of Families and Communities to Care for Vulnerable Children

Research has identified that family environments are better able to meet the needs of vulnerable children than more institutional models. Many families caring for these children are already impoverished and overextended, putting the children within them at greater risk of malnutrition, disease, and limited access to education and health care. Community structures are often the first to step in with support to struggling families and therefore are an essential component of an effective response to OVC. PEPFAR prioritizes family-focused and community-based programs that strengthen the capacity of parents as the primary caregivers of children, and of communities as providers of social safety nets.

Provide Need-based and Situation-appropriate Response to Children Affected by HIV/AIDS

OVC programs assess, monitor, and address, as needed, the well-being of OVC within six key areas: food and nutrition, shelter and care, protection, health, psycho-social, and education. The needs of vulnerable children vary according to age, gender, socio-economic status, and geography; and strategies and priorities must be based on these realities.

VI. SCOPE OF WORK

Based on a comprehensive review of PEPFAR strategy, policy, and evaluation documents and preliminary key informant interviews, the review team will propose a framework and methodology for the review. The overarching question to be answered through the review is whether PEPFAR OVC programs are making the most effective difference in the lives of orphans and vulnerable children and their families and communities. This must be evaluated within the broader context of child protection and the PEPFAR mandate to increase country ownership and program sustainability. To address these broader issues, the review should consider such specific questions as:

- *Funding distribution & coordination* - Are PEPFAR OVC funds appropriately distributed across different interventions? For example, is there an appropriate balance between systems strengthening and various direct services? Are funding allocations for OVC programs based appropriately on available evidence about the epidemic and its impact on children? Are PEPFAR OVC funds strategically coordinated with other investments (i.e., local government, multi-lateral and bi-lateral assistance)?
- *Technical Leadership and the Evidence-base*— Are interventions and areas of investment in the OVC portfolio programmed according to the best available evidence? Are there omissions of any evidence-based approaches or any significant gaps in the interventions employed or in populations targeted? How have PEPFAR policies, guidance, monitoring and reporting structures impacted on the strategic approaches employed by programs?
- *Sustainability, Country Ownership and Participation* - What is the role of local communities, including children and their families, in programming? Are PEPFAR OVC programs building local capacity and fostering country ownership to establish a long term response for vulnerable children? Are OVC programs being transitioned from INGOs to indigenous partners? What is best practice in making this transition? If not transitioning, why not? What is the likelihood that programs and services for children will continue post PEPFAR? What practices (if any) are being implemented to make programs more likely to be sustainable post-PEPFAR, and have they worked?
- *Integration & Wrap-around*— Are OVC programs well integrated with other health and development activities (including and especially HIV-related, GHI, and MCH services)? What

are the strengths/weaknesses, including management constraints, of PEPFAR support globally and in country missions in terms of enabling integration and wrap-around?

- *Promising Practice & Innovation*— What are some of the practices that have been, or should be, taken to scale? Are PEPFAR OVC strategies, policies and guidelines conducive to encouraging and harnessing innovation and promising practices?
- *Research and Evaluation*— Are programs adequately monitored and evaluated? Are there knowledge gaps that need to be further explored?
- Final review questions will be developed collaboratively during the Team Planning Meeting and submitted together with the Work Plan for USAID approval prior to start of work.

VII. METHODOLOGY

A PEPFAR steering committee will provide direction at key points during the review process. Composed of senior staff at S/GAC and USAID/OHA, and the OVC TWG co-chairs, the steering committee will be consulted for input and approval at the following decision points:

- 1) Selection of review team members
- 2) Review methodology
- 3) Dissemination of external and internal reports
- 4) Plan for strategic consultation

The review team is expected to propose a detailed work plan for collecting the necessary information and data. The plan will be submitted for approval by the steering committee. This work plan should include a description of how the plan responds to the above tasks and questions and from whom and how the data will be collected and analyzed. The plan should also include a process for the full review of the background materials, preliminary listed in Annex A, and any other material deemed appropriate.

Methodologies to be considered in this review include:

- 1) An initial three day Team Planning Meeting to agree on the process and methodology needed to achieve the objectives and desired outcomes of the assignment. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the evaluation, and refinement of agenda. In the TPM the team will:
 - a. Share background, experience, and expectations for the assignment
 - b. Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
 - c. Agree on the objectives and desired outcomes of the assignment
 - d. Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
 - e. Develop data collection methods, instruments, tools and guidelines, and methodology and Develop an assessment timeline and strategy for achieving deliverables
 - f. Develop a draft report outline for Mission review and approval
- 2) Data and Document Review (a list of key resources are found in Annex A) and any in-country program evaluations;
- 3) Interviews and Consultation Meetings with key stakeholders to include national government and field personnel (a list of key informants is included in Annex B);
- 4) Country/field visits— To ensure a representative sample of programs, the steering committee proposes visits to three to five shortlisted countries, including possibly South Africa, Malawi, and Tanzania, based on the following criteria for selection:

- a. The amount of PEPFAR investment with preference for countries that represent a substantial share of the OVC portfolio;
- b. Maturity of PEPFAR OVC program (countries receiving funds relatively recently should be excluded);
- c. Epidemic & geographical variations;
- d. Potential synergy with other major initiatives including GHI;
- e. Absence of extenuating circumstances such as disaster and conflict.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

The Review team will consist of up to four core team members. The team will draw from experts bringing a mix of research, policy/advocacy, governmental, and particularly programmatic perspectives. Collectively, the team members should be able to comprehensively evaluate OVC programming and implementation in the HIV/AIDS context, national social systems strengthening, policies related to vulnerable children, and monitoring and evaluation of OVC portfolios/programs at international, national, and community levels. In addition to the four team members, several contributing members may, at the steering committee's discretion, accompany the team including, for example, representatives of UNICEF.

A Team Leader will be designated to be responsible for ensuring a quality review and finalizing all deliverables. The Team Leader will also designate other responsibilities, as appropriate, to other team members.

IX. LOGISTICS

The Steering Committee will provide overall direction to the review team, identify key documents and key informants, and liaise with PEPFAR country teams for this review including planning of the site visits. The steering committee shall be available to the team for consultations regarding sources and technical issues, before and during the review process.

X. DELIVERABLES AND PRODUCTS

Work Plan: The team will prepare a detailed work plan which shall include the methodologies to be used in this assessment. The work plan will be submitted to the Steering Committee for approval no later than the third day of work and prior to beginning key informant interviews or site visits.

Preliminary/Draft Report: The team will submit a preliminary report including findings and recommendations upon completion of the field work and at least two weeks prior to the Washington Consultation but after the first steering committee debriefing (so that comments and feedback can be incorporated into the draft report). This report will highlight achievements and best practices as well as shortcomings and lessons learned. This draft will include findings and recommendations for S/GAC and implementing agency review. Implementing partners will be included in the review of the draft. The Steering Committee will provide the team with one consolidated set of written comments on the report within 10 working days of submission.

PEPFAR Consultation & Debrief: The findings of the external review team will be shared with U.S. Government staff. Potentially this will involve a series of teleconferences with field and/or an in-person meeting. The purpose of these will be to discuss key findings and recommendations, and to propose any changes in a forward strategy. By involving PEPFAR leadership and OVC staff from Washington and the field, as well as other key technical working group members; the consultation will both validate the review recommendations and forge consensus for any changes in strategy.

Final Report: The team will electronically submit the revised/final report, in English, to GH Tech approximately two weeks after the final consultation. The report will include an executive summary, table of contents, findings and recommendations, and the conclusions of the Washington Consultation. GH Tech will review this report and send it to the Steering Committee within one week of reception for content approval. The final report document will be edited/formatted by GH Tech and provided to the Steering Committee approximately three weeks after the Committee has reviewed the content and approved the final unedited content of the report. The report, along with the recommendations, will be shared with all implementing agencies, partners and field staff.

Once the Steering Committee signs off on the final unedited report, GH Tech will have the documents edited and formatted and will provide the final report to the Steering Committee for distribution (x hard copies and CD ROM). It will take approximately 30 days for GH Tech to edit/format and print the final document. This will be a public document and posted on USAID/DEC.

XI. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will regularly report on progress to USAID contact which will in turn be shared with the steering committee.

XII. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON

The OHA point of contact is:

Gretchen Bachman, Sr. OVC Advisor, OHA

XIII. COST ESTIMATE

GH Tech will develop a cost estimate when the SOW is finalized and the consultants selected.

APPENDIX B. METHODOLOGY

THE TEAM

The team invited to conduct the external portfolio review come from multidisciplinary backgrounds (anthropology, development, economics, education, social work, psychology, and public health) and all have extensive experience of program evaluation, particularly programs for children, including OVC— local, national, and international.

The team leader, DeeDee Yates, conducted the PEPFAR OVC Track I final evaluation, the PEPFAR-funded PC3 Project in Ethiopia final evaluation, and the STRIVE Zimbabwe final evaluation. Julia Zingu, former Save the Children Country Director for South Africa, is currently supporting NPI capacity building in Mozambique and sits on the South African Council for Social and Professional Services. Chipso Mwetwa is a long-standing consultant in the field and has worked in many countries reviewing and facilitating the development of National OVC Plans and related policies and the writing of Global Fund proposals. Dr. Linda Richter co-led the Joint Learning Initiative on Children and AIDS, has evaluated the REPSSI program and UNICEF work in the OVC field, and contributes actively to research in the field. She works on the Human Science Research Council in South Africa and the Global Fund in Geneva. Dr. Rachel Yates has 20 years of development experience as a social policy advisor with DfID, and currently convenes the Inter-agency Task Team work on children affected by HIV/AIDS and co-chairs with the World Bank the UNAIDS social protection working group on social protection and HIV. She works for UNICEF. She kindly agreed to act as an auxiliary member of the team providing UNICEF's perspective and her own extensive experience in the field of vulnerable children. Jason Wolfe is an economist with policy and in-country experience in the field of economic strengthening. He works for USAID and served as an auxiliary team member, providing insights into operation mechanisms and best practices in household economic strengthening.

THE APPROACH

The review employed a utilization-focused methodology for the evaluation. Initial meetings were held in Washington, D.C., with key stakeholders from OGAC, partner agencies, and civil society. These included senior staff in OGAC, GHI, PL 109.95, USAID, CDC, DOD, Peace Corps, HRSA, NIH, the PEPFAR OVC TWG, the OVC Task Force, and civil society.

These in-briefs highlighted areas from the scope of work and suggested approaches to the field work. As a group, the team members brought their past and current training, knowledge, and experience to the assignment. They used these background perspectives, together with available documentation and wide consultation with stakeholders, to assess PEPFAR's work in the OVC area and make recommendations for future priorities and actions. By necessity, this is a high-level review, not an assessment of particular programs. All members of the team have recently been in the field, including for PEPFAR programs.

Review of Background Material and Data

The team decided on three types of documents to review:

- PEPFAR commissioned reports and evaluations and other PEPFAR- and non-PEPFAR-funded evaluations. Given that a research synthesis review commissioned by PEPFAR/USAID was occurring at the same time as this review, the team referred to the preliminary key findings from the overview given by the research team during the Team Planning Meeting. The Research Synthesis Team was requested to consider “what works, what doesn't, and

what are the gaps in the evidence” for non-practitioners to inform those unfamiliar with OVC about the basis for current strategic directions.

- The major PEPFAR OVC guiding documents and other additional frameworks.
- The Country Operational Plans of all PEPFAR-funded countries with an OVC portfolio.

Data Collection

- The team developed a questionnaire that OGAC distributed to all 26 countries with a PEPFAR OVC program in their COP. The questionnaire was sent through the PEPFAR Coordinator in-country for distribution to the OVC focal person in each implementing agency. Seventeen countries responded.
- A questionnaire was developed for the members of the OVC Task Force, a U.S.-based group of NGOs with overseas development programs. Three replies were received.
- Semi-structured interview and discussion question guidelines were developed for the country visits.

Country Visits

The Review Steering Committee identified three countries, Malawi, South Africa, and Tanzania, as suitable based on the following criteria for selection:

- The amount of PEPFAR investment, with preference for countries that represent a substantial share of the OVC portfolio
- Maturity of PEPFAR OVC program (countries receiving funds relatively recently would be excluded)
- Epidemic, geographical, and size of program variations
- Potential synergy with other major initiatives, including GHI
- Absence of extenuating circumstances such as disaster and conflict

At least four team members spent five days in each country. In each country the team had the opportunity to meet with the PEPFAR country team, prime partners, local and international NGOs, subgrantees, government partners in key ministries or departments at national and sub-national levels, UNICEF, and local community committees.

ANALYSIS AND REVIEW

The team used their shared experience and expertise to review and analyze their findings during team meetings convened in South Africa, Tanzania, and Malawi during the country visits. A questionnaire was circulated to 26 PEPFAR countries to capture and incorporate the view of a wider audience. A draft report and summary presentations were then presented in Washington to an OVC Steering Committee and members of the OVC Technical Working Group in a Webinar session. The elicited comments and insights were incorporated into the first draft, which was circulated for further comments.

U.S. Government responses to the questionnaire:

Country	Replied	Organization	Country	Organization	Replied
Botswana	yes	PEPFAR	Mozambique	USAID,CDC	yes
Cambodia	yes	USAID	Namibia		interviewed
Caribbean Regional	yes		Nigeria	USAID, CDC, DoD (combined response)	yes
Côte d'Ivoire	no		Rwanda	USAID	yes
DRC	no		South Africa		field visit
Dominican Republic	no		Sudan		no
Ethiopia	no		Swaziland		no
Ghana	yes	USAID	Tanzania	USAID	yes& field visit
Guyana	yes	2 responses. CDC & UASID	Uganda	USAID	yes
Haiti	yes	PEPFAR	Ukraine		no
India	yes	USAID	Vietnam	no indication	yes
Kenya	yes	PEPFAR	Zambia	USAID	Yes
Lesotho	yes	USAID/PEPFAR	Zimbabwe	USAID	yes
Malawi	field visit				

Non-U.S. Government Responses:

Organization	Replied	Country of Operation
Catholic Relief Services	yes— 1 combined response	(Track 1) Kenya, Botswana, Haiti, Tanzania, Rwanda & Zambia
Family Health International	yes— 1 combined response	Burundi, Côte d'Ivoire, DRC, Ethiopia, Kenya, Mozambique, Nigeria, Tanzania, Haiti, Cambodia, India & Vietnam
UNICEF	yes	Guyana

TIMELINE

Week in 2011	Major Activity and Place	Venue
Week 1 Jan. 31–4 Feb	Document Review	Home work station
Week 2 February 6–14	Team Planning Meeting Key Informant Interviews	Washington, D.C.
Week 3 February 15–19	South Africa country visit	Pretoria

Week in 2011	Major Activity and Place	Venue
Week 4 February 20–26	Malawi Country Visit	Malawi
Week 5 Feb 27–Mar 5	Tanzania Country Visit	Tanzania
Week 6 Mar 6–12	Finish South Africa country visit Begin Analysis	Pretoria
Week 7 Mar 13–19	Finish Analysis and Write ups Reading as necessary	Home work stations
Week 8 Mar 20–26	Individual and group write up	South Africa
Week 9 Mar 27–April 2	De-brief and revise draft report Hand in draft	Washington, D.C.

ORGANIZATIONS AND PEOPLE INTERVIEWED

Type	Country	Number of People Interviewed
State Dept/OGAC/	Washington, D.C.	10
USAID	Washington, D.C.	14
Other USG agencies	Washington, D.C.	5
Implementing partners	Washington, D.C.	9
U.S. Government	Tanzania	9
Government	Tanzania	15
UNICEF	Tanzania	3
Implementing partners—INGOs		22
Subpartners—local	Tanzania	18
Community groups, e.g., crèche committees, village committee	Tanzania	45
USG	Malawi	6
Government	Malawi	29
UNICEF	Malawi	4
Implementing partners—INGOs	Malawi	16
Subpartners—local	Malawi	23
Community groups	Malawi	53
USG	South Africa	12
Government	South Africa	15

UNICEF	South Africa	4
Implementing partners—INGOs	South Africa	17
Subpartners—Local	South Africa	25
Community groups	South Africa	38
Questionnaire Responses		
U.S. Government		17
Implementing partners		3

QUESTIONNAIRE RESPONSES

General Comments:

The questionnaire information is neither complete nor representative. We did not receive questionnaires from all countries, nor from the same level or position of people in each country. Therefore they are neither additive nor comprehensive. They do, however, give a sense of some of the concerns and issues facing in-country OVC focal persons and HIV teams.

I. Funding distribution and coordination

1.1 What factors do you take into consideration when deciding how funds are divided between OVC service areas (e.g., education/economic-strengthening/nutrition) and between direct service delivery systems and system strengthening?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
Used the national priorities as criteria for funding distribution.	5	1
Used the gap analysis as their guideline.	4	
Used the government's emerging policies, national strategic plans, and OVC strategies as guideline to distribute funds.	3	1
The targets reached are used as a factor in deciding which implementing partner or NGO would be receiving the funds.	3	
The implementing partner makes the decision as to how the money is being distributed.	1	
More funding invested in direct service delivery than for systems strengthening.	16	1

Most countries used the following criteria for funding distribution: national plans of action, national strategic documents, country priorities, existing gaps as determined during national-level consultations with Government and the PEPFAR COP Guidance, and technical considerations. The funding mechanism used to channel funding varied from national OVC structures at the national and local level and the country's HIV/AIDS funding mechanisms.

Countries with low prevalence rates reported they also take existing community networks and welfare structures into consideration.

All countries have more funding invested in direct service delivery than for services for systems strengthening. U.S. Government teams are still trying to find a balance between services and systems strengthening.

1.2 How are PEPFAR OVC funds coordinated with other investments for vulnerable children in country?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
Collaboration between host government, USAID, PEPFAR, IP's, CDC & UNICEF to develop national plans of action	8	1
Using Partner Groups, Technical Working Groups and existing Country Coordinating Mechanisms or Steering Groups	8	1
Using the PEPFAR/ UNICEF partnership	6	1
Partnering with GFTAM	4	

From the responses it would appear as if most U.S. Government teams work very closely with in-country coordinating mechanisms. Some of these coordinating mechanisms are: national steering committees, national-level coordination and national activities, and joint planning and country coordinating mechanisms for the Global Fund.

The U.S. Government and other donors ensure coordination of OVC funds at the national level through existing coordination mechanisms. This may be replicated at the district and subnational level. The respondents mentioned positive partnerships with UNICEF and coordination with other investments such as the Global Fund.

2. Technical leadership and evidence

2.1 What type of PEPFAR or non- PEPFAR guidance or direction is helpful to you in your OVC programming?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
PEPFAR OVC guidance	13	3
Next generation indicators	4	
Sharing of best practices	3	
COP Guidance	1	
CSI	1	
UNICEF report on the state of the world's children	1	

The respondents reported a number of different guidance documents. These include:

U.S. Government tools: U.S. Government Technical Briefs, U.S. Government OVC Programming Guidance Document (2006), Next generator indicators, Child Status Index, COP and quarterly and annual OVC implementation partners' progress report; ovcsupport.net. U.S. Government guidance on special intervention areas such as gender, and M&E were reported to be very helpful.

Other sources: JLICA 2008 report, project evaluations and reports, sector-specific technical documents, the World Bank OVC toolkit; UNICEF Child Status reports.

Voices from the field

“The recent Violence against Children which has significant implications for Child Protection. It should result in a refocusing of programs to a greater emphasis on protecting children from physical, emotional and sexual abuse.”

“Field experience however is most valuable and direct experience of visiting families, communities and programs informs the program management more than anything, as to what has been successful, and what less successful and requires strengthening.”

“Conferences and workshops are also useful to widen horizons and learn from others.”

“The Joint Learning Initiative on Children with AIDS (JLICA) conference and research findings have been particularly significant in terms of influencing thinking.”

2.2 Which of your OVC interventions are best supported by evidence?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
Education	8	2
Health	8	
Economic strengthening	6	1
Nutrition	5	1
Food security and direct financial support (block grants) & savings clubs	2	

Voices from the field

“We use the CSI which has not been validated. It has been helpful in orienting case managers towards outcome based thinking but it is not clear how well the CSI is to meaningfully measure constructs.”

Question 2.3 How are you ensuring partners are delivering quality OCV interventions rather than chasing numbers?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
Regular site visits	7	2
CSI	6	
Minimum standards of care	4	
Through linkages and coordination	4	
Reading and tracking program reports	3	
Technical assistance	3	1

Field visits are cited as the predominant means through which quality assurance is done followed by the use of the CSI. All respondents reported addressing quality improvement.

Voices from the field

“The program has been implemented without a standardized M&E system, Standard of Quality, SOP and procedure for QA and QI. The CSI tool was performed by many partners without standardization and validation of how it works.”

“Despite these efforts, some IPs are still chasing numbers and seeking to achieve their SAPR and APR results, which are number based. The current OVC OGAC indicator is (1) Number of OVC receiving minimum one care service, which doesn't allow partners to report on the quality of their programs.”

“The PEPFAR Technical Considerations and Indicators Guidance are used to guide the design and monitor the quality of OVC services.”

3. Sustainability, ownership, and participation

3.1 Please give example of where you feel relative to OVC programs, you have achieved country ownership, sustainability and participation.

In the responses, country ownership is associated with planning processes, development of national plans of actions, DHS reports, and surveys. There appears to be no standard understanding of country ownership in the context of the second phase of PEPFAR's 5 year strategic plans.

In the responses sustainability is associated with skills transfer and economic capacity development; technical and financial empowerment to undertake programming

Participation is considered as involving all key stakeholders from government non government organizations and donors.

Voices from the field

“There is a national OVC Program funded, coordinated, and implemented by the government. Additionally, the government has accommodated and built partnerships with civil society working with OVC - the government recognizes the role that civil society plays in caring for OVC.”

“The PEPFAR funded OVC program is aimed at strengthening government systems by investing in the national and district level leadership for them to effectively coordinate and manage the OVC response.”

“National ownership and extensive participation of key government and civil society actors is promoted.”

“We took the lead in developing the OVC Policy, guidelines, standards and currently leading the review of the National Strategic Plan for OVC.”

3.2 What could assist you in achieving this?

Response	Frequency USG Country Teams N=17	Frequency Task Force N = 3
Stronger leadership & capacitating governments	13	2
Funding resource mobilization	7	
Stronger coordination	5	
PEPFAR Guidance	2	
Integrate with existing systems & systems strengthening	2	1

Capacity building for government and advocacy to get governments to commit more resources and leadership to children’s issues rank as the most important requisites for achievement of country ownership.

Technical assistance, capacity development, especially of the local government and economic empowerment of communities are listed as the predominant factors for sustainability and participation.

4. Integration

4.1 Please give an example of where you have successfully integrated your OVC program with another PEPFAR or U.S. Government initiative relative to OVC

Most of the examples given are of integration with other PEPFAR programs, notably PMTCT. HCT and HCBC are also mentioned as areas of successful integration.

The examples were varied and country specific and no conclusive uniform models or uniform examples could be extrapolated.

Voices from the field

“Projects integrate health, HIV (OVC, HBC, and Prevention) water/sanitation, and rural enterprise program components to contribute to an overall objective of strengthening communities and leverage.”

“The project aims to bring together, in conjunction with funds from other sectors, income growth, increased use of child survival and reproductive health services, community-based safe motherhood programs, and programs to reduce the transmission of HIV and Care and Support for PLHIV, OVC and their families.”

“Work in progress to integrate the under five OVC support in the diagnosis and management of severe febrile illness.”

“The Care and Support program has combined Home based Care, palliative Care, HIV Prevention including PMTCT, Youth interventions, and Malaria with OVC activities.”

4.2 What are the benefits and what are the challenges to such integration?

Responses from the Field	
Benefits	Challenges
Ensures a comprehensive continuum of prevention and care model	OVC budget may get lost in many activities
It fosters a family-centered approach	Who gets to count? Hence partners are reluctant to refer
The family model maximizes the use of available human resources	Management & planning skills needed by program and administrative support staff
Leveraging with other programs diminishes the cost	It takes time to build linkages and referral systems
It reinforces partnerships	The complexity of the project in terms of integrating activities of various sectors and different approaches

The prominent benefit of integration is cost effectiveness. The prominent challenges relate to issues around capacity to manage the integration, both in terms of human resources (increased responsibilities for staff) and skills and the modus operandi (lack of clarity on modus operandi).

Some responses mentioned the fear of health or PMTCT taking up resources for OVC and “swallowing” it up.

5. Promising practice

5.1 What are the PEPFAR funded or other OVC programming successes in your country?

The responses were very country-specific. Two countries made reference to workforce strengthening. Programming success all relate to increased access to service for children, even though they range in the type of service accessed. This again points to the “numbers” requirement by PEPFAR, against which a program seems to measure its success.

Responses are varied but a focus on achieving “numbers” and targets stands out. Despite this, an emerging theme from the responses was the need to move away from “counting” children to increasing the focus on quality and sustainability, as seen in the comments below.

Voices from the Field

“Building the capacity of government community social workers to lead the case management.”

“The provision of health insurance as a family-based approach for all children and household members.”

“Promising family based approaches resulting in increased involvement of caregivers in responding to the needs of OVC under their care.”

5.2 What in your opinion could PEPFAR do to encourage innovation or expansion of good OVC practices?

Responses varied and included calls for more analysis, research, advocacy, sharing of information and defining exit strategies. There was also mention on finding appropriate partnerships and synergies

5.3 What hinders innovation or expansion of good practice?

Respondents mention i) “rigidity” in program requirements, ii) insistence on standards, and iii) limited research or access to research information on what works as hindrances to innovation.

Six countries indicated that the lack of sufficient funding or the type of funding available may hinder innovation or expansion of good practice to varying degrees.

Voices from the Field

“Organize a few country “community discussions” to determine how nationals feel the international OVC support process is going in their country.”

“Increase funding to the hard-to-reach.”

“Increase funding for evaluations.”

“Increased funding for Operations Research specifically added to RFA guidance.”

“Disseminate Track 1 OVC Final Evaluation study results more widely to implementing partners.”

“Encourage more partnerships with the private sector.”

6. Research and evaluation

6.1 Are there areas of your work which you think are not recognized because they are not included in the indicator framework?

The responses were varied. The areas of work which may go unrecognized included child protection, gender, quality programming, and social welfare work force strengthening systems.

Voices from the Field

Specific response to the PEPFAR five year strategy:

“The review should focus identifying opportunities for a paradigm shift on how we plan to program OVC funds under PEPFAR with an increased focus on country-led, country-owned, and sustainable OVC programs.”

“We are currently working on guidance that was developed under PEPFAR I. Given the new landscape, we need to develop, revise, and/or adapt these guidelines to suit the new environment and emphasis areas as articulated under PEPFAR II.”

“Implementation of the Public Law 109-95 framework with speed.”

“An analysis of cost effectiveness of PEPFAR I programming relative to the 6 + 1 services as articulated in the OGAC Guidance for OVC programming.”

“Country ownership and what countries understand it to mean.”

6.2 What could PEPFAR do to advance research and evaluation that is useful to you in your OVC programming?

Nearly all the countries referred to the need for funding for operational research.

The shift from emergency in the first phase of PEPFAR to a developmental focus in the second phase of PEPFAR should entail more focus on areas like research/program evaluations to inform programming and improve program quality.

What are your top three recommendations that this OVC review should take up?

The themes emerging from the questionnaires are:

- A need for increased focus on national, local, and family systems strengthening
- Shift in focus from “counting” children to strengthening households to support children
- Increased support and capacity building of institutions providing support to children
- Documenting and disseminating good practice models

Voices from the Field

“Lack of flexibility in the funding mechanisms at times, hinders the innovations.”

“Best practice interventions are not always in the original scope of the award and partners will push back and say they do not have funds available.”

“Local NGOs not having direct access to PEPFAR OVC funds, hence unable to replicate best practice.”

“Lack of funding is sometimes a limitation to innovation.”

“Limited and short-term funding, limited staff and limited technical capacity of staff.”

Opportunities

It is the Review Team’s observation that there is an urgent need to brief and sensitize country programs, missions, implementing partners on the five-year strategy.

Voices from the Field

Specific responses related to funding:

“More funding needs to be channeled to local organizations who are working with the grassroots population.”

“PEPFAR to start focusing on sustainable intervention i.e. increased funds to be used for economic strengthening directly with families vs. number needed and Congress indicators.”

“Provide specific funding and TA on the economic strengthening and link to PPP.”

“PEPFAR to consider putting a cap on money distribution so that more money is spent on project activities instead of the current trend where more money goes to administrative costs and less gets to reach beneficiaries.”

“Consider doing cost studies so as to get impact per cost guides.”

From PEPFAR’s five-year strategy:

“There has been some degree of interagency conflict at both country and headquarters level. PEPFAR was launched as a new way of doing business, causing some uncertainty among health and development experts who were unclear about their role in the new model. Field perspective and input have not always been reflected in policy or planning decisions. PEPFAR’s extensive reporting requirements were not always harmonized with other U.S. Government development programs or other international indicators. Partner governments and country teams appropriately raised concerns about the impact of reporting requirements on field programming. Finally, the program has represented a significant scale-up of resources at Embassies without always having the commensurate increase in staff.”

APPENDIX C. STRENGTHENING FAMILIES

Strengthening families is a key strategy for supporting children affected by HIV and AIDS, protecting children from suffering, preserving human capital, and preventing HIV infection in the next generation.

Efforts to assist families financially, either through general social protection mechanisms or specific economic strengthening activities, comprise one approach to strengthening families.

BACKGROUND

Strengthening families is a key strategy of the widely endorsed 2004 Framework for the Protection, Care and Support for Orphans and Vulnerable Children Living in a World with HIV and AIDS (UNICEF et al, 2004).

The framework recommends the following five strategies:

- 1) Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psycho-social and other support
- 2) Mobilize and support community-based responses
- 3) Ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration, and others
- 4) Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities
- 5) Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS

Strengthening families is also one of the main recommendations of the two-year global Joint Learning Initiative on Children and AIDS (JLICA, 2009, Richter, Sherr & Desmond, 2008; Richter & Sherr, 2009; Richter et al., 2009). Backed by an extensive review of evidence and practice experience, the JLICA recommended four lines of action:

- 1) Support children through families
- 2) Strengthen community action that backstops families
- 3) Address family poverty through national social protection
- 4) Deliver integrated, family-centered services to meet children's needs

Strengthening families is also one of three prongs of the approach to orphans and vulnerable children in PEPFAR's five-year strategy (p. 22).

RATIONALE— WHY IT IS IMPORTANT

Supporting families must be a key strategy of mitigating the impact of HIV and AIDS on children for the following reasons:

Children Need Families²²

Human beings have evolved a child rearing strategy to complement the needs of growing children and young people. Devoted “parental” care, with perspectives and motivations oriented

²² Families comprise people who are committed to each other and to children because they are biologically, legally, or socially related.

to a child's future as well as the present, are part of the deep structure of human social organization. The stable, affectionate care that families provide uniquely responds to the unfolding capacities of a developing child. These features of parental and family care are not replaceable. For this reason, institutional group residential care and changing foster care is damaging for young children (Rutter et al., 2010).²³

Families Have and Continue to Take In and Care for Children

Families have been, and continue to be, the first to respond to children affected by orphaning and other stresses resulting from HIV and AIDS. The first published paper on the topic in 1990 noted that extended families were taking in and looking after children of kin (Hunter, 1990).

Families Affected by HIV and AIDS are Under Stress, but Have Not Disintegrated

In her 1990 paper, Hunter warned that family networks were vulnerable to health and social stresses as a result of increased dependency and impoverishment in the absence of assistance from the community or the state. The last 20 years of the epidemic have proved this point. Demographic and ethnographic analyses indicate that families continue to be formed and dissolved as they always have, even under conditions of extreme hardship (Hosegood, 2009; Mathambo & Gibbs, 2009). Nonetheless, it is well documented that everyone involved experiences significant stress when HIV/AIDS enters a family and very large numbers are affected— up to 60% of families in the hardest-hit countries (Belsey, 2005). In addition, families affected by HIV/AIDS, whether under high or low prevalence conditions, become poorer as their income and livelihood declines and expenditures related to HIV and AIDS and increased dependency increase (Collins & Leibrandt, 2007; Franco et al., 2009).

Family Cut Backs Severely Affect Children

Already poor families have few if any assets and savings to cushion the impact of HIV and AIDS. Affected families cut consumption— they buy less food, and they have less to spend on schooling, hygiene, and transport. These reductions have their greatest negative effect on children. Hunger, hard compensatory household and livelihood work, isolation, and stigma worsen the situation of children (Drimie & Casale, 2009). Parents and other caregivers are forced to juggle diverse family needs in the face of very scarce resources.

Family Impacts Contribute to Vulnerability in the Next Generation

Several studies have indicated increased vulnerability to HIV infection among young people in families affected by HIV/AIDS and poverty. Apart from greater stress and disrupted education, young people affected by AIDS in their family report earlier sexual debut, more multiple partners, less protection against infection, younger pregnancies and more STIs and HIV infection. (Cluver & Operario, 2008)

For the reasons cited— and because family strengthening is an essential element of prevention into the next generation— strengthening families is essential for child development and well-being; protection of children from suffering, disadvantage, and isolation as well as the preservation of human and family capital.

WHAT IS OR COULD BE DONE

²³ It is also why it is inappropriate, except in a very small number of cases of exceptional children, for strangers, outsiders, volunteers, community workers, project and program staff, and others to try to provide psycho-social support directly to children rather than, if deemed necessary, strengthening, bolstering, and improving the support children receive from family, friends, teachers, community members, and other people in their day-to-day environment.

Strengthening families involves four major sets of actions.

- 1) Putting families at the centre by recognizing and acknowledging the importance of families in the lives of children in all policies, programs, and services
- 2) Ensuring that families have sufficient material resources to provide adequate care for children (economic strengthening)
- 3) Assisting families in accessing services that enable children to thrive and have opportunities to realize their human potential (health care and education)
- 4) Providing services (including building family/parenting capacity) in ways that sustain and reinforce family relationships and mutual commitments to build long-term, sustainable protection for children (Richter, 2010)

Putting Families at the Center

The image of an “orphan” as a child alone and abandoned might sometimes be true in the West, where nuclear families predominate. But it is not necessarily the case in the context of the HIV and AIDS epidemic in other parts of the world. The reasons for this include the following:

- Most orphans²⁴ have a surviving parent, and all but very few, have family (Richter, 2008).
- In most non-Western cultures, children are part of a precious heritage and they belong to families, kin, clan, and tribe in addition to their biological parents.

It undermines, not strengthens, families when they are bypassed— for example, by giving material goods directly to children instead of to a parent to give to a child, or by providing children with psycho-social support instead of first trying to strengthen the caring relationship between the child and one or two intimate adults in the family. Similarly, it is wasteful to bypass families at the policy and program level by attempting to provide all the costs, resources, and care needed to raise a child. With assistance, in all but a very small minority of socially challenged families, parents prioritize children’s needs, spending the bulk of their resources on food and education. For these reasons, assistance for children affected by HIV/AIDS must supplement, not replace, what is provided by families (Desmond, 2009).

Economic Strengthening

Families affected by AIDS get poorer by virtue of loss of income, reduction of livelihood activities, and increased dependency and expenditure on illness and death. Families without savings quickly deplete their reserves, sell their assets, and may slip into destitution. For these families, economic strengthening is necessary to:

- Be able to continue to access treatment²⁵
- Mitigate the impact of AIDS on children and other vulnerable groups
- Prevent children’s vulnerability to infection in the next generation

Social protection, as one form of economic strengthening is described in more detail in Annex E.

Assisting Families in Accessing Services that Benefit Children

Health and education, including early childhood services, benefit children. Because they are instruments of human capital development, they are especially important for children affected by HIV and AIDS (Chandan & Richter, 2009). Food, health care, and education are at the top of the

²⁴ UNAIDS defines an orphan as a child who has lost one or both parents, presumptively as a result of AIDS.

²⁵ As outlined in the UNAIDS Business Case.

list of expenditures of poor people around the world (Banerjee et al., 2007), but are cut when shocks hit a household.

Family-centered Services

HIV and AIDS are family diseases (Richter & Sherr, 2009). There are four reasons for taking this perspective.

- HIV/AIDS clusters in families in high-prevalence settings through both vertical and horizontal transmission (Dunkle et al., 2007; De Cock et al., 2007).
- Everyone in a household where one person is infected with HIV is affected, including in the most marginalized populations (Levine, 1990; Shang, 2009).
- Families carry the greatest burden of care and support for those individuals who are infected and affected (Pequegnat & Bray, 1997).
- Families play an important role in HIV prevention, especially among young people (Gregson et al., 2005).

A 2010 Supplement of the *Journal of the International AIDS Society* (Richter et al, 2010) documents the benefits of family-centered services with respect to pediatric treatment, prevention of mother-to-child transmission, and support for children of sex workers and drug users, among others.

OPPORTUNITIES AND RECOMMENDATIONS

Following the Joint Learning Initiative on Children and AIDS (JLICA), many policy, program, and project documents make reference to family-centered services. In 2009,²⁶ in response to a request, several PEPFAR OVC Focal Points submitted examples of family-centered approaches, including family health insurance in Tanzania, home-visiting, and parent support, among others. But available published and grey literature, program reports, conference presentations, and field observations indicate that most OVC programming is still directed at individual children, frequently bypassing parents, kin caregivers, and families. Programs thereby miss opportunities to strengthen families, bolster the capacity of families to provide care for children, and increase bonds of affection between caregivers and children that will stand children in good stead over their lifetime.

Missed Opportunities

In a program offering support to vulnerable children, a young volunteer hands a hand-made doll to a child sitting on her mother's lap in a clinic line. Both the mother and child are thin and look unhappy. The girl's eyes come alive and she grasps the doll while her mother looks on helplessly. The mother has never had the wherewithal to give her child a gift, and the day might come when she'll have to sell the doll to buy food for the family.

How different would both mother and child feel if the volunteer had found a moment to give the mother the doll to give to her child at a good time— tonight when she puts her daughter to bed, when the older brother comes home on the weekend from work in the town, or on the little girl's birthday next month?

Every opportunity must be taken to strengthen the bonds of love and affection between families and children. While projects may go on for a year or two, families endure for a lifetime.

²⁶ PEPFAR OVC Leadership Forum, 19 May 2009.

PEPFAR needs to lead the way in demonstrating innovative family-centered approaches to support children affected by HIV/AIDS by:

- Putting families at the center.
- Ensuring the security and stability of families
- Assisting families in accessing health and education for their children
- Providing HIV and related services in a way that contributes to family well-being

To achieve this, PEPFAR funds and programming guidelines, monitoring and evaluation, and reporting requirements must reinforce family strengthening as the primary intervention for children affected by HIV and AIDS.

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APPENDIX D. PSYCHO-SOCIAL SUPPORT

BACKGROUND

Psycho-social support (PSS) is one of the seven direct services intended to children affected by HIV and AIDS with PEFAR funding, which also include food and nutrition, shelter and care, protection, health care, education, and economic strengthening.

Each of these domains has come to be associated, in the OVC practice field, with a number of specific interventions. For example, paying fees through individual bursaries and/or school block grants, and providing uniforms and stationery are commonly used to support children's education. PSS is associated with Kid's Clubs, Memory Boxes, and a variety of self-disclosure and counseling tools.²⁷ Large numbers of volunteers and community-based workers have received brief training in PSS applications and most so-called "OVC programs" include one or other PSS interventions, often in response to donor or funder expectations.

PSS is often one of the least expensive services. For example, it was found to be one of the three lowest cost-per child services in costing exercises in Botswana and Ethiopia. PSS is thus often an option for small community groups with limited budgets and for large service providers looking to provide an additional service.

The underlying assumptions of PSS work are the widely agreed considerations that:

- Children need to know and talk about HIV in their family, and be informed about the illness and death of their parents.
- Children need to talk about their fears for their future, their bereavement and loss, and discrimination and cruelty they may experience as a result of losing a parent.

It is also argued, though no specific evidence could be found, that groups of bereaved or vulnerable children benefit by being together and sharing their concerns.

RATIONALE— WHY IS PSS IMPORTANT?

Any child who witnesses the illness and death of parents and other loved ones, and who experiences hunger, uncertainty, and stigma is likely to feel anxious, afraid, or angry. Several studies have confirmed that children who have lost their parents to AIDS do indeed suffer psychological distress (for example, Cluver et al., 2007). Such reactions have also been found with respect to child bereavement from a range of causes of parental death (Dowdney, 2000). However, the research is clear that outcomes for bereaved children are extremely heterogeneous, depending critically on the child's age and the context of support and stability available to the child, both before and after the bereavement. About a fifth of children show symptoms over follow-up periods of two years, and boys are more affected than girls (Worden & Silverman, 1996). Critical reviews of the literature, however, suggest that parental death in childhood has no effect on long-term, adult, depressive morbidity (Crook & Eliot, 1980; Tennant et al., 1980).

But the death of a parent is only one aspect of a continuum of challenges and hardships that children affected by AIDS are likely to face. Parents and caregivers living with HIV may be distracted and emotionally labile; money may become scarce, affecting food security and education; the family may become isolated and the subject of gossip; children may have to take

²⁷ See, for example, REPSSI - <http://www.repssi.org>

on the hard labor of adults to keep the household functional; and a child may have to provide daily nursing care for a sick beloved adult. After parental or caregiver death, children may face uncertainty about where they will live and who will care for them; they may change residence and school, losing friends and family support; and they may be forced to leave school, marry early or work, bringing to an end many childhood dreams (Williamson & Foster, 2000).

Awareness of these impacts is a substantial part of the motivation for the 10% budgetary requirement in PEPFAR for supporting children affected by HIV and AIDS.

However, there is considerable debate as to how to effectively prevent and manage these effects.

Controversy surrounds three issues:

- Whether PSS is a technical service that must be provided to a child by someone (a community worker, program volunteer, social worker) outside the family, versus the need to ensure that children have psycho-social support by sensitizing parents and everyday caregivers to be responsive to a child's emotional needs and ensuring they have friends during a difficult period in his or her life.
- The ad hoc nature of many PSS interventions: Little of current practice in the field is based on theory or empirical findings, there is scant use of research on childhood adversity and resilience to inform practice, and there is no scientific evidence as of yet to show the effectiveness of currently used interventions (Richter, Foster, Sherr, 2006).
- A subject about which surprisingly little is known is whether psycho-social interventions—provided by skilled professionals, volunteers, or caregivers who have received a few hours or days of training— can achieve benefits and avoid doing harm through brief interventions to improve mental and psychological health in the absence of supervision and referral, including among children affected by HIV and AIDS (Ruhle, 2005; Stallard & Salter, 2003; Wessely & Deahl, 2003).

WHAT IS BEING DONE, AND WHAT COULD BE DONE?

All children in difficult circumstances understandably enjoy the creative and recreational activities involved in many PSS interventions and such activities are important for this reason alone— to provide respite and pleasure for children in living in harsh conditions. However, there are reports in the scientific literature that being encouraged to focus on or talk about one or more difficult problems with even relatively well-trained facilitators might overwhelm rather than help children, and could be harmful (for example, Wei et al., 2010).

In contrast to PSS interventions, Richter et al. (2006, 2008) have argued that psycho-social support is best provided to children through their everyday interactions with parents, family, peers, teachers, and others— that is, the “ordinary magic” that supports and builds children's adaptive capacities (Masten, 2001). For this reason, interventions to ensure psycho-social support for children should be directed at families, schools, peer groups, and other everyday social systems from which children derive reassurance and security.

The AIDS epidemic is not the first occurrence of widespread distress, suffering, and separation affecting children. Such events recur throughout human history (de Mause, 1995). The concept of non-specific psycho-social support, as distinct from psychotherapy or psychiatric treatment, gained visibility in the context of disaster relief and work with refugee populations and other

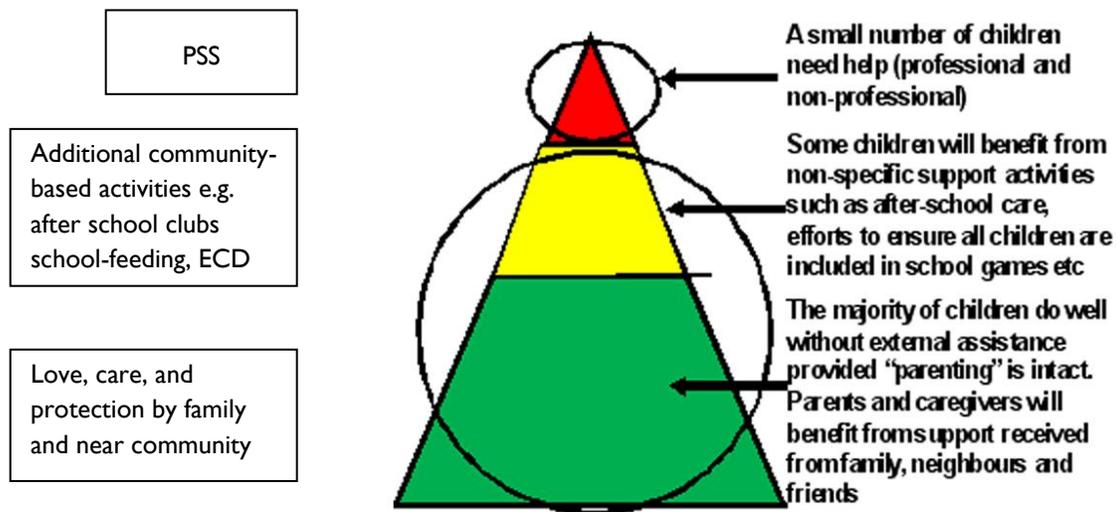
groups affected by war and conflict.²⁸ A great deal could be learned from this field to assist children affected by HIV and AIDS.

If we have learnt anything over the last two centuries of public and private assistance and services, it is that we cannot assume that intentions to do good will produce benefits and avoid unanticipated ill effects. For this reason, all treatments, services, and interventions are objectively evaluated to ensure that they produce benefits that are cost-effective.

Field observations provide some worrying examples of “psychobabble” and lack of understanding of children’s psychological and social needs in the provision of so-called PSS. For example, orphaned children should not be identified and spoken of in public and in their presence as “orphans and vulnerable children” or worse, as “OVC.” Every effort should be made to avoid pressuring children to speak about difficulties and hardships at home, thereby suggesting psychological reactions that the child may not have had, or causing secondary traumatization through lack of sensitivity and skill.

There is an urgent need in this field for clarification of which children need additional outside assistance at an individual level, and when and by whom such assistance should be delivered, as suggested in the figure below (Richter et al., 2006). In particular, there is not enough recognition of the role of parents, intimate caregivers, and other family members in supporting children, or sufficient effort to provide families with assistance to support children.

Figure 4: Interventions to Assist HIV/AIDS-affected Children and Families



OPPORTUNITIES AND RECOMMENDATIONS

Psycho-social support is clearly justified by the suffering and hardship caused for children in the HIV and AIDS epidemic and requires leadership, including by PEPFAR.

A large scale “knowledge project” needs to be initiated, bringing together theory and evidence from the broad fields of child development, pediatrics, social work, child psychiatry, and related

²⁸ See, for example, the Red Cross—<http://www.rotekreuz.at/i18n/en/participate/enspredcrossat/history-of-the-european-network-for-psychosocial-support-enps/>

disciplines to take stock and derive principles of good practice based on existing evidence.²⁹ Based on this assessment, interventions with the potential for large-scale application should be tested in scientifically robust, community-based trials. These trials need to examine important components, including the nature of interventions, staff training, and the length and intensity of interventions needed to achieve benefits.

²⁹ This was done by the World Health Organization, for example, to consider how best to assist the large numbers of children orphaned and displaced during World War II in Europe. The best academics and researchers were brought together to synthesize available knowledge and experience. Based on their findings, the major recommendation was that children should not be separated from families. On the basis of this, orphanages were closed down in Western Europe and hospital practices were changed to allow parents to accompany their children (Richter, 2004). The Joint Learning Initiative on Children and AIDS (JLICA), which operated from 2006-2008, undertook a similar exercise and made key recommendations for government action to support and protect children affected by HIV and AIDS (JLICA, 2009).

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APPENDIX E. SOCIAL WELFARE SERVICES SYSTEMS AND WORKFORCE DEVELOPMENT

For the purposes of the Social Welfare Workforce Conference in Cape Town in 2010, the social welfare system was defined as the system of interventions, programs, and benefits that are provided by governmental, civil society, and community actors to ensure the well-being and protection of socially or economically disadvantaged individuals and families (including and perhaps most importantly children). The term “social welfare workforce” was intended as an inclusive term, describing the broad variety of different workers— paid and unpaid, governmental and non-governmental— that currently make up the workforce. Social workers are called by various titles in different countries, including social workers, para-social workers, child, and youth care workers, community development workers, and child and family probation officers, and so forth.

A clear understanding and consensus of definitions are important in this sector, as the success of PEPFAR as well as the success of the PEPFAR OVC programs depends on a well-functioning child welfare system and competent social work workforce. The first phase of PEPFAR placed emphasis on supporting partners that support services to children orphaned and made vulnerable in the HIV and AIDS epidemic. Building on the successes of PEPFAR’s first phase, the strategic focus of the next five years is on promoting sustainable country programs, strengthening government capacity and country ownership, and coordinating health and development programs. Systems strengthening, particularly strengthening the social welfare services workforce system, would be a more sustainable strategy system for the 26 OVC PEPFAR-funded programs as well as for their respective governments.

TRAINING PROFESSIONAL AND PARAPROFESSIONAL WORKERS IN TANZANIA, MALAWI, NAMIBIA, AND SOUTH AFRICA

The social service welfare workforce sector seems to lack clearly defined role descriptions for professional, semi-professional, and volunteer staff. The terminology used by some countries is not clearly defined; for example, social work practices and social development practices are used interchangeably. Role description and definition and job description (where it exists) adds to the confusion.

The matrix below demonstrates the lack of synergy, common conceptual understanding, and cohesion between the professional groups in four countries. It also demonstrates how career paths and job titles differ in this sector. One could safely assume that as countries are supported in developing the different layers of professionals and service providers, the more diverse and confused the situation may become. To mitigate this risk, the Review Team believes that current work to develop and clarify a framework for this sector should be strengthened.

Terminology or issue	Tanzania	Malawi	Namibia	South Africa
Statutory body and training	No regulatory body	No regulatory body	Legislation in place	Legislated regulatory body in place
Social Worker	BA degree & MA program conferred by Tanzania Institute for SW. Jane Adams College(US) & American Health Alliance support curriculum development	1 year training at government Institution 47% SW vacancy	400 registered Social Workers. University of Namibia offers BA –Ph.D. 57% of post filled within government Graduates slow—only 6 graduates 2006	2008/9: 14 072 social workers 11 universities offered to Ph.D. level
Auxiliary Social Worker	No auxiliary social workers	No auxiliary social workers	Auxiliary social workers—numbers not known	2,065 auxiliary social workers and 1,452 have conditional status. 4 yr higher education training
Paraprofessional Social Worker	2,408 workers, 329 PSW supervisors	Terminology not used	Terminology not used	Terminology not used
Social Welfare Officers	Terminology not used	Para social welfare workers	Task shifting from social workers to this cadre	Terminology not used has category of probation officers
Community Development Worker	Terminology not used	Yes— 3 year degree	Terminology not used	Trained by dept of Public Works
Child & Youth Care Worker	Terminology not used	Terminology not used	Terminology not used	6,000 workers. 3 year accredited training
Main constraints	Absence of a comprehensive assessment of social welfare workforce and a coordinated plan to strengthen the workforce	Low % of population pass secondary school	No audit of human resource requirements	The scarcity of social workers and ancillary workers

EFFORTS OF PEPFAR TO STRENGTHEN THE SOCIAL WELFARE WORKFORCE

Recognizing the demonstrated success of investments in human resources for health through PEPFAR, and the mandate of PL 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, to help maximize the effectiveness and sustainability of U.S. assistance for vulnerable children, USAID in coordination with the PEPFAR Technical Working Group commissioned a study of the child welfare workforce and social work in Africa.

A landmark PEPFAR-funded conference was held in November 2010 with the goal to “further strategies to strengthen the social welfare workforce and social welfare systems in Africa in order to promote the well-being and welfare of children orphaned and made vulnerable by HIV/AIDS, highly vulnerable children and their families.” Emphasis was placed on improving social welfare systems and ultimately the wellbeing of children orphaned and made vulnerable by HIV and AIDS. Among the promising practices reported by the Social Workforce Strengthening Conference Report were the following:

- Several countries have carried out detailed capacity assessments and South Africa recently completed comprehensive budgeting exercises, resulting in higher funding commitments from the Ministry of Finance. Tanzania, Zambia, and South Africa have succeeded in establishing new cadres of auxiliary and assistant social workers and have begun to shift lower-level social work tasks to reduce caseloads.
- Several schools of social work in the United States and Africa are collaborating to develop new curricula and pilot more interactive teaching techniques and internships. The Jane Addams College of Social Work in Chicago and the Addis Ababa University School of Social Work have developed courses to train new cadres of social workers. The University of Kwa-Zulu Natal in South Africa has launched an innovative distance learning course for community social workers in 10 countries.
- In addition, several initiatives have been designed to better support the workforce and promote retention. Two projects in South Africa have specifically designed courses for social work supervisors. The courses both teach better management as well as enable supervisors to more effectively address the psycho-social needs of frontline staff. Tanzania and Malawi are in the process of working with government and training institutions to develop social work career paths and career development opportunities

Some countries have moved forward by analyzing workforce gaps. Examples are the human resource gap analyses supported by PEPFAR/USAID’s Capacity Project in Tanzania, Malawi, and Namibia, and social welfare human resource analyses and human resource development strategies in South Africa and Lesotho.

CHALLENGES

Current social welfare workforce staffing plans lack clearly defined strategy and realistic implementation mechanisms due to funding constraints; the absence of accurate human resource data and cost projections and ineffective, sometimes corrupt, systems for recruiting, hiring, and promoting workers. In addition, educational opportunities are inadequate to meet the demand for social welfare workers due to out-dated, often culturally inappropriate curricula; lecture-based, primarily theoretical teaching methods; inflexible course schedules; small-scale training programs; and few mechanisms for recognizing skills acquired on the job or through non-formal training. Finally, the few individuals who are employed as social workers are often ineffective and difficult to retain. This is due to factors that include the following: an inability to access existing training and professional development opportunities; under-appreciation for social work as a profession; lack of resources, supervision, and support to carry out social work tasks; and poor compensation and work environments. Social workers are generally undertrained, poorly distributed, and overworked.

There is a lack of comprehensive assessment of the social welfare workforce and few coordinated plans. In addition, there is a lack of understanding of government’s roles and functions and how social welfare services contribute to an overall development agenda.

The lack of training and deficit in skills has prevented staff from effectively engaging in policy and planning processes. They tend to be less articulate and unable to eloquently and persuasively

speaking about the importance of the role of the social welfare workforce in servicing the needs of children orphaned and made vulnerable by HIV and AIDS.

OPPORTUNITIES

The second phase of PEPFAR should continue to build on the human resources for health systems strengthening model to improve the social services welfare workforce. Already the Southern African Human Development Coalition (SAHDC), funded by PEPFAR\USAID, supported Botswana, Lesotho, Namibia, Malawi, and Swaziland in strengthening their health systems. SAHDC is now supporting Namibia in strengthening its social welfare workforce.

RECOMMENDATIONS

- Support the establishment of country-level as well as Global Social Service Workforce Strengthening Alliances to support coordination, unified leadership, and the development of shared goals, benchmarks, and strategic plans; support additional coordination meetings to take stock of achievements against strategic plans; support future planning
- Develop related strategies and plans for country regulatory mechanisms and advocacy and to identify critical resources, tools, and sources of support for social welfare workforce strengthening initiatives
- Continue to support the sharing of best practices and technical assistance through the publication of key documents, OVCsupport.net, study tours, webinars, and new targeted technical assistance mechanisms
- Contribute to the growing body of knowledge regarding components of a functioning social welfare system and social welfare workforce through establishment of a forum for coordinating and vetting research and targeted research on key topics

CONCLUSION

Moving forward with programming for children orphaned and made vulnerable by HIV/AIDS requires a unique partnership between developed and developing countries. It requires government commitment and coordination across multiple departments and ministries at the national, provincial, district, and local levels with the support of international, national, and local donors. It also requires a well-functioning social welfare workforce and competent staff.

The investment by the U.S. Government for social welfare workforce strengthening is starting to change the landscape in this field. The recent conference in Cape Town, South Africa has helped countries articulate gaps and allowed opportunity through joint learning and dialogue to develop clear measurable outcomes for the future.

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APPENDIX F. SOCIAL PROTECTION AND ECONOMIC STRENGTHENING

BACKGROUND

Families affected by HIV/AIDS, whether under high or low prevalence conditions, become poorer as their income and livelihood declines and expenditures related to HIV and AIDS increase (Collins & Leibbrandt, 2007; Franco et al., 2009; Piot et al., 2007). Already poor families have few if any assets and savings to cushion the impact of HIV and AIDS. Affected families cut consumption—they buy less food, and they have less to spend on schooling, hygiene, and transport. These reductions have their greatest negative effect on children. Hunger, hard compensatory household and livelihood work, separation from the routines and social network of school, and stigma may worsen the situation of children (Drimie & Casale, 2009).

For these reasons, as well as the fact that poverty limits uptake of HIV/AIDS prevention and treatment, there is wide agreement on the need to economically strengthen households affected by HIV and AIDS (JLICA, 2009). Families can be assisted financially in a number of ways, including through general social protection mechanisms or through specific economic strengthening interventions, such as savings clubs, work programs, livelihood training, and so on.

Families and households may be at different stages of poverty, and therefore differentially limited in the portfolio of strategies available to them. For example, families may lie somewhere along a continuum, as indicated below (Dunn et al., 1996):

- Families may be able to use insurance and reversible mechanisms— such as livelihood diversification; increasing wage labor and migrating for work; liquidating assets by selling, for example, subsistence crops and livestock; formal and informal borrowing; dependency on kin and social networks; and reducing consumption and expenditures on health and education. Families in this category may be able to take advantage of entrepreneurship training, work programs, micro-savings, and other economic interventions that require capacity to work and repay loans.
- Families may be so desperate that they resort to irreversible actions— such as selling productive assets like land and tools needed for future production; catastrophic borrowing; and dangerous cuts in consumption, especially food. These families are already at high risk and are usually not able to participate in economic interventions that require capacity to invest time, primarily because of exhaustion and undernutrition and the need to spend most of their time scrounging or begging for food.
- Families may be utterly destitute, and reliant on charity, resorting sometimes to distress migration. These families, usually comprising aged, disabled, or sick adults, have very limited capacity and require assistance.

Social relations are among the most important assets of people living in poverty, and these are disrupted by stigma and discrimination associated with HIV and AIDS, further increasing economic vulnerability and risk across the continuum (Masanjala, 2007).

Rationale—Why It is Important

PEPFAR began as an emergency response, and the humanitarian responses included food assistance and other commodities to support poor HIV-affected households. With a more developmental approach to HIV and AIDS, there is a growing focus on a broader range of social protection programs, economic strengthening interventions, and livelihoods approaches.

There are many approaches to, and tools for, household economic strengthening, including savings cooperatives, microcredit, public works programs, and entrepreneurship training. The most appropriate approach, in any particular situation, depends on the depth of poverty and the availability of labor within the household. Households with able-bodied adults, including those on ARV treatment, are able to take advantage of income-generating and livelihood programs, these are not suitable for ultra-poor and labor-constrained households. In these cases, protective measures, aimed at supporting basic household consumption, including predictable social transfers (food, vouchers, and money, as examples) are more suitable. Older persons and those who are AIDS-sick or have young children in their care) are less able to work for food or pay, or to re-pay loans. (Heymann, 2006).

While food assistance is important when markets fail, as might occur in a fragile state as well as in emergencies, it is often inefficiently converted into cash by families who need both income for food and non-food related expenditure flexibility— such as money for transport (Adato & Bassett, 2009). Families often sell commodities given to them, such as school uniforms and shoes, for the same reason.

Direct income transfers take many forms— as time-bound initiatives in emergencies, stand-alone incentive in health care, and as one aspect of social welfare. Those currently in use have developed differently in various parts of the world as a result of history, ideology, and political imperatives. Income transfers in Europe, which are part of a larger social security system, evolved out of the World Wars. Old-age pensions, child grants, and subsidies for health and education, among others, emerged from the perceived need for a common minimum level of state protection and a shared belief that this constituted a basic element of citizenship (Richter, 2010).

In contrast, conditional cash transfers (CCTs) evolved in Latin America during the 1980s out of a mix of food, school, and fuel subsidies. Typically, CCTs involve regular payments of money (too small to have perverse effects on labor supply) on condition that beneficiaries use prescribed health services and send children to school. Some 16 countries currently implement CCTs, with more than 11 million beneficiaries in Brazil and 5 million in Mexico. CCTs are intended to provide both relief and stimulate human and social development (Lomeli, 2008). Several of the CCT programs have been rigorously evaluated, providing some of the most convincing social intervention evidence to date (Rawlings, 2005). Food consumption, school enrollment, health visits, and growth monitoring increase, while stunting, school dropout, grade repetition, child labor, and illness decrease (Adato & Bassett, 2009). In addition, poverty levels drop, as do indices of inequality. CCTs are credited with impacting growth in countries like Brazil and Mexico (Easterly & Cohen, 2009).

CCTs are effective as well as palatable to tax payers, who feel reassured that the poor are not getting something for nothing. However, they are not suitable for much of Africa, because services on which payments are conditioned are not always available to everyone, especially in rural areas. In addition adding conditionalities increases the complexity and cost of scaling up programs. Finally, there is as yet no convincing evidence to suggest that conditionality is essential to the effectiveness of cash transfers in protecting poor children and promoting their development (Hailu & Soares, 2008).

What Has Been Done and What Could Be Done?

About 25 African countries already have one or another form of social assistance or income transfer (Barrientos et al., 2010). These are non-contributory schemes paid for by the state or, with some emerging programs, with the help of donors. They include social assistance to the poor (Namibia, Zambia), child and family allowances (Botswana, South Africa), social pensions for the aged or those with disabilities (Botswana, Kenya, Lesotho, Mozambique, Namibia, South

Africa, Swaziland), employment guarantee or public works programs (Burkina Faso, Egypt, Ghana, Kenya, Liberia, Malawi, Mali, Tanzania, Uganda), and asset protection through financial or food aid (Ethiopia, Nigeria).

Many of these programs are paid for by countries themselves. For example, Lesotho introduced a non-contributory old-age pension in 2004, paying close to \$30 per month to all citizens older than 70 years. The program, paid for entirely by the Government of Lesotho, reached 69, 000 people (3.8% of the population) and cost \$25 million in 2005 (1.37% GDP).

In addition, several countries have completed pilot studies of income transfer programs for vulnerable children and families. The Kenyan program now reaches some 75, 000 households (Handa et al., 2011), and the Malawian government is expanding toward a national program and aim to reach 300, 000 ultra-poor and labor-constrained beneficiaries, the majority of whom have been shown to be HIV-affected (Kulumeka, 2010). Several of the African programs have been demonstrated to have beneficial effects on children's nutrition, growth, health, schooling, and labor—specifically, in Ethiopia (Hoddinott et al., 2011), Malawi (Miller et al., 2011), and South Africa (Samson et al., 2011).

In addition, several non-experimental evaluations have attested to the benefits of even very small transfers on children and families, including on the psycho-social well-being of children in beneficiary households. The KwaWazee Project in Kagera, Tanzania, provided monthly pensions of \$5 per month to 600 older people, and an additional \$3 if the pensioner was the child's main caregiver. The reported benefits were heart rending. Children felt loved because they received a sweet occasionally, they had time to play and be with friends, they had more varied and nutritious food and their body mass index improved, they had soap for most of the month (an important resource because children who could not wash themselves or their clothes tended to stay away from school), they attended school more often and did better, and they had kerosene which gave them light at night (Hoffman et al., 2008). An independent evaluation concluded that the cash transfer was efficient in reaching the many families who needed it, effective with clear impacts on poverty and children's psycho-social wellbeing, and cost-effective compared to other interventions.

The International Labour Organization (ILO) has undertaken several costings of a basic social security package for selected African and Asian countries (Pal et al., 2005). These costings have been based on universal basic old age and disability pensions, basic child benefits, universal access to essential health care, and social assistance/100 day employment scheme. The analyses indicate that a basic social protection package is needed and demonstrably affordable (generally below 1.5% of GDP). The ILO concludes that even if a basic social protection package cannot be implemented at once, a sequential approach can generate immediate benefits in terms of poverty reduction, pro-poor growth, and social development. "Initially the envisaged package would have to be implemented through the joint efforts of the low-income countries themselves (reallocating existing resources and raising new resources) and of the international donor community—which would in some cases have to refocus international grants on the supplementary direct financing of social protection benefits, on strengthening the administrative and delivery capacity of national social protection institutions in low income countries and on providing the necessary technical advice and other support" (Hagemejer, 2009, p. 102).

A comprehensive review of the potential of cash transfers, conditional and unconditional, to protect children affected by HIV and AIDS was undertaken for the Joint Learning Initiative on Children and AIDS (Adato & Bassett, 2009). This review concluded that "Cash transfers appear to offer the best strategy for reaching families who are the very poorest, most capacity constrained and at-risk, in large numbers, relatively quickly, in a well-targeted and systematic manner, compared to alternative approaches" (p. 72).

In 2010, UNAIDS published an expanded business case for social protection, outlining the reasons for including social protection for people and families affected by HIV among the 10 priority areas in the UNAIDS Outcome Framework for 2009-2011. The Business Case sets out the rationale for investing in social protection as part of the HIV response and shows how social protection can reduce vulnerability to infection, improve and extend the lives of people living with HIV, and support individuals and households affected. There is also growing evidence on how investments in impact mitigation such as keeping girls in school, supporting economic strengthening of households, and empowerment of vulnerable groups can feed back into reduced infection risk (Baird, 2010).

African countries themselves have indicated a readiness to adopt national social security mechanisms, albeit in stages. The Livingstone Call for Action, an agenda for social protection, was signed by 13 countries in March 2006. Income transfers were advanced as a mechanism to reduce poverty and inequality, promote growth, and increase social cohesion by strengthening the social contract between citizens and the state. Following close on its heels, the Social Policy Framework, drafted by the African Union, was endorsed by the AU Executive Council of Ministers and the Assembly of Heads of States and Governments in Addis Ababa in January 2009. For the first time in history, investment in human capital through social cash transfers and other mechanisms is accepted within Africa as a necessity and as a driver of economic growth. It is also accepted that social transfers meet some of the rights of citizens to be protected by the state from extreme vulnerability through redistributive mechanisms (Richter, 2010). To a large extent, interventions to mitigate the impact of HIV on families and children have given new impetus to social protection in Africa (Webb, 2011).

Opportunities and Recommendations

In high HIV-prevalence contexts, income transfers have been shown to be a high impact and cost-effective response for the poorest households affected by HIV and AIDS. They can have a long-term positive impact on children and on their families and caregivers and address HIV-related vulnerability at scale.

Targeting data from Malawi, Mozambique, Uganda, and Zambia shows that the proportional gain in per capita consumption and schooling is maximized when transfers are directed to the poorest households with children rather than to orphan households, not all of whom are the most vulnerable (Adato & Bassett, 2009).

Income transfers are best implemented as part of a comprehensive system of social protection and complemented by family-based care, support to access social services, and progressive legislation to reduce social exclusion.

Social protection programs need to be government-owned to ensure they can go to scale and are progressively brought onto national budgets. This requires investments in the capacity of ministries responsible for delivering social protection programs, both at national and decentralized levels, as well as investment in community-led responses to improve targeting and transparency in grants management.

PEPFAR can play a lead role in scaling up social protection programs particularly by developing social systems at national and local levels to operationalize social transfers and monitor their scale up and impact.

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APPENDIX G. KNOWLEDGE

KNOWLEDGE UNDERPINNING PROGRAMS TO SUPPORT CHILDREN IN THE EPIDEMIC

Background and Rationale

Interventions on the scale needed to address the hardships experienced by children in the epidemic— to ensure that children are protected from HIV infection, and receive treatment if needed, and care and support when affected— must be grounded in vibrant, innovative, and scientifically sound research and evaluation to justify the resources allocated to them and to ensure their effectiveness.

This is sadly lacking with respect to children affected by HIV and AIDS. In fact, the absence of intervention research to advance this field manifests the neglect of children in the epidemic, which is also seen in prevention and treatment (Richter, 2008).

Several comprehensive reviews have concluded that there is an absence of scientifically tested evaluations of the interventions currently being implemented to achieve core areas of support for orphans and vulnerable children and their families.

Schenk (2009) and Schenk and Michaelis (2009) reviewed community interventions for the care and support of children affected by HIV and AIDS. They identified 21 studies, inclusive of both published and unpublished, controlled and uncontrolled studies, as well as those employing qualitative and quantitative methodologies. Of these, no study had baseline and follow-up measurement, a comparison or control group, and was representative of the population of interest. Schenk concluded that the quality and rigor of evidence is mixed and that a strategic research agenda is urgently needed to inform resource allocation, program management, and scale up.

King et al. (2009), in a published Cochrane review, found not a single randomized trial, cohort, or case-control study of psycho-social interventions for OVC. Park (in Sherr, 2010) found no impact studies of economic strengthening interventions other than evaluations of cash transfer programs. He identified one randomized control trial of an economic strengthening intervention that had a positive effect on children's mental health functioning (Ssewamala et al., 2009).

The "OVC community" evolved as a field of practice in a silo, largely separated from the bodies of knowledge and methodology established over more than a century in the disciplines of child psychology, education, pediatrics, child psychiatry, and so on. Practice has been driven, in large part, by profound sympathy for and a desire to assist vulnerable children affected by HIV/AIDS under conditions of poverty and stigmatization without the assistance and backing of solid empirical science or even disciplinary theory.

By and large, descriptive studies and "grey literature" predominate in this field, with generally low levels of scientific literacy and poor understanding of the need for and criteria of evidence-based practice. There is considerable re-cycling of information and a pervasive assumption that intentions to help children translate automatically into benefits for children and their families. There are also unquestioned beliefs that apparent sources of difficulties are to be addressed by commonsense counterparts— for example, if families have social problems, the obvious solution to this is to provide families with social services. In fact though, there is some suggestion that many of the social problems experienced by families affected by HIV/AIDS (Hoffman et al, 2008), and even some of the psychosocial problems experienced by children (Cluver et al, 2009), arise from extreme poverty and deprivation— and that interventions to reduce poverty improve

mental health (Ssewamala et al., 2009). Despite this, there appears to be little consciousness in large-scale program implementation of the importance of testing the effectiveness and cost-effectiveness of competitive interventions, such as economic support compared with social and psychological services provided to families and children.

PEPFAR-funded program evaluations, generally of processes, supply, and participation, appear to be somewhat isolated from the emerging research literature, including work funded by the U.S. National Institutes of Health. NIH-funded studies, on the other hand, seem to be out of touch with many of the questions arising from the field and in-country program implementation.

What Has Been Done?

There are four main sources of information about children affected by HIV and AIDS of relevance to PEPFAR programming.

Unpublished “Grey” Literature Comprising Mainly Project and Program Reports

This literature is too numerous and diverse in quality to summarize for this evaluation. It generally serves advocacy purposes of drawing attention to the harsh situations in which affected children find themselves, the good work of organizations and/or projects, and funder-driven evaluations of projects and/or programs. The latter are generally process- rather than impact-oriented and focus on services provided and benefits reported by, or assessed among beneficiaries.

Published Scientific Literature

For this evaluation, we drew on published (for example, Foster & Williamson, 2000; King et al., 2009; Schenk, 2009; Schenk and Michaelis, 2009,) and unpublished reviews of research (for example, Miller, 2007), as well as a scan of published literature since 2000.³⁰

Research on children affected by AIDS is predominantly cross-sectional and descriptive, with an emphasis on the effect of the epidemic on children’s health, education, living arrangements, mobility, and labor. However, a great deal of this research is inconclusive because of unreported and inconsistent definitions of orphans and of vulnerable children, as was established in a review of 383 studies (Sherr, 2008). Some studies include only maternal orphans or paternal orphans, all orphans, vulnerable children and orphans, and the like, making comparison among groups and generalization from findings extremely difficult.

Moreover, studies are highly variable with respect to child age, control groups, baseline measurements, integrity, and standardization of assessment instrument and procedures, making it almost impossible to discern trends. Nonetheless, the general gist of this category of studies indicates that children orphaned by AIDS report and are assessed to have more health, education, psychological, and social problems than comparison groups. A few valuable longitudinal studies have documented the long-term adverse impact on children of growing up in an AIDS-affected household, including increased vulnerability to HIV infection as a young adult (Nyamukupa & Gregson, 2004; Urassa et al., 2001).

A second major group of studies involve analyses of secondary data collected through country-wide household surveys of nationally representative households, such as the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS). While the long intervals between surveys and the lack of specificity to the purpose of generating data about orphans and vulnerable children reduce the usefulness of these studies, these analyses have provided an important counterbalance to non-representative, descriptive studies (for example, Monasch & Boerma, 2004). A recent review by Akwara et al. (2010) of data from 60 nationally

³⁰ Scans of PubMed, Medline, and PsychLit from 2000 to date.

representative surveys from 36 countries found that neither orphanhood nor co-residence with a chronically ill or HIV-positive adult were as predictive of poor outcomes as measures of household poverty. The outcomes assessed were wasting among children aged 0-4 years, school attendance among children aged 10-14 years, and early sexual debut among adolescent boys and girls aged 15-17 years.

As indicated earlier, there is a serious lack of good research on the efficacy, effectiveness, and cost-effectiveness of single and combination interventions for children affected by HIV and AIDS (King et al., 2009). Of the few program evaluations that have been published, the results generally show small effects (for example, Chatterji et al., 2010).

Evaluations Commissioned or Funded by PEPFAR

PEPFAR through USAID has contracted two consultants to summarize the evidence base for PEPFAR-funded Orphans and Vulnerable Children's programs (Contract No. GHS-I-00-05-00005-00). Lorraine Sherr and Miriam Zoll have examined 17 evaluations of 21 programs in nine countries (Kenya, Tanzania, Uganda, Mozambique, Rwanda, Namibia, Zambia, South Africa, and Haiti)— see Appendix L for the list of evaluations. They are examining trends and issues in the seven OVC service areas (nutrition/food security, health, education, psycho-social support, economic strengthening, child protection, shelter) and HIV prevention.

In an early presentation of results,³¹ Sherr and Zoll pointed out that none of the evaluations could conclude unambiguous evidence of benefits to children in the program areas because of serious methodological problems, including the absence of baseline information in 16 out of 17 evaluations.

An independent reading of the evaluations indicates:

- Many of the evaluations have similar design problems. For example, intervention and control groups are composed from geographically or program-targeted areas according to self-reports of having received or not received services. Unfortunately, the same selection bias responsible for receipt of services conceivably accounts for reported benefits. For example, in one evaluation, the children of guardians who attended meetings to raise awareness of child abuse reported lower levels of abuse.
- There is a general lack of strong positive findings. Many findings are stated as significant levels with respect to differences on scales measuring psychological attributes with largely unknown psychometric properties.
- In addition, sizable numbers of children in program catchment areas, or who reported accessing one or other program, still reported an absence or shortage of basic necessities, including birth certificates, meals, health care, stigma reduction, and HIV prevention knowledge.

In a separate review of monitoring and evaluation in support of orphans and vulnerable children in 15 countries in East and Southern Africa, Campbell et al. (2008) observed that many countries experienced challenges in defining and monitoring programs, and that therefore the consistency and quality of services is largely unknown. The authors conclude that:

- Quality assurance mechanisms should be established to monitor service coverage.
- No pilot program should be undertaken without the design and implementation of an evaluation to accompany it.

³¹ 10 February 2011, Washington D.C.

- Such evaluation should include a baseline and the establishment of comparison control groups— both essential design features to isolate and assess the impact that the intervention is having on children.

Studies Funded by the National Institutes of Health

Both the National Institute of Mental Health (NIMH) and the Eunice Kennedy Shriver National Institute of Child Health and Development (NICHD) are currently supporting research in the field of orphans and vulnerable children.

In March 2008, NIMH convened a three-day meeting of international researchers, program implementers, and representatives from donor organizations to address four critical questions in an effort to craft a comprehensive strategy to tackle gaps in research related to children rendered vulnerable to HIV/AIDS. The four questions were: 1. What is currently known with regard to children rendered vulnerable to HIV/AIDS in sub-Saharan Africa? 2. What research is currently in progress? 3. What are the gaps in strategic and operational knowledge? 4. What are the U.S. Government's priorities in moving forward to address these gaps?

Two of the four studies funded by NIH under way at the time of the meeting were evaluating residential care. This is not a policy option with any favor in sub-Saharan Africa, the region of the world hardest hit by HIV and AIDS.

The meeting concluded with the following recommendations: 1. Forge stronger links between researchers and practitioners. 2. Increase interdisciplinary research efforts. 3. Expand research efforts in key understudied areas, and 4. Give higher priority to rigorous evaluation studies. Studies currently funded by NIMH include investigations of a model of risk and protective factors, interventions to promote resilience among children affected by AIDS, cash transfers and economic strengthening for prevention as well as care and support, and adherence to treatment, among others. None of the results of the studies appear to have yet been published.

In October 2010, NICHD put out a request for applications (RFA) for R01 awards (RFA HD-10-017), Identifying and Understanding Effective Interventions for Orphans and Vulnerable Children Affected by HIV/AIDS, with \$2 million committed for three to five awards in FY2011. The RFA solicits applications that “propose to conduct effectiveness studies on programs that deliver essential services and HIV prevention programs to orphans and vulnerable children (OVC) affected by HIV/AIDS. Emphasis is on outcome effectiveness and the impacts programs have on the lives of children, adolescents, caregivers, and community members. Of prime interest are studies involving outcome evaluations (impact), economic evaluations (cost analysis, cost effectiveness, and cost-benefit analysis), and comparative effectiveness. Program evaluation may include formative evaluation (needs assessment) and process evaluation (program monitoring) as part of a larger study to determine the impact of the program on the health and well-being of the recipient population and to enhance our understanding of core mechanisms responsible for effective interventions.” The applications are still under review and the earliest anticipated start date is July 2011.³²

In the fourth annual report on Public Law 109-95, The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005— A Whole of Government Approach to Child Welfare and Protection— PEPFAR funding for OVC through NIH is listed as \$200, 000. While several of the Institutes, including the Fogarty International Center, support capacity development and research of relevance to vulnerable children, the investment in the care and support of children affected by AIDS seems disproportionately small relative to the PEPFAR budgetary requirement.

³² <http://grants.nih.gov/grants/guide/rfa-files/rfa-hd-10-017.html>

In addition to the above four sources of information on research and evaluation, the PLI09-95 secretariat lists the following four activities: 1. Expanding the database of indicators of vulnerability. 2. Expanding the database of projects. 3. Developing indicators of coordination and providing guidelines and case studies, and 4. Expanding the use of better designs for evaluation and providing guidelines and case studies. However, no more detailed information is available.

CONCLUSIONS AND RECOMMENDATIONS

Relative to other aspects of the AIDS response (prevention, including prevention of mother-to-child transmission; treatment and care and support in general), there has been serious neglect of knowledge needs in all aspects of providing care for children affected by AIDS.

There is little basic research, and much of it is somewhat self-evident—for example, investigating whether orphaned children are worse off than non-orphaned children. As the philosopher Jan Smedslund notes, there is a psychology of common sense inherent in language (1997). To be useful, such research needs to investigate what proportion of orphans are worse off, how to identify this group, why some orphans are resilient, and what is the most cost-effective way of helping those orphans who suffer ill-effects. There is very little information on these issues, all important to developing interventions.

Proportional to the size of the PEPFAR allocation to orphans and vulnerable children (10%), little is known about the components and combinations of effective interventions, including the most cost-effective targets and targeting levels.

No PEPFAR scientific advisory board has been established for this important area of the AIDS response. Impacts on children are important links between prevention, treatment, care and support, and mitigation in a cycle of effects now evident two to three generations into the epidemic.

We strongly urge that research and evaluation to understand how best to assist children and families affected by HIV/AIDS, and how to mitigate the impacts of HIV/AIDS on families and communities, receives the highest priority from PEPFAR leadership.

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APPENDIX H. RESEARCH DISSEMINATION EXAMPLE

Welcome to the 79th issue of *HIV This Week!*

Effect of Economic Assets on Sexual Risk-taking Intentions among Orphaned Adolescents in Uganda

Ssewamala, F.M., C.K. Han, T.B. Neilands, L. Ismayilova, E. Sperber. *Am J Public Health*. 2010 100(3):483-8.

The authors examined the effect of economic assets on sexual risk-taking intentions among school-going AIDS-orphaned adolescents in rural Uganda. AIDS-orphaned adolescents from 15 comparable schools were randomly assigned to control (n=133) or treatment (n=127) conditions. Treatment participants received child savings accounts, workshops, and mentorship. This economic intervention was in addition to the traditional care and support services for school-going orphaned adolescents (counseling and school supplies) provided to both treatment and control groups. Adolescents in the treatment condition were compared with adolescents in the control condition at baseline and at 10 months after the intervention. After control for socio-demographic factors, child caregiver/parental communication, and peer pressure, adolescents in the economic intervention group reported a significant reduction in sexual risk-taking intentions compared with adolescents in the control condition. The findings indicate that in Uganda, a country devastated by poverty and disease (including HIV), having access to economic assets plays an important role in influencing adolescents' sexual risk taking intentions. These findings have implications for the care and support of orphaned adolescents, especially in poor African countries devastated by poverty and sexually transmitted diseases.

http://www.ncbi.nlm.nih.gov/pubmed/20075323?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=1

Editors' note: Two conceptual frameworks underpinned this trial, which tested a combined microfinance youth empowerment and health promotion programme for adolescents orphaned by AIDS against health promotion alone.

The first was risk and resilience theory, which suggests that family resources, including economic assets, can buffer the effects of factors that would otherwise push adolescents toward engaging in sexual risk behavior.

The second is asset theory, which posits that people with more present assets expect to have more in the future. By extension, adolescents who have an increased belief that their future holds the promise of success might reduce their risk of unsafe sex.

This innovative trial found significantly lower intentions to engage in risky sex among the adolescents in the intervention arm which consisted of twelve 1 to 2 hour workshops on asset building and financial planning, a monthly mentorship programme with peer mentors on future planning, and a child savings account dedicated to paying for secondary schooling or a family small business, in addition to the health promotion received by the other group. The savings were matched 2 for 1 by the study; in the end, all the subjects opted to use the funds for schooling rather than a small business. What may have happened is that participation in the program instilled a sense of hope for the future that did encourage adolescents to be more careful in making decisions affecting their future.

There is no doubt that further research addressing the multidimensional aspects of orphan hood, or for that matter of poverty among adolescents, is needed for a combination prevention approach that includes behavioral, biomedical, and structural components and that uses the incidence of HIV or sexually transmitted infections as endpoints.

APPENDIX I. EARLY CHILDHOOD DEVELOPMENT (ECD) INTERVENTIONS

An Essential Ingredient for Addressing the Needs of Children and Families Affected by HIV

BACKGROUND

The PEPFAR Guidance on Orphans and Vulnerable children recommends programming according to age groups, including:

- Under 2 Years Infancy
- 2-4 Early Childhood/Toddler

A recent brief on early childhood development from AIDSSTAR outlines the extensive evidence base for including early childhood development interventions in a program for children in the HIV epidemic. Early childhood development interventions are effective—targeting children at an age when the foundation for later learning and behavior is laid; efficient—a low cost methodology with long term effects; equitable—able to improve learning outcomes for girls and vulnerable groups; and sustainable—relying on existing community and family structures.

“Highly effective programs prioritize integrated interventions that secure children’s human capital — in particular, nutrition, early childhood development (ECD), and education services.” JLICA: Home Truths

RATIONALE

Scientific evidence highlights the critical importance of ECD on outcomes for children. Recent reviews of ECD programs (Engle et al., 2007; Irwin, Siddiqi, and Hertzman, 2007) demonstrate that the benefits of early intervention for vulnerable children are far-reaching and lead to reduced instances of stunting, heart disease, and mental illness; increased school attendance; improved social and gender equality; and enhanced prospects for income generation throughout life. The parts of the brain and neurological pathways that influence health, learning, and behavior are all substantially influenced by experience and brain development early in life. (Garcia, Pence, and Evans, 2008).

It is during a child’s first few years that the neural connections that shape physical, social, cognitive, and emotional competence develop most rapidly and show the greatest ability to adapt and change. Connections and abilities formed in early childhood are the foundation of subsequent development. As a result, providing the right conditions for healthy early development is likely to be much more effective than treating problems later in life (Center on the Developing Child, 2007). The well-documented benefits of ECD, including enhanced school achievements (readiness, enrollment, completion) and extending the age at which women marry and have their first child and improved empowerment of women (Garcia, Pence, and Evans, 2008), are the very same outcomes which HIV and OVC programs hope to achieve to address HIV prevention and care.

Social protection programs—including cash transfers to families, universal primary education, health care, early childhood development, and school feeding—are increasingly seen as critical in addressing the impact of HIV (JLICA), but resources for early childhood development remain inadequate and insecure. Younger children, 0–8 years of age, in families and communities affected by HIV and AIDS will be at the dangerous confluence of two major currents: the relative invisibility of younger children and the additional stress to parents and guardians brought on by the HIV pandemic and increasing poverty. This occurs at a time when children are at a critical and key period of development.

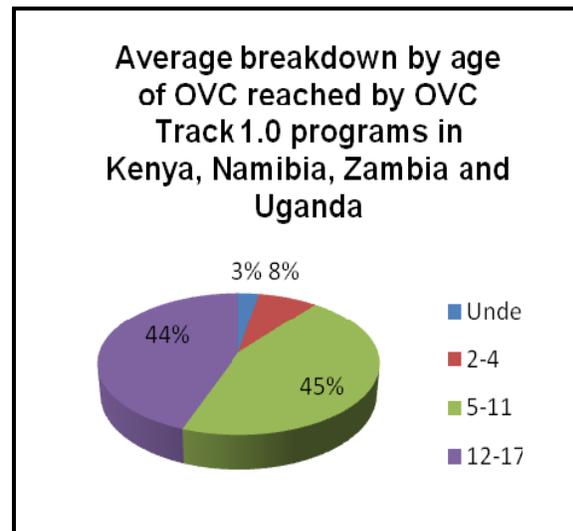
WHAT IS BEING DONE?

In sub-Saharan Africa, 16% of all orphans, approximately 6.5 million children, are under 6, with an unknown number of children in this age group made vulnerable by HIV and AIDS and poverty (UNAIDS, UNICEF, and USAID, 2004). Yet few programs for orphans and vulnerable children focus on the needs of pre-school age children (0–8) or even devise developmentally informed or differentiated programs that would cater for this age group. Early childhood development (ECD) programs do not provide adequate coverage, reaching fewer than 12% of all the children in the age group 0–8 years in sub-Saharan Africa. The percentage of vulnerable children who attend ECD programs may be even lower.

A study from Namibia shows that in all 13 regions on average, no more than 10% of the children reached by an ECD program are orphans (ranging from 1.6–18%), while only 32% of all children aged 3–6 years attended an ECD program. (Ehrenberg, 2006)

A rapid review of orphans and vulnerable children program reports and evaluations suggests that many PEPFAR-funded OVC programs concentrate on school age children 8–17 years. Few of the OVC programs focus exclusively on younger children, either in the home setting or at community facilities or centers. While this age group may statistically not be the largest group of orphans, it is a particularly vulnerable group in a critical stage of development that requires greater attention.

There are examples of projects, funded by PEPFAR, in this field that are promising and should be explored and shared. Some are center-based, others combine centers with home visits or parent meetings, and others concentrate on home visits by trained mentors. One project that used the later approach reported positive changes in over 58% of the participants in feeding practices, food production, and hygiene (Speak for the Child in Kenya). An ECD project in Zimbabwe (J.F. Kapnek Trust) targeting 3–6 year olds integrates center-based care for young children with health and community outreach to parents, including discussions of PMTCT in parenting classes.



Community-based child care centers (CBCCs) in Malawi cater for 3–6 year olds and reach over 83,500 children, of which 40% are orphans. CBCCs are a convergence point for safe childcare, early learning, play, stimulation, and primary school readiness; in addition they can be a point of access for additional services for children under 5, such as immunization and growth monitoring and promotion, referrals for sick and malnourished children, and nutritional support and

supplementation. All children in a community are invited and encouraged to participate in CBCCs, especially those considered highly vulnerable or orphaned. (AIDSTAR-One, 2011)

OPPORTUNITIES

A life-cycle approach is needed to break the cycle of HIV infection. Maternal health and early nutrition, the quality of parenting and social integration, and opportunities for learning contribute to child outcomes, child development, and child reactions. HIV in households can lead to illness and separation, unsatisfactory care arrangements, rapid turnover of adult figures, and poor role models. This, in turn, can have long-term effects on a child's behavior and achievement, including on sexual decision-making. (Sherr, 2005)

Early childhood development is a critical component of the prevention, PMTCT, treatment, and care work funded by PEPFAR and needs to be strengthened and scaled up.

A good ECD intervention would ensure:

- A focus on the basics— good early nutrition for infants and young children
- The stress on parents and primary caregivers is lessened and actions taken to promote positive parenting
- A stable and responsive environment, which provides young children with consistent, nurturing, and protective interactions with adults
- A safe and supportive physical environment, which provides places for children that are safe
- Sound nutrition and disease prevention, which includes immunization and health-promoting levels of food intake, beginning with the mother's health (adapted from AIDSTAR-One, 2011)

Creating opportunities for young children to attend childcare centers can:

- Offer relief to sick parents and elderly caregivers
- Enable surrogate parents to work during the day
- Allow children who are caring for siblings to remain in school
- Provide educational, recreational, and spiritual support
- Give caregivers relief, reducing the risk that children will be neglected, abused, abandoned, or left in full-time institutional care
- Be beneficial in terms of social, emotional, and cognitive development (Matter of Belonging)

Small and basic ECD interventions can be a stepping stone to more holistic care. They can encourage families to keep their own or even to take in other infants and young children. Custodial care provides guardians with an opportunity to engage in economic or household activities. Such care can be supplemented, resulting in more comprehensive service with little additional cost. Home visits can provide opportunities for improving parenting skills, for checking on the health of young children, and for providing psycho-social support to a guardian.

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APPENDIX J. EDUCATIONAL SUPPORT FOR CHILDREN AFFECTED BY AIDS

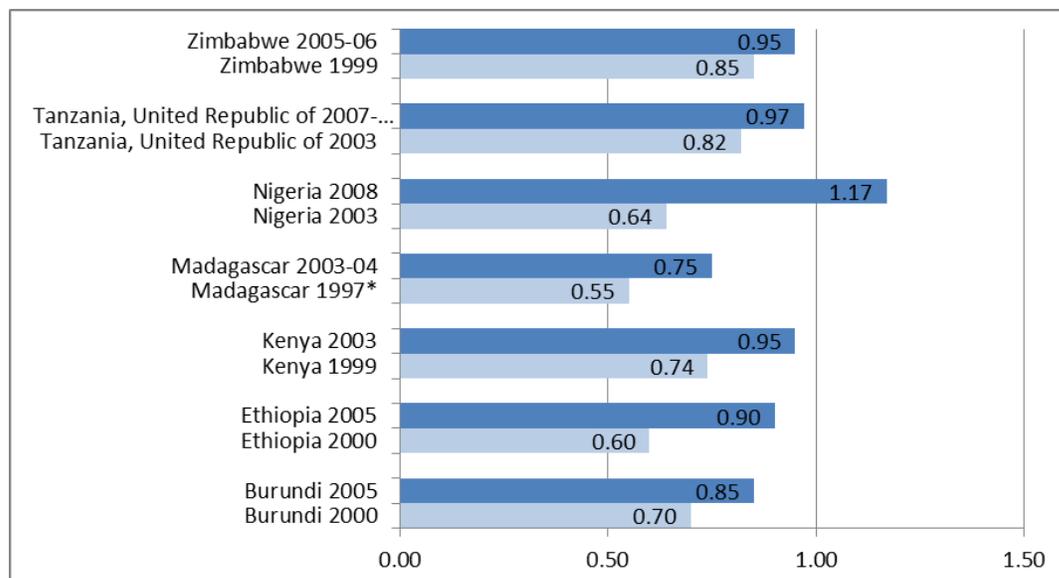
BACKGROUND

Ensuring access to quality education remains a high priority within national responses to children in the epidemic and consumes a large proportion of many national OVC budgets. Children in the epidemic, especially older boys and girls, may be more frequently absent or drop out of school due to increased economic pressures, caring responsibilities for sick relatives, stigma and discrimination, lack of permanency in living arrangements, and loss of parental guidance.³³ To ensure an effective response, the education system must address a number of issues, including cost of schooling, protection, and service provision within the school setting, and relevance of curricula to the needs of children in the epidemic as well as other vulnerable children.³⁴

RATIONALE

Globally there are indications that investments may be yielding benefits for children and families. For example, the difference in access to education between orphaned and non-orphaned children is not as wide as a decade ago. Most countries in sub-Saharan Africa have made significant progress toward parity in school attendance for orphans and non-orphans aged 10-14 (Figure 5). Demographic Health Survey data in 27 out of 31 countries in sub-Saharan Africa indicates the rate of school attendance among children who lost both parents has increased.³⁵

Figure 5: Trends in Orphan and Non-Orphan School Attendance Ratios in Selected Countries with Increasing Ratios, 1997–2008



³³ UNDP (2010). “Cambodia’s Socio-economic Impact Study for the Increased Frequency of Girls Absence in AIDS Affected.” H/H, Robson 2007, Landis 2002.

³⁴ “Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.” UNAIDS IATT on Education, 2008.

³⁵ UNICEF. “Progress Report for Children Affected by HIV/AIDS.” New York: 2009.

School Expenses

The realization of commitments on free and universal education is fundamental for ensuring vulnerable children's access to education. School fee abolition has a direct impact on increasing enrollment of vulnerable children.³⁶ There is potentially a critical role for PEPFAR to play (either through advocacy or sector-based financing) in ensuring equitable financing of primary and secondary education to ensure access of the poorest children affected by HIV to schooling. But even where education is nominally free, out-of-pocket expenses for learning materials, uniforms, and transportation costs prevent children from attending school. Consequently, many programs focus on reducing financial barriers to education.

Integration of Primary HIV Prevention and Life Skills into OVC Programming

All children, especially those embarking on their sexual lives in high-prevalence regions, need access to effective HIV prevention programming, including information, education, and services. This need is particularly acute for children in the epidemic for at least two reasons: There is evidence from Africa that orphaned girls are more likely to be sexually active than their non-orphaned peers, placing them at higher infection risk. For example in Zimbabwe, adolescent girls who lost their mothers at any age and their fathers before age 12 were more likely to be sexually active than those not orphaned³⁷; those in key population groups at higher risk of HIV infection may be less likely to access protective commodities, services, and schooling than other population groups despite their heightened risk of infection.

Schooling has a critical role to play in protecting vulnerable children from infection: Schools can provide age-appropriate, gender-sensitive life skills or sexuality education interventions, key to equipping students to avoid HIV.³⁸ Yet the schooling of girls from HIV-affected households and families and key population groups is often jeopardized for social, economic, legal, and health reasons. This means that those with the greatest need of protection are most likely to miss it, compounding their vulnerability.

Incorporating culturally appropriate, comprehensive sexuality education into schooling is part of a strategy to equip young people with the information and skills they need to protect themselves against HIV, which must be combined with additional efforts to reach young people out of school.

WHAT IS OR COULD BE DONE

In many countries governments, civil society organizations, and individual well-wishers provide support through bursaries for individual students. In Malawi we heard that bursaries are not always well-coordinated, with an individual school receiving bursaries for five or core partners often using different criteria, which can place a large reporting burden on schools. For both block grants and bursaries managed through NGOs, greater consideration needs to be given to ensure sustainability of access after the duration of the NGO grant.

³⁶ SFAI. "Six Steps to Abolishing Primary School Fees: Operational Guidelines," 2009.

³⁷ Birdthistle et al., 2008.

³⁸ Kirby, Laris, and Rolleri, 2005.

Block grants to schools have been shown to be an effective mechanism for exempting the poorest and most vulnerable children from paying fees or development levies.³⁹ A study from Africare/Uganda showed substantial cost savings in using a block grant versus a tuition payment scheme. In one school, enrolling 100 children would have cost U.S. \$100,000, while the same children were accommodated for a block grant of U.S. \$2,000. In addition the strategy helps reduce stigma by not targeting an HIV-affected child or orphan in particular, while increasing teachers' knowledge of HIV and AIDS and the psycho-social needs of children. (Track One evaluation). Block grants have the added advantage of addressing the supply and demand side constraints of the education system. In most cases the block cash grant is transferred directly to the school, along with an agreement to exempt a number of the most vulnerable children from school fees and levies. As well as overcoming financial barriers to accesses for vulnerable children, they can provide schools with a much-needed injection of resources (in cash or in-kind) to improve the learning environment. The Centre for Global Health and Development (with U.S. Government funding) is currently undertaking a cost effectiveness analysis of block grants versus individual bursaries, which should help determine future funding priorities in this area.

The Zomba Cash Transfer Experiment for Adolescent Girls

One of the few experiments from Africa comparing the relative benefits of conditional and non-conditional cash transfers for adolescent girls (using school attendance as the conditionality) substantially increased school attendance among beneficiaries who were currently enrolled in school or had dropped out at baseline. The intervention also led to a significant decline in early marriage, pregnancy and self-reported sexual activity among beneficiaries in both the conditional and non-conditional arms. And importantly, preliminary findings indicate that HIV prevalence among “baseline schoolgirls” (beneficiaries who were enrolled in school at baseline) was 60% lower than in the control group following the intervention, although there was no HIV effect among the “baseline dropouts” (girls who returned to school as a result of receiving cash transfers).

Researchers found that the sexually active beneficiaries reduced their risky behaviour; they did not cease having sex, but rather with the cash in hand from the transfer, moved away from older partners to peer partners, who were less likely to be HIV-positive. The researchers went on to investigate the relative roles of additional income and increased schooling leading to the large HIV effect. (Temin 2010)

Small, predictable cash transfers targeted at ultra-poor households delivered as part of a comprehensive social protection system can dramatically impact educational access for children in the epidemic. Cash can be used for educational materials and school fees, compensating for lost income from child labor, and improving children's nutrition for better school performance.⁴⁰

The evidence from high HIV prevalence, low-income settings suggests that non-conditional cash transfers (i.e., given to a child or family regardless of whether a child is attending school) are as effective as conditional cash transfers for improving vulnerable children's school access. Evidence from sub-Saharan Africa shows that poor people use cash transfers wisely, without conditions, to invest in their children's health, nutrition, and education.⁴¹

As well as ensuring access to education, there is a need to support school policies that identify and provide support for vulnerable children, including those HIV-affected; learning environments that are healthy, safe, and inclusive; and provision of social, health, and nutritional services

³⁹ Africare. “Innovations in Education,” 2006.

⁴⁰ Adato and Bassett.

⁴¹ Ibid.

through schools to vulnerable children.⁴² Similar interventions can also be delivered by CBOs within or outside schools. Teacher or peer-led clubs and activities have been effective in providing psycho-social support and ensuring a supportive learning environment, free of stigma and discrimination. Out-of-school children and adolescents need alternative learning interventions, interactive radio instruction programs, and in the case of children living on the street, street educators with responsibility for a small number of children.

OPPORTUNITIES/RECOMMENDATIONS

- Helping ensure the community networks and educational policies needed to make sure that children and adolescents affected by AIDS access primary and secondary education remains critical. Education can help with both protection and HIV prevention objectives— and is especially critical for adolescent girls.
- There are good opportunities to ensure that the needs of AIDS-affected children are better integrated in sector and school planning processes for a more scaled-up response.
- There is a need for more analysis of the effectiveness and cost-effectiveness of educational interventions for children in the epidemic, including comparisons between individual bursaries, block grants, provision of learning materials, and other approaches to be sure that funds are being used in the best possible way to ensure that the maximum number of children can be supported in accessing schooling.

⁴² “Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.” UNAIDS IATT on Education, 2008.

APPENDIX K. COUNTRIES WITH LOW PREVALENCE RATES AND CONCENTRATED EPIDEMIC

BACKGROUND

Children have become the center of focus in the HIV and AIDS epidemic, especially those in the worst-affected regions such as sub-Saharan Africa. There has been no shortage of global initiatives and innovations to reduce the risks and vulnerabilities of children in the epidemic. At the same time, PEPFAR funding has also reach children in low-prevalence areas and in countries with a more concentrated epidemic.

The Review Team attempted to ascertain whether the program approach and design differs in programs in low- and high-prevalence countries. The information was drawn from AIDS Care: Evidenced based for children affected by HIV and AIDS in low-prevalence and concentrated-epidemic countries applicability to programming guidance from high-prevalence countries (Lynne Miller Franco, et al.) <http://dx.doi.org/10.1080/09540120902923089>. PEPFAR country operational plans for low prevalence and countries with a more concentrated epidemic such as Brazil, China, Caribbean, and India have also been reviewed. It is important to note that no review for low-prevalence countries and concentrated epidemic existed until 2008.

OVERVIEW

In countries with a high HIV and AIDS prevalence rate such as in sub-Saharan Africa, services to children orphaned and made vulnerable in the HIV and AIDS epidemic during the first phase of PEPFAR initially took the form of a typical emergency response and slowly migrated to a more comprehensive, holistic, and integrated approach. A more specialized approach emerged from high-prevalence settings, with strengthening of the social welfare workforce sector, design of high-quality programs, and a focus on outcomes, impact, and mitigation of vulnerability risks central elements of most programs. Country operational plans in Tanzania, Malawi, South Africa, Namibia, and other countries in sub-Saharan Africa where the prevalence is high have a distinct focus on children orphaned and made vulnerable in the HIV and AIDS epidemic.

Some country operational plans for low and concentrated prevalence rates often have little reference to children orphaned or made vulnerable in the HIV and AIDS epidemic, as in the case of China. The China program focuses on counseling and testing, behavior change, and peer education. The Caribbean COP does not mention OVC at all.

Findings show that children face similar vulnerabilities irrespective of prevalence setting. The 2009 country operational plans indicated that countries with low prevalence or concentrated epidemics are increasingly introducing special programs to support children affected by HIV and AIDS. Orphans and vulnerable children are not mentioned as a priority under India's third AIDS Control Plan; however, they are identified in five areas of programming: strengthening government systems, direct implementation of selected OVC programs, increase the definition of OVC, promote linkages with government and NGOs, and mainstream OVC issues in government systems. The Caribbean Country Operational Plan reflects a focus on prevention and treatment, including prevention of mother-to-child transmission.

The country operational plans of all the three countries support the findings of Lynne Miller Franco et al. that the context in low-prevalence countries varies so much that it would be unwise to draw broad conclusions about what should be done for children across these settings.

It seems as if the jury is still out about how best to meet the needs of children in low-prevalence settings and whether information from high-prevalence settings can guide programming in low and concentrated settings. However, there are several approaches, highlighted below, that suggest programming guideline principles.

POSSIBLE DIRECTIONS

JLICA (2008) [*http://jlica.org/userfiles/file/JLICA_LGI_FINAL\(1\)*](http://jlica.org/userfiles/file/JLICA_LGI_FINAL(1)) research offers some guidance by suggesting that there are three programming principles from high prevalence settings which should be considered irrespective of the prevalence rate:

- Keeping families together through parental and child HIV prevention and treatment is integral to prevention and support for HIV- and AIDS-infected children.
- Support should focus on family, not just the children, to ensure the functional family capacity essential for children's welfare, protection, and care.
- Preservation of household financial capacity helps mitigate the negative impact of HIV and AIDS on children and households.
- Activity designers should be cognizant of the local content in developing mitigating strategies, as low-prevalence countries are extremely diverse.
- It is necessary to understand the driver of HIV in a country context.
- Understanding the needs of children affected by and made vulnerable as a result of HIV and AIDS requires a situational analysis.
- Finally, family-centered care in low-prevalence settings should be seen as a cost-effective and practical means of reaching out to children within most-at-risk populations.

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