The U.S. President's Emergency Plan for AIDS Relief

GUIDANCE FOR ORPHANS AND VULNERABLE CHILDREN PROGRAMMING

July 2012

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
CoR	Continuum of Response
CSO	Civil Society Organization
DFID	Department for International Development (U.K.)
ECD	Early Childhood Development
FBO	Faith-Based Organization
GBV	Gender-Based Violence
GHI	Global Health Initiative
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
ITN	Insecticide-Treated Bed Net
JLICA	Joint Learning Initiative on Children and HIV/AIDS
M&E	Monitoring and Evaluation
MCH	Maternal/Child Health
MERL	Monitoring, Evaluation, Reporting, and Learning
MIS	Management Information System
NGI	Next Generation Indicator
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President‘s Emergency Plan for AIDS Relief
PMI	President‘s Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
RCT	Randomized Control Trial
SRGBV	School-Related Gender-Based Violence
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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1. INTRODUCTION

1.1 Orphans and Vulnerable Children (OVC) Programming and PEPFAR's AIDS Response

> *For people infected and affected by the epidemic, HIV is not only a medical experience. It is also a social and emotional experience that profoundly affects their lives and their futures. Programming for children orphaned and made vulnerable by HIV/AIDS contributes to the achievement of an AIDS-free generation by responding to the social (including economic) and emotional consequences of the disease on children, their families, and communities that support them.*

PEPFAR programs for AIDS-affected children have promoted resilience in children and broader society by reducing adversity and by building services and systems that reach people directly in their households and communities.[1] And the evidence – highlighted here and throughout the document – shows that these interventions are working. They have kept children in school and improved education[2,3] and psychosocial outcomes at the child level.[4] They have developed household economic strengthening (HES) initiatives; established parent/caregiver education and support groups;[5] and increased health care access and food and nutrition outcomes at the family and household level.[6,7] Over 4 million children have benefitted from these efforts in 20ll alone.

OVC programs also support the medical goals of the response in key and mutually beneficial ways. For example, efforts to keep children in school have positive impacts on prevention.[8] Economic strengthening activities help remove barriers to accessing facility-based services,[9] and child-focused health interventions are important platforms for targeting mothers for prevention of mother-to-child transmission (PMTCT). In addition, OVC community-based programming helps to reduce stigma and discrimination and create an enabling environment for people infected and affected by HIV/AIDS to access services.[10,11] By addressing socio-emotional effects of the epidemic, OVC programs reduce the likelihood of children and adolescents moving from being affected by the epidemic to infected.

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[1] Binagwaho A, Noguchi J., et al. (2008). *Community-Centered Integrated Services for Orphans and Vulnerable Children in Rwanda*. Joint Learning Initiative on Children and HIV/AIDS.

[2] Blackett-Dibinga K, Anah K, Matinhure N. (2006). *Innovations in Education: The role of the education sector in combating HIV/AIDS*. Africare: Office of Health and HIV/AIDS;

[3] Bryant M, et al. (2011) *Evaluating the Effectiveness of Educational Block Grants to Orphans and Vulnerable Children*. USAID Project SEARCH Research Report: Boston University OVC-CARE Project.

[4] Nyangara F, Obiero W, Kalungwa Z, Thurman T. (2009). *Community-Based Psychosocial Intervention for HIV-Affected Children and their Caregivers: Evaluation of The Salvation Army.* USAID MEASURE Evaluation Project.

[5] Thurman T, Rice J, Ikamari L, Jarabi B, Mutuku A, Nyangara F. (2009). *The Difference Interventions for Guardians Can Make: Evaluation of the Kilifi Orphans and Vulnerable Children Project in Kenya.* USAID MEASURE Evaluation Project.

[6] Adato M, Bassett L. (2009). Social protection to support vulnerable children and families: the potential of cash transfers to protect education, health and nutrition. *AIDS Care.* 21(S1), 60-75.

[7] Nyangara F, Kalungwa Z, Obiero W, Thurman TR, Chapman J. (2009). *Promoting a Home-Based Program Model for Supporting Children Affected by HIV/AIDS: Evaluation of Tumaini Project in Iringa Region, Tanzania.* USAID MEASURE Evaluation Project.

[8] Cho H, Hallfors DD, Mbai II, Itindi J, Milimo BW, Halpern CT, Iritani BJ. (2011). Keeping Adolescent Orphans in School to Prevent Human Immunodeficiency Virus Infection : Evidence From a Randomized Controlled Trial in Kenya. *J Adolesc Health*. 48(5), 523-526. Epub 2011 Feb 18.

[9] Stene A, Chandani T, Arur A, Patsika R, Carmona, A. (2009). *Economic Strengthening Programs for HIV/AIDS Affected Communities: Evidence of Impact and Good Practice Guidelines.* Private Sector Partnerships One Project, Abt Associates, Inc.

[10] Apinundecha C,. Laohasiriwong, Cameron M, Lim S. (2007). A community participation intervention to reduce HIV/AIDS stigma, Nakhon Ratchasima province, northeast Thailand. *AIDS Care* 19, 1157-1165.

[11] Nyblade, L, MacQuarrie K, Kwesigabo G, Jain A, Kajula L, Philip F, Tibesigwa WH, Mbwambo J. (2008). *Moving Forward: Tackling Stigma in a Tanzanian Community: A Horizons Final Report.* Washington, D.C.: Population Council.

1.2 Purpose

The purpose of this guidance is to help PEPFAR country teams and implementing partners develop country operational plans (COPs) and design programs that support vulnerable children in their contexts, align with known best practice, and incorporate potential innovation. It seeks to aid teams in identifying and implementing appropriate, evidence-based, and cost-effective activities that will maximize improvement in the well-being of vulnerable children in the epidemic and close gaps in past programming efforts. Importantly, ***the guidance clearly places the OVC programming within the HIV/AIDS continuum of response at the country level***.

This guidance, however, is not a "how to" manual for implementing specific technical activities. Those resources already exist and can be referenced for more detailed implementation guidance. Rather, this document outlines in general terms strategic, evidence-based interventions that PEPFAR OVC programs can consider implementing based on assessed context and need.

1.3 Important Themes in this Guidance

This guidance builds on past programming and guidance, with new emphasis on the key points highlighted in the box below. These points are elaborated upon and emphasized throughout the document.

Key Points

- *There is no "minimum package of services." Program planners and implementers should ensure prioritized and focused interventions that address children's most critical care needs through family strengthening.*
- *While programs must continue to improve child outcomes, the primary strategy for achieving this is strengthening parents and caregivers so they can provide for their children's basic needs. The seven core areas have been reinterpreted to better reflect this shift*.
- *Child-focused, family-centered interventions at the household level take precedence over handing out materials only to children identified as "OVC."*
- *Sustainability through capacity building and transfer of program responsibility to promote country ownership are imperative and must be balanced with careful planning and monitoring to ensure children's immediate needs are also met.*
- *A young person who turns 18 while receiving OVC services should not automatically be terminated from receiving assistance. Programs should plan for appropriate transition strategies and be prepared to cover a buffer period for a seamless transition to adulthood*.
- *There is a growing evidence base for OVC programming reflected in this document. Programs should build interventions on evidence-based practice. This guidance includes summaries of the evidence for the efficacy of a range of child and family support interventions.*
- *Programs should allocate at least 10 percent of project funding to monitoring and evaluation (M&E) to ensure that the evidence base continues to grow and to inform better practice.*
- *Experienced and specialized technical expertise is required for many types of interventions included in this guidance. Country teams and implementing partners should call upon individuals and resources with this expertise when designing programs and country strategies.*

1.4 Summary of Priority Activities

The technical sections included in this guidance (Sections 4-11) include explanatory narrative on how and when to prioritize specific technical interventions. These prioritized interventions are summarized below, although the more detailed technical sections should be referenced, along with the guidance on strategic planning processes, for clarification and better understanding when planning programs.

Education: PEPFAR OVC programs should support efforts to reduce educational disparities and barriers to access among school-age children through sustainable "systemic" interventions (for example, school block grants) and by:

1) Ensuring children have a safe school environment and complete their primary education
2) Promoting access to early childhood development (ECD) programs
3) Ensuring personnel create child-friendly and HIV/AIDS- and gender-sensitive classrooms
4) Strengthening community- school relationships, including partnering with out-of-school programming
5) Consider supporting post-primary school programming and especially the transition for girls from primary to secondary school
6) Implementing market-driven vocational training only when previous lessons learned are integrated into intervention designs

Psychosocial Care and Support: PEPFAR OVC programs should prioritize psychosocial interventions that build on existing resources and place and maintain children in stable and affectionate environments through:

1) Parents and family support programs
2) Peer and social group interventions
3) Mentorship programs
4) Community caregiver support

Household Economic Strengthening (HES): HES aims to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care through:

1) Money management interventions for savings, access to consumer credit, and fostering knowledge and behaviors for better family financial management
2) Integration of HES activities with complementary interventions, such as parenting skills
3) Income promotion using low-risk activities to diversify and stimulate growth in household income

Social Protection: PEPFAR support for social protection aims to reduce vulnerability and risks, foster human capital development, and interrupt the transmission of poverty from one generation to the next through:

1) Supporting host-country governments to initiate, expand, or be innovative in their social protection initiatives at both the policy and operational levels

Health and Nutrition: PEPFAR OVC programs aim to improve children's and families' access to health and nutritional services through:

1) A child-focused, family-centered approach to health and nutrition through ECD and school-based programs
2) Effective integration with existing or planned child-focused community- and home-based activities, including PMTCT, treatment, the President's Malaria Initiative (PMI), and child survival

3) Reducing access barriers to health services through HES and social protection schemes, such as health insurance opportunities
4) Establishing linkages and referral systems between community- and clinic-based programs

Child Protection: PEPFAR OVC programs aim to develop appropriate strategies for preventing and responding to child abuse, exploitation, violence, and family separation through:

1) Implementing child safeguarding policies
2) Integrating child protection activities
3) Supporting communities to prevent and respond to child protection issues
4) Strengthening linkages between the formal and informal child protection systems
5) Building government capacity to carry out and improve child protection responses

Legal Protection: PEPFAR OVC programs aim to develop strategies to ensure basic legal rights, birth registration, and inheritance rights to improve access to essential services and opportunities through:

1) Raising awareness about birth registration and succession planning
2) Linking birth registration and succession planning to other essential services
3) Improving government birth registration systems and legal mechanisms for enforcing fair and equitable inheritance laws and guardianship

Capacity Building: PEPFAR programs should prioritize within their country context the following capacity-building and systems-strengthening interventions:

1) Investing in efforts to build strong leadership and governance
2) Pursuing strategies to strengthen the social service workforce
3) Supporting strategies to improve financing for social service systems
4) Strengthening information management and accountability mechanisms of the social service system
5) Supporting coordination and networking within the social service system

1.5 Background

The HIV/AIDS epidemic has exacted a terrible toll on children and their families. During the 30 years of the global HIV epidemic, an estimated 17 million children have lost one or both parents due to AIDS; 90 percent of these children live in sub-Saharan Africa. In addition, 3.4 million children under age 15 are living with HIV. Despite some decline in HIV adult prevalence worldwide and increasing access to treatment, the number of children affected by or vulnerable to HIV remains alarmingly high.[12]

The social and emotional effects of the disease are numerous and profound. While poverty is at the core of many of these issues, HIV/AIDS deeply complicates the environment both for the consequences of and the response to the epidemic. As a result of the social effects of HIV/AIDS, millions of HIV-affected children are highly vulnerable, as they are more likely to be victims of abuse, live in institutional care or on the street, and engage in hazardous and/or exploitive labor. More specifically, children who live with an ill adult or who have been orphaned by AIDS have a dramatically greater risk of abuse and exploitation,[13] school drop-out (as children leave school to care for ailing family members), and

[12] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). *UNAIDS Report on the Global AIDS Epidemic 2010.* Geneva: UNAIDS.
[13] Cluver L, Orkin M, Boyes ME, Gardner F, Meinck, F. (2011). Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. *Journal of Acquired Immune Deficiency Syndromes*. 58, 336-342.

psychosocial distress.[14,15,16] ***Orphaned and vulnerable children are also far more likely to move from being "affected" by the virus to becoming infected,*** as well as facing other risks. [17] This is especially true for adolescent girls who have lost a mother and who are then more likely to engage in risky sexual behavior.[18]

Children infected by the disease are even more greatly impacted. Where there is no PMTCT program, children are often infected by the virus at birth or soon after. Even with the mother on treatment, HIV-negative but exposed children experience delayed cognitive development.[19,20] Additionally, HIV-positive children sometimes have the compounded tragedy of being rejected by their families and abandoned to orphanages, further contributing to impaired cognitive and physical development.[21]

1.6 Response

Over the 30 years of the pandemic, families and communities have led a massive response to protect, care for, and support children affected by HIV/AIDS. Since 2003, $2 billion in funding and technical support from PEPFAR has greatly enhanced these efforts for orphans and vulnerable children. In 2008, the Hyde-Lantos Act reauthorized PEPFAR, including a requirement that programs for orphans and vulnerable children continue to be 10 percent of all PEPFAR program funds, a recognition of the importance of these holistic interventions and the strong foundation built during PEPFAR's first phase.

These investments have enabled children to stay in school, strengthened households, and allowed families to reclaim their roles as primary caregivers. Efforts to build the capacity of local organizations and improve the quality of community-based services have also helped communities to better address the needs of vulnerable children and families.[22] PEPFAR OVC programs support a vast network of community groups and organizations addressing the needs of orphaned and vulnerable children and their families. In 2011, one-third of all PEPFAR OVC prime partners were national organizations,[23] and substantial resources went directly to national organizations as subgrantees to larger organizations.

> *Adolescents girls affected by AIDS orphanhood showed a sixfold higher likelihood of transactional sexual exploitation, compared with those in healthy families.*
>
> - *Operario et al, 2011*

[14] Guo Y, Sherr L. (2012). The impact of HIV/AIDS on children's educational outcome: A critical review of global literature. *AIDS Care.* Apr 23 Epub ahead of print.
[15] Cluver L, Orkin M, Boyes ME, Gardner F. (2012). AIDS-orphanhood and caregiver AIDS-sickness-status: Effects on psychological symptoms in South African youth. *Journal of Pediatric Psychology*. DOI: 10.1093/jpegsy/jss004. (IF 2.943)
[16] Atwine B, Cantor-Graae E, Bujunirwe F. (2005). Psychological Distress among AIDS Orphans in Rural Uganda. *Science & Medicine.* 61 (3), 555-564.
[17] Operario D, Underhill K, Chuong C, Cluver L. (2011). HIV Infection and Sexual Risk Behavior Among Youth who have Experienced Orphanhood: Systematic Review and Meta-Analysis. *International Aids Society.* 14:25.
[18] Ibid.
[19] Smith R, Malee K, Leighty R, Brouwers P, Mellins C, Hittelman J, Chase, C, Blasini, I. (2006). Effects of Perinatal HIV Infection and Associated Risk Factors on Cognitive Development Among Young Children. *Pediatrics*. 117, 851.
[20] Sherr,L, Mueller J, Varrall, R. (2009). *A* systematic review of cognitive development and child HIV infection*. Pscyhology, Health & Medicine.* 14 (4), 387-404..
[21] Nelson C, Zeanah C, Fox N, Marshall P, Smyke A, Guthrie D. (2007). Cognitive Recovery in Socially Deprived Young Children: The Bucharest Early Intervention Project. *Science.* 318 (5858), 1937-1940.
[22] Yates, D, Richter, L, Zingu, J, Yates, R, Wolfe, J.(2011).PEPFAR HKID Portfolio Review: Children in the Epidemic. *Global Health Technical Assistance Project, USAID.*
[23] According to a review of 2011 Country Operational Plans.

Increasingly, PEPFAR has complemented strong community-level investments with investments at the national level to care for millions of children through country-owned, sustainable solutions. For example, as a result of PEPFAR systems- strengthening efforts, the global social welfare workforce has greatly expanded in number and capacity, and 17 countries in sub-Saharan Africa have formulated national plans of action for vulnerable children with robust coverage data.

While significant progress has been made, multiple factors continue to challenge effective care and support for vulnerable children. These include the challenges of implementing complex, multisectoral interventions; limited rigorous program evaluation; only partial integration with prevention, care, and treatment activities; and limited evaluation of child outcomes achieved. This guidance builds upon the solid foundation of past PEPFAR OVC programming and addresses some of the challenges to more effectively respond to children and achieve a generation free from AIDS and its devastating effects.

2. PEPFAR OVC PRINCIPLES AND APPROACH FOR PROGRAMMING

2.1 PEPFAR OVC Guiding Principles

This guidance mirrors principles found in the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS* (The Global Framework) as well as those found in the UNAIDS Investment Framework for HIV/AIDS. The principles are also aligned with the objectives included in the U.S. Government (USG) *National Action Plan for Children in Adversity: A Framework for U.S. Government Foreign Assistance,* which was developed under the auspices of the USG Secretariat for Children in Adversity (PL 109-95).

Specifically, the following principles undergird all PEPFAR OVC programming:

- Strengthening families as primary caregivers of children
- Strengthening systems to support country ownership, including community ownership
- Ensuring prioritized and focused interventions that address children's most critical care needs
- Working within the continuum of response to achieve an AIDS-free generation

2.1.1 Strengthening families as primary caregivers of children

Within PEPFAR OVC programs, the family should be the primary unit of intervention. In fact, 95 percent of all children affected by HIV/AIDS live in families, and interventions that support entire households to provide for children's needs are encouraged. Interventions that promote family involvement in children's development, build parental knowledge and skills, and improve family stability through, for example, efforts toward economic security and social inclusion fall under the rubric of "family strengthening."[24] These efforts are foundational to programs addressing children affected by HIV/AIDS.[25] Programs should not singularly target any child within the family without considering the needs of other siblings/children as well as the needs of primary caregivers at the household level.

2.1.2 Strengthening systems to support country ownership, including community ownership

All PEPFAR OVC programs should support country ownership and systems strengthening (see Section 11) and remember that the USG is only one of many funders and implementers supporting the HIV/AIDS response. Working with host-country governments as well as other key stakeholders, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, is a key facet of building country ownership. The principles and approaches within this guidance should inform collaboration and interaction with all players at the country level.

C*ommunity ownership* is a central but often overlooked element of country ownership at the micro level. It contributes to macro outcomes and is crucial for sustainable, positive outcomes for children in both the short and long terms. It is also a central and long-standing feature of OVC programming. Country ownership is central to the PEPFAR strategy and has been widely endorsed by both donor and recipient nations. The Paris Declaration, developed in 2005 and supported by the United States, outlines country ownership as one of five fundamental principles for aid effectiveness.[26] ***Without strong***

[24] Caspe M, Lopez M. (2006). *Lessons from family-strengthening interventions: Learning from evidence-based practice.* Cambridge, Mass.: Harvard Family Research Project.
[25] Richter L, Sherr L, et al. (2009). Strengthening families to support children affected by HIV and AIDS, *AIDS Care*. 21 (S1), 3-12.
[26] Organization for Economic Co-operation and Development; Development Co-operation Directorate; [web site]. Accessible at: http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html. Online. Internet. Accessed 2011 Sept. 7.

community ownership, government initiatives and services can ultimately be weak and ineffective at the point of delivery, where effectiveness matters most.[27] PEPFAR OVC programs also support country ownership at the national level through social welfare workforce strengthening to increase human resources that serve children and complement health systems strengthening.

2.1.3 Ensuring prioritized, focused interventions that address children's most critical care needs

The number of intervention areas pursued by country programs, as well as the level of technical competence required to deliver different interventions, depends largely on country context and the budget and longevity of the program. There are thus no preset minimums for the number or range of interventions required by partners, nor is there a "one size fits all" package for most country programs. When working with children with multiple needs, it is tempting to try to do everything. However, such attempts generally lead to poor quality programming with little depth or sustainable impact. In all programs, assessments should be done to identify children's most critical care needs, prioritized based on urgency as well as proven effectiveness. In this guidance, the seven core areas have been reinterpreted to better acknowledge the important role of strengthening parents and caregivers so that they may provide for their children's basic needs. While all needs cannot be met through OVC programs, linkages can be made within and throughout a system of care to help cover the range of needs identified through household assessment.

2.1.4 Working within the continuum of response to achieve an AIDS-free generation

When considering OVC interventions and program implementation, all actors should intentionally consider how the interventions planned fit into the HIV/AIDS continuum of response (CoR). The CoR approach addresses the lifetime needs of the target populations to ensure adequate access to a wide range of prevention, care, and treatment services based on the changing needs and circumstances of the families that are being served. HIV services, including OVC programming, are part of the larger CoR that addresses the entirety of the population's needs, including social and emotional needs that result from the effects of the epidemic. The CoR approach should be set within an organized and coordinated system of community- and facility-based services and providers. OVC programs find their place in the continuum by considering the ways in which HIV/ AIDS is a biosocial event and how the different interventions advance the goal of an AIDS-free generation (see Section 2.3).

2.2 PEPFAR OVC Program Approach

Stable, caring families and communities and strong child welfare systems are the best defenses against the effects of HIV AIDS in the lives of children**. *Nurturing families are critical to children's lifelong health and well-being, including their prospects for living HIV-free, or positively with HIV.*** [28, 29] The PEPFAR approach to children in the epidemic is based on a social-ecological model that considers the child, family, community, and country contexts and recognizes the unique yet interdependent contributions of actors at all levels of society to the well-being of children affected by HIV/AIDS.[30]

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[27] Busza J, et al. (2012). Community-based approaches for PMTCT in resource poor settings: a social-ecological view. *JIAS.* Special issue, forthcoming.

[28] Felitti V, Anda R, Nordenberg D, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 14(4), 245-258.

[29] Hillis S, Anda R, Felitti V, Marchbanks, PA. (2001). Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study. *Fam Plann Perspect.* 33(5), 206–211.

[30] Bronfenbrenner U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*. 22, 723–742.

Families, communities, and governments share responsibility to protect children from HIV infection and to ensure children thrive despite the impacts of HIV/AIDS. Meeting the needs of children made vulnerable by HIV/AIDS provides a unique opportunity for collective action on individual, local, and national levels. No single government, civil society organization, or community can do it alone, and each of these has an important role to play in improving the lives and futures of all children affected by HIV/AIDS.

As shown in Figure 1, children and families and the communities that surround them are at the center of PEPFAR efforts. Governments and nongovernmental organizations (NGOs) working from national to local levels also play a critical role in the response to children. The following sections discuss each of these actors in terms of their role and contribution as partners in PEPFAR's response to children in the epidemic.

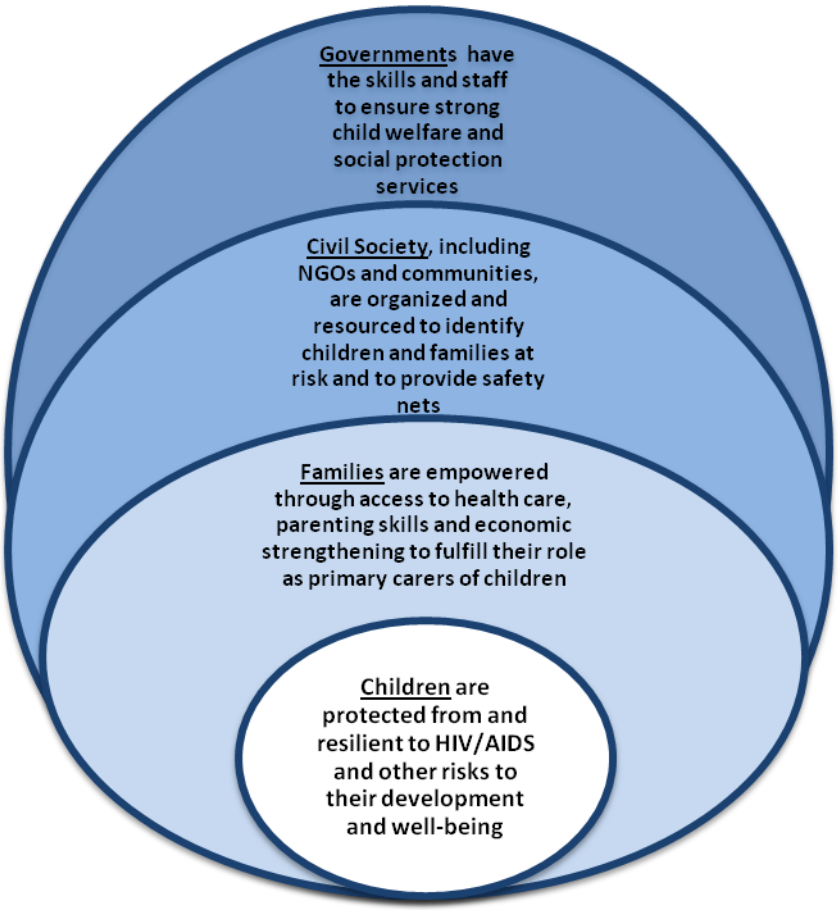

Figure 1: PEPFAR's Approach to Programming for Orphans & Vulnerable Children

2.2.1 Children and Families

Families are the first line of support and defense for children. Even in the most resource-deprived settings, families and communities have critically important strengths. Programs should focus on the promotion of the "strengths and resources" of children, families, and communities, rather than their "needs and deficits". Providing direct support to children rather than empowering families to provide for children's needs can undermine family relationships and capacity to care for children over the long term.

2.2.2 Civil Society

Communities

Community actors include organizations and individuals operating at a very local level, in a social unit larger than a household, and who share common values and social cohesion and commit themselves to

the group's well-being.[31] Communities contribute to the welfare and protection of children and families by establishing a set of norms and expectations of community members that encourage mutual responsibility. Community members serve as frontline responders, identifying and responding to children and families in crisis before they come to the attention of government and civil society as well as monitoring their well-being and advocating on their behalf.

The importance of communities in the lives of at-risk children has been studied over decades, and such research informs evidence-based practice for programs aiming to minimize childhood adversity.[32] Community-oriented programs have positive benefits for children in both the short and long term. This is especially true when such efforts are linked with government structures that facilitate access to financial and technical resources and when faith-based groups are a leading part of the response. Poorly executed assistance at the community level can, however, undermine the community's sense of responsibility toward vulnerable children.[33,34]

Nongovernmental Organizations

Local NGOs and other civil society organizations (CSOs) or community-based organizations (CBOs) play an important role in championing the rights of children affected by AIDS and in holding governments accountable to commitments made on their behalf. They often have the advantage of working quickly and flexibly and tend to be well suited to working with marginalized groups, including children of sex workers and injecting drug users and street children. This work includes conducting assessments of vulnerable children to identify priority needs, making referrals or directly providing services, and monitoring service delivery. PEPFAR OVC programs should support NGOs in their role as champions for marginalized populations and as watchdogs for government accountability to vulnerable children.

International NGOs support the host-country response for vulnerable children at all levels to strengthen the care management system. Larger international NGOs are also a channel for technical and financial resources to smaller NGOs and CBOs. The balance between larger and smaller organizations can often be uneven, however, resulting in usurped local ownership and bottlenecks to effective distribution of resources at the local level.[35] At the same time, funneling large amounts of resources to smaller local NGOs before they have the absorptive and technical capacity can also undermine local ownership. A balance between smaller and larger CSOs is required.

Faith-based organizations (FBOs) are defined as faith-influenced NGOs. FBOs are often structured around development and/or relief service delivery programs and can be local, national, or international.[36] Such organizations play a central role in the civil society response to children in the

[31] Khumalo-Sakutukwa, G, et al. (2008). Project Accept (HPTN 043): A community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand. [Randomized Controlled Trial Research Support, N.I.H., Extramural]. *J Acquir Immune Defic Syndr.* 49(4), 422-431.

[32] Leventhal T, Brooks-Gunn J. (2000). The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes. *Psychological Bulletin*. 126 (2), 309-337.

[33] For example, provision of material supplies to children identified as "children affected by AIDS" led neighbors and community members in Kenya and Tanzania to resent children and families who benefited and to refer to them as the responsibility of NGOs. Nyangara F, et al. *Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania*. MEASURE Evaluation for USAID. New Orleans: Tulane University School of Public Health.

[34] Thurman T, et al. (2008). Barriers to the community support of orphans and vulnerable youth in Rwanda. Soc Sci Med. 66(7), 1557-1567.

[35] Foster G. (2005). *Channelling Resources to Communities Responding to Orphans and Vulnerable Children in Southern Africa*. Save the Children Fund.

[36] Definition taken from the UNAIDS Partnership with Faith-based Organizations UNAIDS Strategic Framework (2009).

epidemic. They have a unique and powerful ability to mobilize resources and faith communities at the local level for the benefit of children. FBOs are also central to the spiritual elements of response to the epidemic that often undergird emotional and social responses for individuals and communities.

Private Sector

Private sector entities have been actors in the response to the AIDS pandemic in several notable ways. They provide health care and other social services to employees and area residents; they provide job opportunities for families that contribute to economic strengthening of households and youth empowerment; and many undertake corporate social responsibility actions that contribute to community infrastructure. Opportunities to partner with private sector entities to expand access to market opportunities and health and social services for children and families should be considered.

2.2.3 Governments

Government actors include publicly funded ministries and departments at the national, regional, and local levels. They contribute to the welfare and protection of children and families by developing large-scale and long-term government-endorsed policies and action plans. They coordinate all actors in the response to vulnerable children, provide public benefits and services, and collect and manage official data. Government actors have the authority to ensure the safe and equitable delivery of essential services and to provide safety nets that alleviate poverty.

The many needs of children and families affected by HIV/AIDS require a multisectoral effort that leverages a "whole of government" response. All government actors are concerned to some extent with the welfare of children, including "allied" ministries, such as ministries of education, health, justice, etc. However, social welfare ministries play a central role in the overall HIV/AIDS response by ensuring the welfare and protection of marginalized groups, including persons living with and children affected by HIV /AIDS. OVC programs should engage all child-serving government agencies in the AIDS response and provide focused systems-strengthening efforts to social welfare agencies. They should also partner with governments to support AIDS-sensitive social welfare and child protection policies and programs that benefit all highly vulnerable children

2.3 From Affected to Infected: Categories of Interventions to Reduce Vulnerability

In addition to the above principles and approach, multiple types of interventions must be employed to address the vulnerability of children in the epidemic. Vulnerability is multifaceted and, as the diagram below shows, the destructive social effects of HIV/AIDS also contribute to children moving from being affected by the virus to infected.

Addressing issues included in the accompanying figure entails a multisectoral approach that assesses the complexities of vulnerability at the individual level while understanding contextual and collective effects. Descriptions of evidence-based sectors that can address these effects are included in this guidance and also reflected in brief in the diagram below (color-coded to reflect where sectors correspond to the illustrative effects of HIV above). The sectors are:

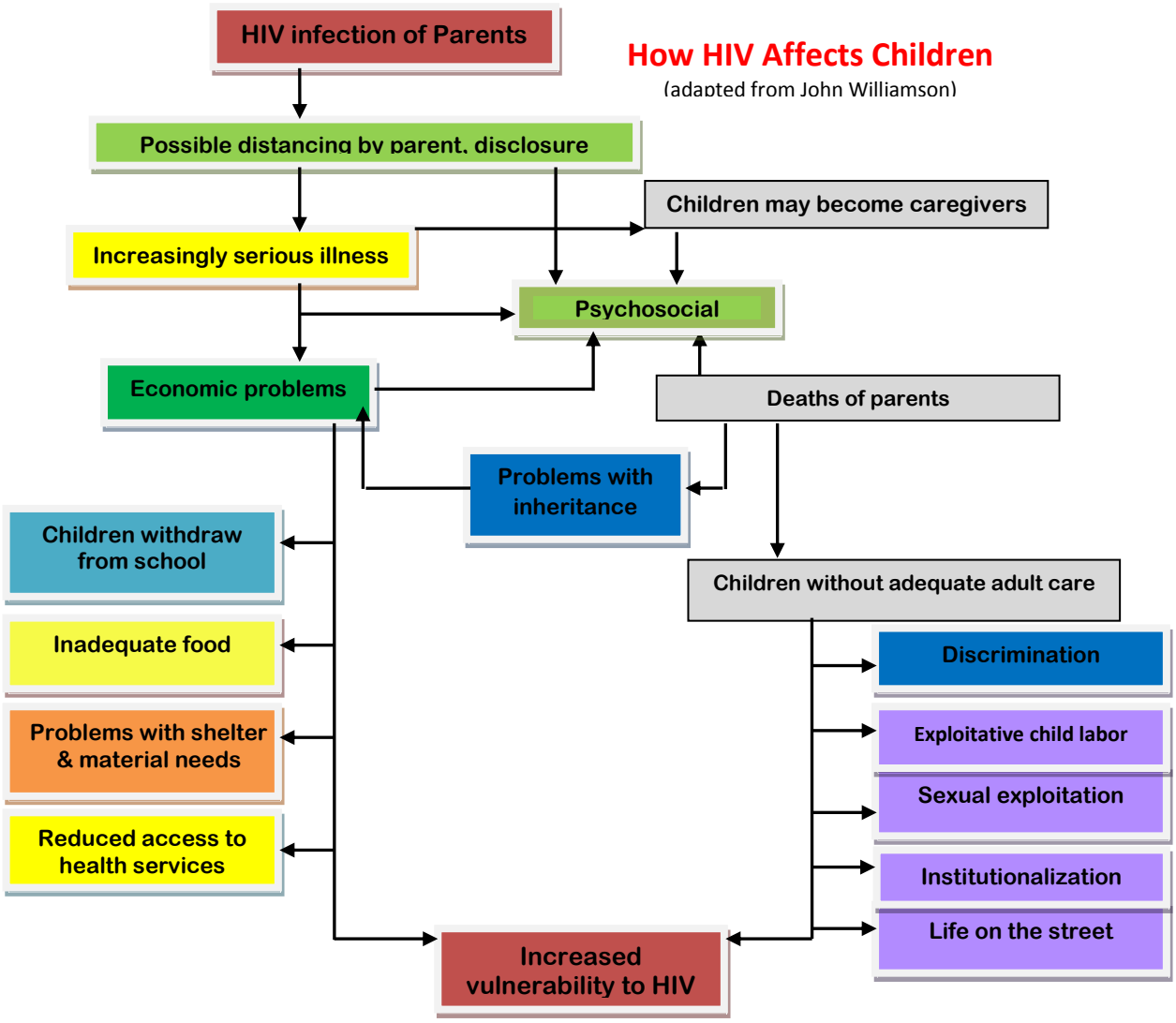

Figure 2: How HIV Affects Children

- Child protection
- Health and nutrition
- Capacity building
- Education
- Household economic strengthening
- Legal protection
- Psychosocial care and support
- Social protection

The various sectors should be integrated in program designs along with other interventions in the HIV continuum of response to serve the needs of children and help achieve an AIDS-free generation. The OVC approach calls for program designs to intentionally consider the types of interventions to be

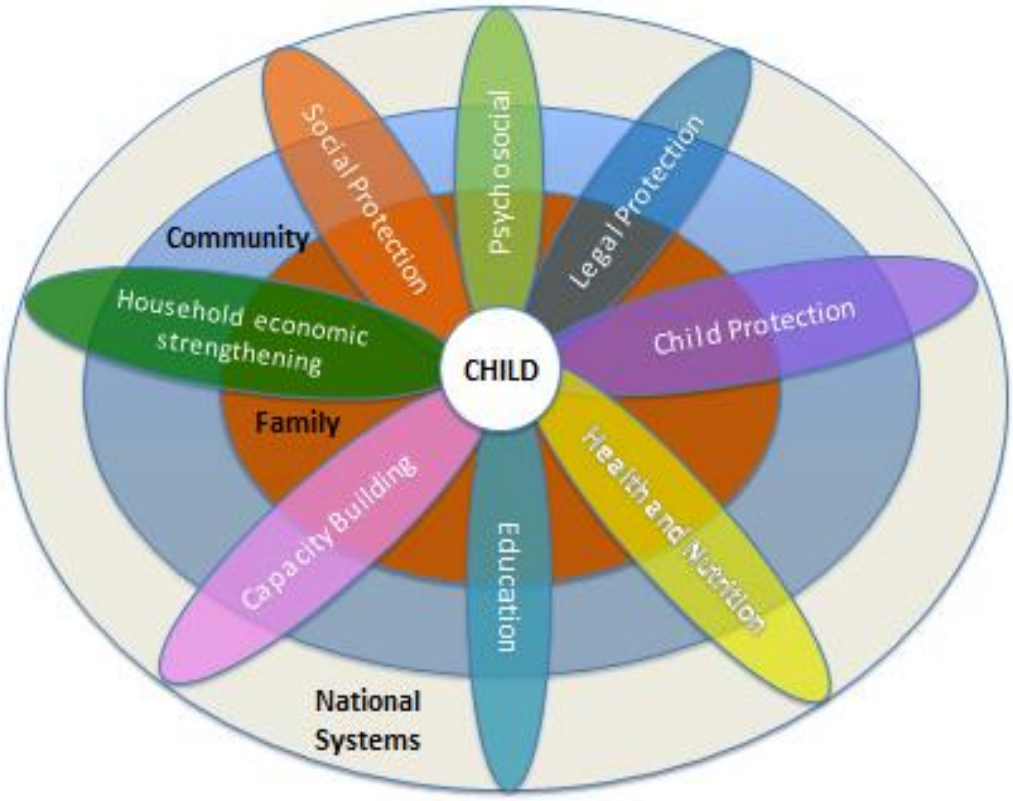

Figure 3: Sectors that Address Child Vulnerability

included across the levels of society to create an overall protective environment for children in the epidemic.

Addressing these multiple effects due to vulnerability resulting from HIV/AIDS also includes ***enhancing integration with and coordination among prevention, care, and treatment activities***. While the majority of care for children in the epidemic happens in the home and in communities, programs should not miss opportunities for integration, especially with PMTCT, antiretroviral therapy (ART), and other health services that are critically important for children to survive, thrive, and avoid infection. The strong presence of OVC programs in the home and community provide a foundation to actualize a true continuum of response across the PEPFAR portfolio. Numerous opportunities exist to ensure that care provided in clinical settings is complemented by socioeconomic, psychological, and spiritual support. ***Section 3 of this guidance on strategic portfolio development is central to designing programs or solicitations and includes more detail on integration and general guidelines for strategic planning for OVC portfolios*.** The technical sections that follow outline specific sectoral interventions as well as linkages to other sectors and across the continuum of response to reach the goal of an AIDS-free generation.

3. STRATEGIC PORTFOLIO DEVELOPMENT

Each PEPFAR country program is responsible for developing a strategic portfolio that includes ***prioritized and focused interventions that address children's most critical care needs*.** In a world of limited resources and a multitude of children in need, ***prioritization and focus are critical***.

The impact of the AIDS pandemic on children's well-being differs across individuals, communities, and countries. Similarly, a child's risk of contracting HIV or of experiencing parental loss also varies across epidemics. ***Strategic portfolio development is predicated on having an evidenced-based understanding of the unique challenges and opportunities faced by children and families within a specific country context as well as an informed perspective of the existing and potential capacity of partners to respond*.**

Building on the "four knows" outlined in the PEPFAR sexual prevention guidance, the evidence required by programs to inform an effective plan of support is outlined below. The additional "fifth know" speaks to the need for clarity on child risk factors that often underlie and impact HIV specific effects.

3.1 Gather and Analyze the Evidence: The "Five Knows"

The "Five Knows" outlined below help to set the parameters of the portfolio as well as identify key priorities particularly at national level.

1.) Know your epidemic: Children's vulnerability to the impacts of HIV/AIDS differs by epidemic. Where transmission occurs primarily between marginalized populations, children may face more intense stigma and discrimination than their counterparts in hyper-epidemics, where almost every family has been in some way touched by AIDS. Conversely, the larger group of children made vulnerable by all causes in more concentrated epidemics are less likely to be exposed to HIV infection. Knowing where HIV epidemic "hotspots" are geographically located and understanding the drivers of the epidemic and how these drivers affect societal perceptions and risk profiles can help programs plan appropriately.

***2.) Know your children*:** HIV/AIDS impacts children's health and well-being outcomes in numerous and often overlapping ways. Evidence can provide a clearer picture of a child's risk *of* HIV as well as *from* HIV/AIDS in regard to defined poor outcomes. By using available evidence, programs can avoid making simplistic assumptions about which children are at risk of a range of poor outcomes over the age span. For example, in an attempt to tease out HIV/AIDS effects on child health and well-being, one recent study analyzed data from 60 population-based surveys[37] across 36 countries. The study examined the relationship between children and age-specific outcome measures (including wasting, school attendance, and early sexual debut) and found that wealth and the educational attainment of senior household members were the only variables that consistently showed power to differentiate across the vulnerability-related outcomes studied.[38] Other studies, however, have found unique correlations

[37] Demographic and Health Survey (DHS] and Multiple Index Cluster Survey (MICS).

[38] Akwara PA, et al. (2010). Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*. 22 (9), 1066-1085.

between children orphaned by AIDS and those orphaned by other causes.[39] These data highlight the importance of not only "knowing your epidemic" but also of "knowing your children" in each country.

3) ***Know your context:*** Knowing your context includes information such as HIV/AIDS' special impact on children due to sociocultural norms, legal and policy environments, and rural-urban disparities. Knowing your context also implies having an appreciation for the feasibility of different investments based on an assessment of local capacity, technical competence, and willingness to commit to long-term interventions. This is particularly important when determining the appropriate balance between systems support activities and direct service activities. Countries and the formal and informal systems within them vary considerably in capacity, so portfolio planners should recognize the rate at which country partners are able to absorb and take ownership of new initiatives. In higher-capacity contexts where portfolios are shifting the emphasis of investment from direct service delivery to technical assistance models, it is critical to set realistic timeframes and to monitor the impact that such shifts have on children's receipt of services.

4) ***Know your response*****:** A true continuum of response relies on the existence of a comprehensive array of support and services, including those that respond to vulnerable children and their families, many of whom include persons living with HIV. Therefore as a first step, portfolio planners must assess how OVC programs are currently integrated within the HIV continuum of response. This involves both geographical as well as resource mapping. Decisions about where to geographically place services should begin with a mapping that identifies gaps in child/family support services in catchment areas surrounding PEPFAR-supported HIV clinical care sites. OVC programs must intentionally situate themselves within the clinical portions of response to both support biomedical goals as well as to leverage clinical interventions to reach the social and emotional goals included in the PEPFAR response.

Knowing your HIV/AIDS child-focused response also includes other related activities aimed at highly vulnerable children (for example, anti-trafficking, child labor, street children, etc.). Mapping of such child-focused initiatives can identify opportunities for complementary or joint programming. More selective mapping of Global Health Initiative (GHI) and specifically PEPFAR-funded HIV/AIDS activities should also be completed in order to ensure that activities are co-located and appropriately integrated across the continuum of response. Programs should also be cognizant of other USG-funded inputs that can be leveraged, including food and economic security and education activities. Under PL 109-95, the USG maintains a database of programs for vulnerable children in numerous countries.

5) ***Know your costs*****:** Accurate costing of OVC activities is essential to achieving a sustainable response at scale. Government and civil society planners require several levels of costing data to inform sound programming decisions, including cost data that informs basic budgeting, indicates the potential outcomes to be achieved by different interventions, and supports scenario planning. Several costing methodologies specific to OVC programs have been developed for this purpose.

[39]For example, a longitudinal study in South Africa found that children who were orphaned due to AIDS or whose parents were ill with AIDS had a higher incidence of physical abuse and sexual exploitation than children orphaned by other causes and children with healthy parents. Cluver, L, et al. (2011). Children of the AIDS Pandemic. *Nature.* 27, 474.

3.2 Assembling a Portfolio

Based on an analysis of evidence gathered under the "Five Knows," programs must determine achievable objectives for the portfolio over for a three- to five-year timeframe.[40] Objectives of the portfolio include those required to achieve PEPFAR global goals and those that achieve the unique goals of the country program as articulated in country national plans of action and the Partnership Framework.

3.2.1 Determining Program Beneficiaries

By any estimate, the vast numbers of children who are potential beneficiaries for USG assistance far outstrip resources available. The intended beneficiaries of PEPFAR programs as defined in the Hyde-Lantos Act include ***"Children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effect***s." The legislation further states that PEPFAR strategies should be guided by an analysis of…''(I) factors contributing to children's vulnerability to HIV/AIDS; and (II) vulnerabilities caused by the impact of HIV/AIDS on children and their families." In addition the Hyde-Lantos Act stipulates the need in "***areas of higher HIV/AIDS prevalence, to promote a community-based approach to vulnerability, maximizing community input into determining which children participate***." [41]

In all epidemics, beneficiaries of direct services can be identified through several channels including:

1) HIV-specific services – PMTCT, voluntary counseling and testing, treatment, home-based care, support groups for people living with HIV, etc.
2) Social services – child welfare services, post-rape care centers, etc.
3) Key populations initiatives – including prevention programs for high-risk persons under age 18

In higher-prevalence areas where populations at large have been impacted by HIV and there is greater opportunity for broader-scale interventions, community identification of beneficiaries is also key.

Aligned with the overarching principle of helping children by strengthening families, programs should employ a "child-focused, family-centered" approach to targeting. One example of a child-focused, family-centered intervention is savings groups that work with adult caregivers but evaluate their success based on child outcomes such as increased school attendance. The child-focused, family-centered approach underlines the importance of avoiding situations that may foment family discord (for example, providing school assistance for only one of several children out of school in the same household) and stresses the value of interventions that support holistic family health.

In addition, OVC programs should strive to be inclusive rather than exclusive in their delivery of services. This is especially critical in higher-prevalence settings where programs have the mandate and flexibility to broaden their efforts to include children that "may be vulnerable to the disease or its socioeconomic effects." An inclusive approach might entail special outreach efforts to ensure that children affected by

[40] Timelines for portfolio strategies should, as is feasible, coincide with country national plans of action and take into account mission exit strategies.
[41] Hyde-Lantos Act: http://www.govtrack.us/congress/bills/110/hr5501

HIV benefit from certain services. However, it would not exclude other poor children in the same high-prevalence setting from benefiting as well.

It is important to note that the distinction between inclusive and exclusive targeting relates as much to *the choice of intervention* as it does to *the choice of beneficiary*. Services that are more specific to persons affected by HIV, such as succession planning, disclosure and bereavement support, or support for treatment adherence, are not likely to cause stigma when given to the few who need it. However, handouts exclusively to HIV-affected households of foodstuffs, school uniforms, and other material goods are likely to cause stigma and should be avoided.

A young person who turns 18 while receiving OVC assistance should not automatically be terminated from receiving assistance; rather, from the outset, programs should plan for appropriate transition strategies.

Policy development and government-strengthening efforts should also employ an inclusive rather than exclusive approach. Many of the policy and national systems-level issues that specifically impact on the lives of children affected by HIV/AIDS also have the potential to improve the lives of a larger group of children, including efforts related to inappropriate institutionalization of children and the availability of alternative family-based care and weak child protection capacity.

3.2.2 Programming for a Range of Ages and Stages

While the bulk of efforts should focus on families as the primary caregivers of children, there should also be attention paid to the unique needs of children across the lifespan. The international community defines children as individuals from birth up to 18 years of age, and this is the age range programmers should use when planning child-specific interventions. However, programmers should also be mindful that the period of transition from adolescence to adulthood is critical and should take care not to abruptly disqualify children from participating in an activity when they turn 18. ***A young person who turns 18 while receiving OVC assistance should not be terminated from receiving assistance; rather, from the outset, programs should plan for appropriate transition strategies and be prepared to cover a buffer period for seamless transition.*** Specific interventions should be employed to support children's transition to adulthood and to monitor their progress. Programs should also recognize the valuable role of parents and other adult caregivers and mentors in the transition from adolescence to adulthood. The following chart presents an illustrative list of interventions by children's developmental stages. While technical priority interventions are summarized in the technical sections and in the introduction, the table and information in this section give guidance on the process of making strategic decisions about interventions, because no one program can be exhaustive and do everything suggested. Programming for children's ages and stages provides rich opportunities for co-planning with other areas of the GHI and PEPFAR portfolio, which are noted in the far right column.

3.2.3 Maximizing opportunities through integration across the continuum of response

The strong presence of OVC programs in the home and community provide a foundation to actualize a true continuum of response across the PEPFAR portfolio. In addition to the activities noted in the ages and stages chart above, numerous additional opportunities exist to ensure that care provided in clinical settings is complemented by socioeconomic and spiritual support. Below is a description of some key opportunities that OVC advisors and their technical area counterparts should investigate in their setting.

Table 1: ILLUSTRATIVE INTERVENTIONS ACCORDING TO AGES AND STAGES ACROSS THE LIFESPAN						
AGES	**STAGES**	**OVC PROGRAMS**	**ACROSS THE AGE SPAN**			**COLLABORATION**
PRENATAL TO THREE	Safety and security	Home visitors encourage adherence to PMTCT and reduce loss to follow-up	Referral for HIV testing and adherence support	Disclosure and bereavement support	Referrals for prevention, diagnosis, and management of TB and opportunistic infections	PMTCT, MCH (vaccinations, etc.), food and nutrition
		Birth registration				
		Training in parental skills reduces toxic stress effects				
PRESCHOOL	Curiosity	Nutrition and ECD programs boost holistic development				MCH, WASH, food and nutrition
		Age-appropriate entry into a safe, nondiscriminatory early learning program, especially for girls				
MIDDLE YEARS	Learning	Access to education, enrollment in school and facilitation for retention				GBV, HIV prevention, education
		Creation of child-friendly, gender-sensitive classrooms				
		Ensure completion of primary school, especially for girls				
		Kids clubs develop social skills				
EARLY ADOLESCENCE	Peer acceptance	Peer support groups				GBV, HIV prevention, education
		Protection from harmful labor/trafficking				
LATE ADOLESCENCE TO ADULTHOOD	Decision making	Referrals to adolescent reproductive and family health services				GBV, prevention, family planning, reproductive health
		If out of school, access to vocational education or other training opportunities that result in sustainable livelihoods				
		Mentorship programs				
		Money management				

Gender and OVC Programming: Gender inequity underpins almost every aspect of both boys' and girls' lives and also affects the capacities, choices, and decisions made by the men and women responsible for caring for vulnerable children. In addition, gender has an impact across all aspects of a child's life (from education to safety to economic opportunities, etc.), and gender can affect girls and boys differently depending on their age and stage of development. Creating the time to step back from specific programs to think holistically about a child's experience across his or her lifecycles and transitions can help identify specific gender issues to focus on in each aspect of an OVC program.

This is especially true when examining incidence and prevalence of the infection among children and adolescents living in the epidemic. Rates of new HIV infections in adolescent girls are up to eight times as high as those of their male peers, driven by early and often coerced sexual debut and activity,

multiple concurrent partners, and high rates of age-disparate sex. [42] These are all influenced by gender attitudes and norms, including those regarding power differentials and sexual entitlement. In spite of this, current epidemiology clearly shows that in most of the countries where PEPFAR is present a large and vulnerable population – adolescent girls – remains invisible, underserved, and at disproportionate risk of HIV.[43]

PEPFAR's OVC platform offers many opportunities for protecting adolescent girls from HIV and for ensuring their overall safety and well-being. In addition to strengthening child protection capacity at all levels (from community up to national systems), other specific examples include the creation of "safe spaces,"[44] the provision of remedial education and other initiatives to ensure girls avoid early marriage and stay in school, and the establishment of post-rape care programs. The OVC platform also offers opportunities for engaging men and boys and changing harmful norms. A number of programming models are being supported that explicitly seek to change male norms, such as community-based violence prevention and response programs and engagement of boys and young men in challenging gender norms as part of youth programming.

Prevention and OVC Programming: Prevention and care programs that work with key populations also serve as a critical conduit to reaching at-risk and HIV-affected children. Children are often overlooked, however, by these programs, especially in concentrated epidemics. Many people who use drugs, sex workers, and men who have sex with men are also parents. Failure to recognize children in a key population program perpetuates a generational cycle of risk where children of at-risk parents become at-risk teens and adults. To reach children, programs with limited funding do not necessarily need to launch separate "child only" interventions. Family-centered interventions that include children and parents (e.g., efforts to promote parent-child communication and bonding) can be effective in improving the health of all family members. Some programs have shown that outreach through children is better accepted and less stigmatizing or threatening to key groups, e.g. night shelters for children of sex workers. Importantly, programs must also recognize children who are themselves sex workers and drug users. These children typically require intensive support that is both family- and individual-oriented and that accommodates the special needs of minors.

Treatment, Home-Based Car, and Support: OVC programs have a broad and deep community base and therefore have great potential to meet the needs of children and adults not captured in clinics or lost to follow-up. Home visiting and ECD centers can identify and refer for diagnostics and treatment as well as provide critical adherence and nutritional counseling support. At the same time, clinic-based programs have a responsibility to ensure that index patients identified in voluntary counseling and testing, PMTCT, and adult HIV treatment centers are asked whether they have children and that these children are referred for more than just medical diagnosis and care.

In addition to facilitating access to clients outside of the clinical setting, OVC programs have a large contribution to make in regard to socioeconomic support of families. Over a million HIV-affected

[42] UNICEF. (2011). *Building a Gender Response: A Synthesis of Findings and Recommendations from Gender Reviews of UNICEF CARI and HIV Programs in Southern Africa.* Accessible at: http://www.unicef.org/esaro/ICRW_Synthesis_Report_28_Oct.pdf
[43] Cluver, Orkin et al. 2011.
[44] In Ethiopia, the PEPFAR OVC program supports "safe spaces" that provide a combination of prevention, mitigation, and protection services for highly vulnerable girls working as domestics in Addis Ababa. Erulkar A, et al. (2008*). Biruh Tesfa: .Creating a 'Bright Future' for migrant girls in urban areas of Ethiopia.* Population Council Transitions to Adulthood Brief series no.21. New York: Population Council.

families are more financially stable and therefore more able to access and maintain health care due to OVC investments in savings groups and market-linked small business opportunities. This is also facilitated by OVC training support to social workers and volunteer home visitors who enable access to social protection schemes, including cash transfers.

3.2.4 Intervention Priorities

Prioritization involves both an understanding of the "Five Knows" in a given country and a firm grasp of the evidence base on the effectiveness of interventions for specified populations. One of the biggest challenges facing OVC programs in the past has been an at times unrealistic expectation that the portfolio can provide numerous interventions and still achieve scale and quality. ***For this reason, there are no preset minimums for the number or range of interventions required by partners.***

Intervention priorities should relate to the scale of the HIV/AIDS epidemic in country. Table 2 provides an illustrative (not exhaustive) prioritization of interventions relative to different scenarios of the epidemic. The second column describes interventions that are appropriate and recommended regardless of prevalence levels and pertain primarily to children within high-risk populations as well those who have family members who are living with/or have been lost to HIV/ AIDS. The third column describes additional illustrative interventions appropriate to higher-prevalence epidemics where a wider circle of the population is affected (directly or indirectly). Generally speaking, the higher the HIV prevalence, the greater the proportion of resources that can be allocated to population-level interventions that provide preventive benefits at scale.

Table 2: RECOMMENDED PRIORITY INTERVENTIONS			
STRENGTHENING MONITORING AND EVALUATION SYSTEMS AND CAPACITY, SUPPORT TO DEVELOPMENT AND IMPLEMENTATION OF EVIDENCED-BASED QUALITY STANDARDS		**HIV/AIDS-AFFECTED CHILDREN & FAMILIES (All PROGRAMS)**	**HIV/AIDS-AFFECTED COMMUNITIES (PROGRAMS IN HIGH-PREVALENCE EPIDEMICS)**
	CHILD & FAMILY	• Parenting skills & support groups • Assist families to access economic-strengthening opportunities including social grants & benefits • Home visiting to at-risk & affected families inclusive of early child development • Succession planning • Testing referrals, adherence support, HIV prevention knowledge • Nutritional assessment, counseling and support • Disclosure and bereavement support	• Structured home visiting in high-prevalence catchment areas inclusive of early child development
	COMMUNITY	• Organizational and service delivery capacity building with local civil society and faith-based partners to respond to children and families affected by HIV/AIDS (including creation of child safeguarding policies) • Create child-friendly, gender-sensitive classrooms; sensitize to the unique needs and interests of children affected by HIV/AIDS. • Establish linkages and referral systems between community-based programs and clinic-based HIV/AIDS support programs • Establish “safe spaces” for children at high risk, especially adolescent girls	• Neighborhood health/social service centers (including safe spaces for children’s recreation) • Child protection committees • Savings clubs • Early child development centers • School block grants • Provide remedial education opportunities to help girls complete school
	GOVERNMENT	• Support a continuum of appropriate care alternatives for children without families including kinship/foster care and local adoption • Support policies and legislation that address the unique needs of children in the AIDS pandemic	• Social welfare workforce strengthening • Support governments to initiate, expand, or be innovative in their social protection initiatives at both policy and operational levels • Build government capacity to carry out and improve its child protection response

4. EDUCATION

4.1 Background

Research on children and HIV/AIDS demonstrates that education can contribute to significant improvements in the lives of orphans and vulnerable children and their families. Learning opportunities (both formal and informal) can provide students with chances to develop age-appropriate, gender-sensitive life skills and also offer sexuality education interventions. Schools can benefit individual children and, by serving as information resource centers, also meet the broader needs of families and communities.

Despite these obvious benefits of education, millions of vulnerable children lack the education they require to fulfill their potential. The HIV/AIDS epidemic continues to lower educational outcomes for children by reducing their abilities to enroll in schools and experience learning and achievement.[45,46] This section thus outlines PEPFAR priority interventions, based on available evidence, for mitigating the impact of HIV/AIDS and promoting equal educational access for children affected by the epidemic.

4.2 Evidence-Based Implementation Recommendations

The OVC portfolio aims to improve educational access and learning for children by first and foremost addressing barriers to education experienced by children affected by AIDS. Established and emerging evidence in the education field demonstrates that sustainable interventions such as school block grants[47,48] and linking communities and schools for integrated support of educational and protection outcomes[49] are positive and sustainable interventions. In addition, researchers have developed a solid foundation of evidence that supports the returns on investment in early childhood development on health outcomes, human capital, and national productivity. This research supports interventions for children under age 5 that promote resilience and mitigate adverse childhood experiences to promote positive brain development and future positive health outcomes.[50,51] Evidence also supports community involvement and the importance of promoting girls education, not only for educational outcomes but also for achieving an AIDS-free generation.[52] Evidence also demonstrates that education can affect infection rates, as "more highly educated girls and young women are more likely to be able to negotiate safer sex and reduce HIV rates."[53] Further evidence for these interventions is included below.

[45] Cluver L, Operario D, Lane T, Kganakga M. (2011). "I can't go to school and leave her in so much pain:" Educational shortfalls among adolescent 'young carers' in the South African AIDS epidemic. *Journal of Adolescent Research.* 26 (5), 543-669.
[46] Guo Y, Li X, Sherr L. (2012).The impact of HIV/AIDS on children's educational outcome: A critical review of global literature. *AIDS Care.* Epub ahead of print
[47] Africare Innovations in Education. (2006). *External Review*. 105.
[48] Center for Global Health and Development. (2011). *Evaluating the Effectiveness of School Block Grants for Orphans and Vulnerable Children.* Boston: Boston University School of Public Health and School of Education.
[49] Kirby D, Laris BA, Rolleri L. (2005). *Impact of sex and HIV education programs on sexual behaviors of youth in developing and developed countries.* Youth Research Working Paper No. 2. Research Triangle Park, N.C.: Family Health International.
[50] Anda R, Felitti V, Bremner J, et al. (2006.) The enduring effects of abuse and related experiences in childhood: a convergence of evidence from neurobiology and epiemiology. *Eur Arch Psychiatry Clin Neurosci.* 256,174-186.
[51] Dong M, Anda R, Felitti VJ, et al. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse Negl.* 28, 771-784.
[52] UNICEF. (2004). *Girls, HIV/AIDS and Education.*
[53] Hargreaves J, Boler T. (2006). Girl power. *The impact of girls' education on HIV and sexual behavior.* ActionAid.

4.2.1 Completion of primary school

Completing primary school is the highest educational priority for children made vulnerable by HIV/AIDS. Given the immediate economic hardships these children and their families face, interventions that provide financial support such as block grants or access to cash transfer programs with multiple eligibility criteria are highly recommended. Newer evidence supports the use of block grants and/or scholarships as ways to bypass nominal or "incidental" user fees for orphans and vulnerable children.

Block grants are sums of money given to a school or community for major projects in exchange for a number of selected students attending school tuition-free. In return, community-led scholarships are used to fund the neediest students affected by HIV/AIDS so they may attend school, with recipients usually chosen by local community groups. This structure fosters country and specifically community ownership of these programs. These grants have been effective at exempting the poorest and most vulnerable children from paying fees or development levies.[54] Some evidence suggests that block grants hold more promise for being cost-effective,[55] although retrospective study design limitations warrant caution in interpreting the findings. Even so, ease of administration and the focus on building local infrastructure for sustainability make block grants in most cases a preferred option to tuition payment. Exceptions would be in concentrated epidemics where blanket-type approaches make less programmatic and contextual sense. Program experience suggests that block grants are slightly more sustainable than scholarships and are better suited for high-prevalence contexts where more students are able to benefit, whereas scholarships are more appropriate for low-prevalence contexts.

Cash transfers, as described in the economic strengthening section below, can be small and targeted at ultra-poor households as part of a comprehensive social protection system. They can have a dramatic impact on 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.[56] The evidence from high-HIV prevalence, low-income settings suggests that conditional cash transfers (and to a certain extent unconditional cash transfers) can improve vulnerable children's school access.[57]

More highly educated girls and young women are more likely to be able to negotiate safer sex and reduce HIV.

Program interventions, such as tutoring or remediation services, to bolster the learning of children orphaned and made vulnerable by HIV/AIDS are important and can help children remain in and complete school. For example, "catch up" classes help young students who have missed school due to illness or domestic duties keep up with their lessons. Mentoring is also important for children whose parents or caregivers are ill, deceased, or otherwise unable to provide support.

Secondary school transition – Given limited resources, primary schooling must be prioritized, but it is nonetheless important to consider the feasibility of supporting post-primary school programming and

[54] Ibid.
[55] Center for Global Health and Development. 2011.
[56] Africare Innovations in Education. 2006. 106.
[57] Baird S, McIntosh C, Ozler B. (2011). Cash or Condition: Evidence from a Cash Transfer Experiment. *The Quarterly Journal of Economics*. doi:10.1093/qje/qjr032. 1-44.

especially the transition for girls from primary to secondary school. Studies in many countries have linked higher education levels with increased AIDS awareness and knowledge, higher rates of contraceptive use, and greater communication regarding HIV prevention among partners.[58] For these reasons, while secondary schooling cannot be a minimum intervention, it is highly recommended for consideration and for integration with complementary programs. In line with all OVC programming, a young person who turns 18 while receiving OVC assistance for schooling or any other essential service should not be terminated from receiving assistance; rather, s/he should be supported to complete the school year and then be linked to prevention or other programs.

4.2.2 Early childhood development (ECD) programs

ECD programs should be considered a high priority in all areas where OVC programming is taking place, especially those with high HIV prevalence. Such programs should be linked to child survival, including PMTCT programs in all areas, regardless of HIV prevalence (see Health section below). Although there is no "one size fits all" approach to supporting ECD interventions, programs may begin by working with communities to establish context-specific priorities. Core principles of child development should guide program development.

When combined with daycare services, ECD centers have the potential to meet the growing demand for a safe and conducive environment for young children. This is especially critical for poor urban mothers who work long hours in the informal sector and may have no alternative than to leave young children alone and unprotected from preventable injury, illness, and abuse. Evidence-based research has revealed that access to ECD centers and services assists with brain development and can help overcome adverse experiences and toxic stress (see Psychosocial section). ECD centers can also play a significant role in women's economic empowerment and girls' education.[59] ECD programs that begin early by identifying pregnant women through PMTCT programs and continue with "mom-baby pairs" to school entry can serve as an excellent community- or household-based platform for achieving multiple maternal/child health (MCH) goals. ECD programs should consistently collaborate with PMTCT and pediatric care as well as nutrition and MCH colleagues to establish programs that provide a continuum of care from pregnancy to school entry in community- and home-based settings.

4.2.3 Child-friendly and HIV-, gender-sensitive learning spaces

Educational systems can either help reduce the stigma that children who have HIV/AIDS often experience or reinforce it. It is critical that educational personnel, including teachers, be equipped with knowledge about HIV/AIDS and be able to respond effectively to their students' needs, including helping to avoid and overcome stigma. This includes supporting efforts that ensure that teachers gain skills to promote participatory culture- and gender-sensitive approaches to HIV/AIDS. While health behavior change and HIV/AIDS knowledge and skills are part of prevention and should not be subsumed under the OVC portfolio, interventions should be intentionally coordinated.

Educational systems can also reinforce societal expectations concerning what it means to be male and female. Boys socialized to act out traditional, often violent, masculine roles often do so at school,

[58] UNAIDS/UNFPA/UNIFEM. (2004). *Women and HIV/AIDS: Confronting the crisis.* Accessible at: http://www.unfpa.org/hiv/women/report/index.htm

[59] Garcia M, Pence A, Evans J (eds.) (2008). *Africa's Future, Africa's Challenge: Early Childhood Care and Development in Sub-Saharan Africa.* Washington, D.C.: The World Bank Publications.

contributing to school-related gender-based violence (SRGBV). SRGBV places girls at increased risk of sexual abuse, sexually transmitted diseases (STDs), and unwanted pregnancies, and is committed by both male students and teachers. SRGBV has detrimental effects on the welfare of all students. While girls are the primary victims of such abuse, boys are not exempt from the effects. Many boys report feeling helpless when they see gender-based violence (GBV) occurring in the classroom and feeling powerless to intervene.

One response to SRGBV is to create mentor-led girls groups in schools[60] that explore HIV, reproductive health, and sexual safety, and develop specific safety strategies for girls and boys in schools (see also Psychosocial section). OVC program planners and implementers should collaborate with gender and prevention colleagues on life skills, school "catch up" for out-of-school girls, and the elimination of violence against children (including GBV) within school settings. Programs should also advocate for countries to realize commitments on free and universal education and include anti-stigma campaigns.

4.2.4 Strong school-community relationships

Family and community involvement — One impact of HIV/AIDS on households and communities has been to change the roles of grandparents, parents, brothers, sisters, and children. Communities need opportunities to re-examine traditional social roles in light of these changes. The burden of caregiving for people living with HIV/AIDS falls disproportionately on women and girls, as it is often the girls in a household affected by HIV who drop out of school to care for sick parents, exacting an emotional, physical, and social toll. Working with communities to support changes in educational norms is necessary for developing appropriate roles and actions for boys and girls. Programs can involve community leaders, faith-based representatives, and district ministry officials to build ownership of initiatives and reach girls in schools on a systemic level to enable sustainable, scalable interventions.

In addition, supporting community involvement in schools through school management committees can make schools generally more effective and safer. While PEPFAR OVC programming prioritizes interventions that promote access and safety, integrating with other education programs to ensure classrooms and curricula are HIV-sensitive is central to community-level education work.

Out-of-school programming – Education can reach those who are out of school by partnering with local stakeholders and organizations to offer access to learning opportunities. The involvement of communities in school management and decisions on HIV response can be instrumental in ensuring that young people who do not go to school are also reached. The active participation of young people in designing and implementing such interventions is essential.

4.2.5 Technical and vocational training

Policymakers and program managers should ensure that older orphans and vulnerable children acquire technical and vocational skills to facilitate their entry into the labor market. Over the last four decades, many research efforts have investigated the returns of academic versus vocational education, especially in terms of increased employment, increased earnings, and increased employability in a dynamic jobs

[60] Simbaya J, Brady M. (2009). *Understanding Adolescent Girls' Protection Strategies against HIV: An Exploratory Study in Urban Lusaka.* Lusaka, Zambia: Population Council.

market. Research findings, however, are either inconclusive or extremely context-specific.[61,62,63] PEPFAR programs can implement interventions in this area, incorporating lessons from prior efforts:

- ***Vocational training for jobs, not entrepreneurship:*** The focus of vocational education on technical skills and competencies is more appropriate for individuals seeking to enter the labor market as employees than for those interested in starting their own business. While some of the same skills are required for both, entrepreneurs require a range of different competencies and support services that are usually not provided through vocational education.
- ***Employer demand for skills:*** Many vocational curricula focus on "hard" skills required for professional trades (e.g., carpentry, masonry, mechanics, cosmetology, tailoring). Academic research and practical experience both show, however, that "soft" skills (e.g., problem solving, teamwork, customer service) are frequently more important to employers. In addition, implementers should not assume that jobs exist for specific vocational skills simply because curricula exist for them. Assessing the labor market and engaging employers are good starting points for successful employment programs.
- ***Use specialized training providers:*** Most countries have existing networks of public and private vocational training institutions that should be leveraged to increase access for vulnerable children. There are rarely compelling reasons for an implementing partner to deliver vocational training directly. The block grant approach can provide targeted strategic investments in return for fee reductions or waivers for disadvantaged students, rather than scholarships, to the extent possible.
- ***Apprenticeships and other applied learning methods:*** Research shows that applied learning methods, such as internships and apprenticeships, are more effective than classroom learning for imparting "soft" skills, for ensuring students acquire skills favored by employers, and for facilitating the networking and acquisition of tacit knowledge that help job-seekers succeed in the labor market. Program managers should favor training institutes that offer these types of learning opportunities and seek to integrate these methods in any efforts to improve the quality of training institutes.
- ***Track results that matter:*** While completion of training may be the easiest performance result to track and quantify, it is often the least important indicator of program success. Program managers should develop performance monitoring plans that gauge longer-term outcomes such as job placement, employment status six months, after completion earnings, and student and employer satisfaction.

4.3 Prioritization of Recommended Interventions

PEPFAR supports efforts to reduce educational disparities among school-age children in high-HIV prevalence areas to enhance children's long-term resilience and development and reduce HIV risk. Even in high-prevalence settings, careful analysis is needed to target populations and areas with the greatest disparities, and interventions with the greatest potential to reduce disparities should be prioritized. Interventions should be designed taking into account the unique needs of those most likely to fall behind, with the recognition of the particular vulnerability of girls. PEPFAR programs should be based on global best practices and evidence-based interventions and prioritize the following education interventions:

1) Ensuring children have a safe school environment and complete their primary education

[61] LaLonde R. (1995). The Promise of Public Sector-Sponsored Training Programs. *Journal of Economic Perspectives.* 9 (2), 149-168.
[62] Attanasio O, Kugler A, Meghir C. (2011). Subsidizing Vocational Training for Disadvantaged Youth in Colombia: Evidence from a Randomized Trial. *American Economic Journal: Applied Economics.* 3 (3), 188-220.
[63] , Regalia F, Rosas-Shady D, Soares Y. (2011). The Labor Market Impacts of Youth Training in the Dominican Republic. *Journal of Labor Economics.* 29 (2), 267-300.

2) Promoting access to early childhood development (ECD) programs
3) Ensuring personnel create child-friendly and HIV/AIDS- and gender-sensitive classrooms
4) Strengthening community- school relationships, including partnering with out-of-school programming
5) Consider supporting post-primary school programming and especially the transition for girls from primary to secondary school
6) Implementing market-driven vocational training only when previous lessons learned are integrated into intervention designs

5. PSYCHOSOCIAL

5.1 Background

There is global consensus that the best psychosocial care and support for children orphaned and made vulnerable by HIV/AIDS is provided through everyday interpersonal interactions that occur in caring relationships in homes, schools, and communities.[64] Such care and support include the love and protection that children receive in family environments, as well as interventions that help children and families cope. Such interventions enable children to form a sense of self-worth and belonging and are essential to learning, developing life skills, participating in society, and having faith in the future.[65]

Although all children benefit from psychosocial support, research has shown that such support is particularly critical for the health and development of children living with HIV/AIDS.[66] Children living with HIV experience more subjective distress than their HIV-negative peers[67,68] and face multiple stressors related to HIV.[69] In addition, several studies suggest that the psychosocial well-being of children and their caregivers can improve adherence to ART and clinical outcomes.[70] There is also evidence that children living in contexts affected by HIV/AIDS may benefit from increased psychosocial attention, due in part to the multiple losses they may suffer, including illness and death of loved ones.[71] Parental death is recognized as one of the most stressful life events a child or adolescent can endure.[72] Interviews conducted in 2005 with orphans and vulnerable children, their parents and caregivers, and students and teachers in communities heavily affected by HIV/AIDS in South Africa and Swaziland found that parental death is one of the major causes of disruption of children's lives.[73] In addition, orphaned children separated from their siblings have significantly higher scores on anxiety, anger, dissociation, and sexual distress than those living with their siblings.[74]

Research findings on early brain development also show that stressful circumstances (toxic stress) in early childhood can have a lifelong effect on brain development and health outcomes. Science has shown that "early experiences determine whether a child's developing brain architecture provides a strong or weak foundation for all future learning, behavior, and health."[75] When a child experiences

[64] Richter L, Foster G, Sherr L. (2006). *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS.* The Hague, The Netherlands: Bernard van Leer Foundation.

[65] To fully recognize the caregiving and family care that are central to OVC programming and that constitute the most fundamental form of psychosocial care and support for young children, this technical area has added *care* to its heading (see Richter et al., 2006, p. 17).

[66] King E, De Silva M, Stein A, Patel V. (2009). Interventions for Improving the Psychosocial Well-Being of Children Affected by HIV and AIDS. *Cochrane Database of Systematic Reviews* (2):CD006733.

[67] Brown LK, Lourie KJ. (2000). Children and Adolescents Living with HIV and AIDS: A Review. *J Child Psychol Psychiat*. 41, 81-96.

[68] Cluver L, Gardner F. (2007). The Mental Health of Children Orphaned by AIDS: A Review of International and South African Research. *Journal of Child and Adolescent Mental Health*. 19 (1), 1–17.

[69] AIDSTAR-One Project. (2011). *Foundation for the Future: Meeting the Psychosocial Needs of Children Living with HIV in Africa.* Technical Brief.

[70] Ibid.

[71] Cluver, L, Gardner, F & Operario, D (2007). Psychological distress amongst AIDS-orphaned children in urban South Africa *Journal of Child Psychiatry & Psychology & Allied Disciplines* 48(8), 755-763

[72] Hallman K. (2008). Researching the Determinants of Vulnerability to HIV among Adolescents. *IDS Bulletin.* 39 (5), 36–44.

[73] Poulsen, H. (2006). The gendered impact of HIV/AIDS on education in South Africa and Swaziland: Save the Children's experiences. *Gender & Development.* 14 (1).

[74] Gong J, Li X, Fang X, Chen X, Stanton B. (2008). Sibling Separation and Psychological Problems of AIDS Orphans in Rural China- A Comparison Analysis. Abstract WEPE0588. XVII International AIDS Conference. Mexico City, Mexico.

[75] Center on the Developing Child. (2007). *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children.* Cambridge, Mass.: Harvard University. Accessible at: http://www.developingchild.harvard.edu

stressful circumstances but receives the support of healthy nurturing relationships, a healthy stress response system develops, with no long-term effect on brain development. "However, if the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened systems and brain architecture, with lifelong repercussions."[76] Therefore, programs that support the presence of "reliable nurturing relationships with adults [that] buffer children from the adverse effects of toxic stress"[77] are essential for healthy brain development and positive lifelong outcomes in emotional health, immune system competence, and the early establishment of health-related behaviors.[78,79,80]

Emerging evidence also shows that psychosocial and mental well-being support treatment adherence and that psychosocial issues such as depression and anxiety can undermine treatment adherence.[81] Cause and effect are still unclear, because psychosocial dysfunction may be a cause or result of treatment failure, or both. The linkage between mental and physical health and the relation to treatment for youth at risk of treatment failure needs to be further investigated in longitudinal studies.

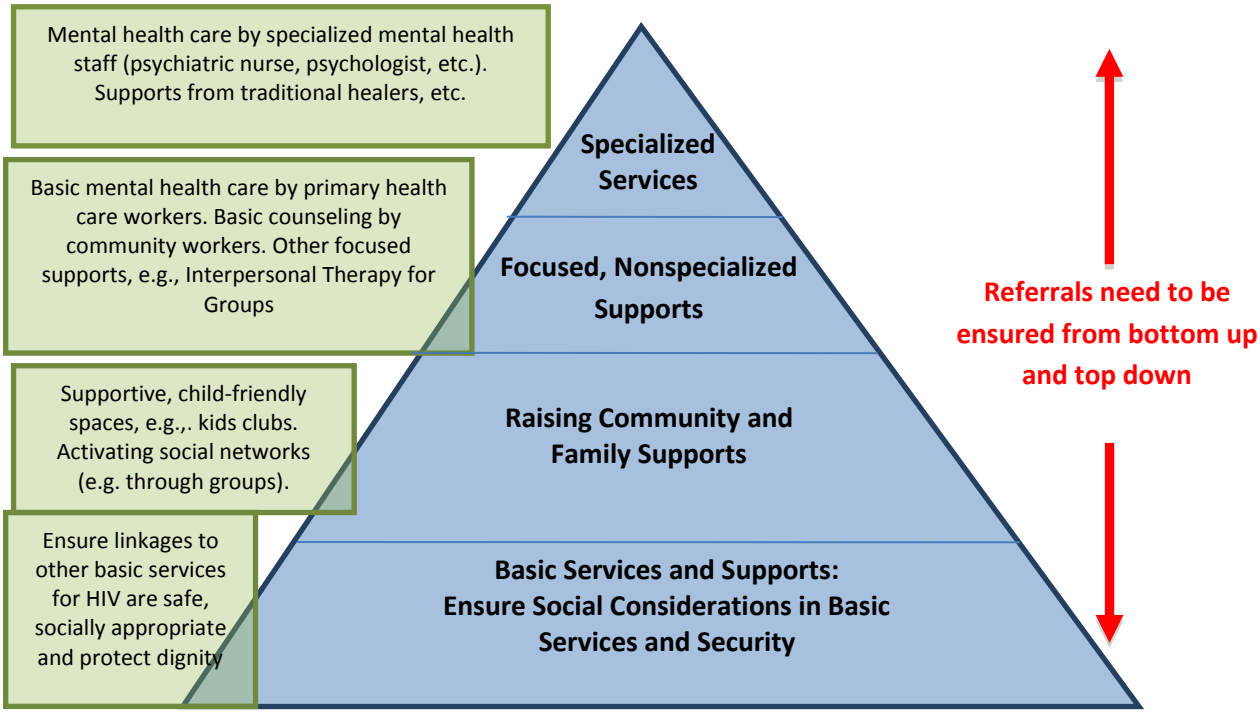

Figure 4: Psychosocial Intervention Pyramid

Global intervention priorities: Pyramid of needs – The majority of children affected by HIV/AIDS do not require standalone or specialized psychological assistance. Only a very small number of these children

[76] Center on the Developing Child.(2010) *Toxic Stress: The Facts.* Cambridge, Mass.: Harvard University. Accessible at: *http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/*
[77] Ibid
[78] Ibid.
[79]Felitti VJ, Anda RF, Nordenberg D, et al. (1998.) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *Am J Prev Med*. 14, 245-258.
[80] Brown D., Anda R, Henning T, et al. (2009) Adverse childhood experiences and the risk of premature mortality. *Am J Prev Med* 2 (37),389-396.
[81] Lowenthal E, Lawler K, Harari N, Seloilwe E, Matome B, Masedi M, Moamogwe L, Masunge J, Gross R. (2011). *Psychosocial Distress and Treatment Failure in HIV African Youth.* Presentation. 6th International Conference on HIV Treatment and Prevention Adherence. Miami, Florida.

need individual mental health interventions from local or foreign professionals. The primary aim of all psychosocial support programs should be to place and maintain children in stable, affectionate family environments. Programs should not seek to meet the psychosocial needs of children and their caregivers in isolation but rather should integrate interventions as appropriate into existing community services. Furthermore, as the evidence above illustrates, most children need the type of care and support provided by families and communities. The lower levels of the pyramid shown in Figure 4[82] illustrate where PEPFAR OVC programming is best-positioned to provide this kind of support. In addition, such support is most easily scaled up and reaches the largest number of people.

5.2 Evidence-Based Implementation Recommendations

All PEPFAR OVC Psychosocial Care and Support programs should build on these ***key guiding principles for implementation*:**

- ***"Do no harm":*** Interventions must be culturally and developmentally appropriate and should avoid causing secondary trauma through lack of sensitivity or skill.

- ***Psychosocial well-being and strength-based approaches:*** In contrast with "medicalized" models of the mental health consequences of adversity that focus on illness and decline, psychosocial support is built upon the concepts of ability, agency, and coping that individuals and communities naturally possess to support psychosocial well-being.[83,84,85,86]

- ***Resilience:*** Children and young people are naturally resilient and able to cope with very difficult circumstances. Resilient children believe that they can cope because they have some control over what happens and are able to perceive deeper meaning in events. To build a child's resilience, programs should nurture the internal resources and increase the external resources available to the child.

- ***Ecological perspective on interventions*:** This perspective explores the confluence of family, community, and institutional factors in human behavior. It posits that restoring support offered within "social ecologies" created by the interaction of the familial, communal, cultural, spiritual, and socioeconomic factors that surround and influence individuals can reduce stress.

- ***Integration with existing community and health systems:*** Activities that are integrated into wider systems, such as community support mechanisms, formal/informal school systems, general health services, and social services tend to reach more people and be less stigmatizing.[87]

5.2.1 Parenting and family support programs

[82] Figure 4 taken from: http://mhpss.net/wp-content/uploads/group-documents/77/1301191936-van_omm_Core_concepts_generic.ppt
[83] Ahearn, F (ed). (2000). *Psychosocial Wellness of Refugees*. New York: Berghahn. xii-xiv.
[84] Wessells M, Moneiro C. (2001) Psychosocial interventions and postwar reconstruction in Angola: interweaving Western and traditional approaches. In D Christie, RV Wagner, D Winter (eds). *Peace, conflict and violence: Peace psychology for the 21st century.* Upper Saddle River, N.J.: Prentice Hall. 262-275.
[85] Boothby N, Strang A, Wessells M. (2006). *A world turned upside down: Social ecological approaches to children in war zones.* Bloomfield, Conn.: Kumarian.
[86] Murphy J, Pagano M, Nachmani J, Kane S, Little M, Kleinman R. (1998). "The relationship between school breakfast and psychosocial and academic functioning: Results from an inner city sample." *Archives of Pediatric & Adolescent Medicine* 152, 899-907.
[87] World Health Organization (WHO). (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Inter-Agency Standing Committee, WHO. 11.

Programs that support young children and promote resilience can be integrated with holistic family programming, including parental involvement and home visitation.[88] Day care centers can provide safe care for preschool-aged children in a supervised environment during the workday in order to relieve the burden for guardians and facilitate their ability to work or care for relatives with HIV. Older children come to the center after school to eat meals, participate in activities, and receive counseling. A family outreach program delivers counseling to children's guardians during home visits. Psychological care can also be integrated into the care package for HIV-exposed or infected children along with clinical, social, and nutritional services; therapeutic education; and community-based pediatric care.[89]

5.2.2 Peer and social group interventions

Peer and social group interventions can be school-based or take place through community organizations. For example, "kids clubs" or safe social spaces for children, preadolescents, and adolescents can be key interventions, although they should not consist solely of recreational activities. Such spaces provide psychosocial support, along with age-appropriate learning materials in reproductive health, nutrition, and HIV prevention. In particular, linking girl heads of households to supportive local women's groups, faith-based programs, or local NGOs can provide them with both psychosocial support and protection. For individuals and communities where mental health issues such as depression and anxiety are present at high levels (assessed by using culturally appropriate and rigorously evaluated scales), some form of nonspecialized focused support, such as interpersonal therapy for groups, may be appropriate.[90]

Another peer group intervention is peer support groups, during which staff address topics of concern to orphans through plays, poems, stories, games, and interactive group therapy techniques, including approaches to problem solving and positive deviance. These groups can be supplemented with monthly health examinations and treatment. Such support groups can lower anxiety, depression, and anger.[91]

Creating dedicated social spaces for girls is a key strategy for changing girls' self-concepts and is a proven approach for transforming the very circumstances that put them at risk of acquiring HIV. These spaces, which can be established inexpensively at community facilities like schools (after hours) and community centers, function as platforms for the delivery of new skills, increased social support, and greater opportunities for girls.[92,93,94] Vulnerable girls and young women gather regularly at these spaces to meet peers, consult with mentors, and acquire skills to help them head off or mitigate crises (e.g., threats of marriage, leaving school, or forced sex). In generalized HIV epidemics, community-based girl-only spaces can help girls to:

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[88] Joint Learning Initiative on Children and HIV/AIDS (JLICA). (2009), *Home truths: facing the facts on children, AIDS, and poverty*. Boston: JLICA. 29. Accessible at: http://www.jlica.org/protected/pdf-feb09/Final%20JLICA%20Report-final.pdf

[89] Odjo F, Azondekon A, Adeyandju I, Monzorgui A, Keitchion A, Sagui A, Toudonou A, Akpoli R, Ogou S, Homawoo E, Sehonou J, Gnangnon A. (2008). *Management of HIV Children Psychological Conditions in Resource-constraints Settings: What Can Be Gained?* Abstract WEAD0104. XVII International AIDS Conference. Mexico City, Mexico.

[90] Bolton P et al. (2003). Group Interpersonal Psycho-Therapy for Depression in Rural Uganda: a Randomized Control Trial. *JAMA*. 289 (23), 3117-3124

[91] Kumakech E, Cantor-Graae E, Maling S, Bajunirwe F. (2009). Peer-group support intervention improves the psycho-social well-being of AIDS orphans: Cluster randomized trial. *Social Science & Medicine*. 68, 1038-1043.

[92] Austrian K, Ghati D. (2010). *Girl-Centered Program Design: A Toolkit to Develop, Strengthen, and Expand Adolescent Girls Programs.* Nairobi, Kenya: Population Council. Available at: http://www.ungei.org/files/2010PGY_AdolGirlToolkitComplete.pdf.;.

[93] Bruce J. (2007). *Reaching The Girls Left Behind: Targeting Adolescent Programming for Equity, Social Inclusion, Health, and Poverty Alleviation.* Presentation prepared for Financing Gender Equality: A Commonwealth Perspective, Commonwealth Women's Affairs Ministers' Meeting, Kampala, Uganda, June 11–14, 2007.

[94] Bruce J, Hallman K. (2008). Reaching the Girls Left Behind. *Gender and Development* 16(2), 227-245.

- Plan for seasonal stresses, like school fees and food shortages, which often increase pressure to exchange sex for gifts or money
- Access entitlements, including HIV-related ones such as social grants for affected households
- Deal with prolonged illness, death, inheritance, and succession planning
- Access voluntary counseling and testing for HIV or ART directly or on referral

5.2.3 Mentorship programs

Mentorship programs can mitigate grief among children and youth, especially those without an adult caregiver. One randomized control trial in Rwanda showed that "… despite disturbingly high levels of depression, maltreatment, and marginalization, and low levels of adult support reported at baseline, follow-up data over…18 months of intervention indicate positive changes in these psychosocial outcomes among youth participating in the mentor program.[95] Overall, the Rwandan mentoring program appears to have enhanced social protection and community connectedness and minimized psychological problems among youth participants.

For more severe forms of depression among youth, more focused supports should accompany mentorship whenever possible. However, the positive outcomes of this intervention show that this is a scalable approach to addressing psychosocial issues, especially among youth and children in vulnerable households without an adult caregiver.[96]

5.2.4 Community caregiver support

It is centrally important to provide emotional and psychosocial support for primary care guardians as well as frontline caregivers such as teachers, community volunteers, health workers, and staff working in AIDS-affected communities. Many of those who provide support to others in these roles live with the trauma of HIV/AIDS in their own lives. Support for caregivers can affect the care they provide to children, and the distress of children may not be reduced without efforts to address the personal suffering of the caregiver.[97] A lack of recognition and recompense for volunteer caregivers can be a barrier to long-term program sustainability.[98] Program implementers found that practices contributing to higher volunteer retention rates included:

- Involving volunteers in key program decisions
- Holding monthly support meetings
- Formally recognizing and appreciating the volunteers' work
- Providing access to income-generating opportunities[99]

Another study of OVC caregivers in Kenya found that "providing support to caregivers is an effective way to serve the needs of vulnerable children." The study found that members of a support group reported

[95] Horizons. (2007). *Psychosocial Benefits of a Mentoring Program for Youth-headed Households in Rwanda.* Accessible at: www.popcouncil.org/horizons/projects/Rwanda_PsychOVC.htm

[96] Brown L, Thurman T, Snider L, Boris N, Rice J, Ntaganira J, Kalisa E, Hutchinson S. (2008). *Impact of Mentoring on the Psychosocial Wellbeing of Vulnerable Youth: Results from a Longitudinal Evaluation in Rwanda.* Abstract WEPE0599. XVII International AIDS Conference. Mexico City, Mexico.

[97] Richter L, Foster G, Sherr L. (2006). *Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS*. The Hague, The Netherlands: Bernard van Leer Foundation. 46.

[98] Schenk, K, Michaelis A, Sapiano TN, Brown L, Weiss E. (2010). Improving the Lives of Vulnerable Children: Implications of Horizons Research Among Orphans and Other Children Affected by AIDS. *Public Health Rep*. 125(2), 325-336.

[99] Ibid.

less social marginalization, better family functioning, and more positive feelings toward the children in their care than nonsupport group members. Furthermore, "children with caregivers in support groups exhibited fewer behavioral problems, higher rates of pro-social behavior, and reported lower incidence of abuse from adults in their household."[100] Support groups are a relatively straightforward and scalable approach to dealing with the psychosocial needs of caregivers.

5.3 Prioritization of Recommended Interventions

The OVC portfolio prioritizes psychosocial interventions that build on existing supports and resources and place and maintain children in stable and affectionate environments. Prioritization should also be based on what is known of global best practices and evidence-based interventions for psychosocial care and support as well as the principles for their implementation – first and foremost, to do no harm. PEPFAR programs should prioritize within their country contexts the following psychosocial interventions:

1) Parents and family support programs
2) Peer and social group interventions
3) Mentorship programs
4) Community caregiver support

Their interventions should build on the lower levels of the intervention pyramid in Figure 4 while also promoting sustainability through culturally appropriate, targeted approaches.

[100] Thurman TR, Jarabi B, Rice J. (2012). Caring for the caregiver: Evaluation of support groups for guardians of orphans and vulnerable children in Kenya. *AIDS Care.* Feb 2. [Epub ahead of print].

6. HOUSEHOLD ECONOMIC STRENGTHENING

6.1 Background

The HIV pandemic affects the economic stability of families and the children in their care by interrupting income streams, depleting assets, introducing labor constraints, and increasing dependency ratios.[101] Approaches to strengthening the economic and food security of families affected by AIDS need to be a part of the continuum of response to preempt a descent into more extreme vulnerability, improve household welfare, and prevent future risk exposure.[102,103]

Household economic strengthening (HES) comprises a portfolio of interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care. Social protection is a similar area of programming, with some notable differences: a greater focus on longer-term outcomes and a greater need for systemic government-led initiatives to sustain interventions. HES tends to focus on shorter-term outcomes, especially on how families accumulate and spend their money. The defining features of both HES and social protection are a focus on families as direct beneficiaries, with success measured by a family's ability to invest in the education, nutrition, and health of its children. School-based businesses, revenue-generating activities for NGOs, and affordable provision of essential services are not included under HES.

When considering HES, food security must also be considered, as they are related to one another. The USG considers food security to consist of three interrelated components: access, availability, and utilization. Recently, a fourth factor has also become prominent: resilience or stability. The HES approaches covered in this section relate directly to the access and resilience dimensions of food security; the utilization dimension of it is covered in the health and nutrition section. Refer to Annex A for definitions of terms, explanation of concepts, and further review of evidence cited in this section.

6.2 Evidence-Based Implementation Recommendations

HES encompasses a broad range of evidence of varying quality, rigor, and validity for OVC programs.[104] Many categories of interventions could be appropriate, each with its own evidence base. The preponderance of evidence to date validates a conceptual framework for the role of HES approaches in OVC programs and justifies a prioritization of interventions that seem most appropriate and effective for families participating in these efforts.

[101] African Forum and Network on Debt and Development (AFRODAD). (2007). *The Macroeconomic Framework & the Fight against HIV/AIDS in Africa*. No.3. AFRODAD.
[102] Bachmann M, Booysen, F. (2003). Health and economic impact of HIV/AIDS on South African households: a cohort study. *BMC Public Health*. 3 (14).
[103] Fox M et al. (2004). The Impact of HIV/AIDS on Labour Productivity in Kenya. *TropMed and International Health*. 9 (3), 318-324.
[104] Child Protection in Crisis Network Livelihoods and Economic Strengthening Task Force. (2011). *The Impacts of Economic Strengthening Programs on Children: A Review of the Evidence.* Child Protection in Crisis Network.

Of all HES interventions, cash transfers have the most robust evidence base employing the most rigorous methodologies and systematically demonstrating impact across multiple dimensions such as poverty, education, health, and nutrition outcomes.[105,106,107] Evidence from specific contexts has also shown that cash transfers can have infection outcomes by reducing risky sexual behavior among adolescent girls.[108] Some new efforts are under way to investigate whether sequenced interventions (with cash transfers as a starting point) may be more effective for building sustainable livelihoods and resilience against shocks.[109,110]

Ethnographic research outlines three general areas in which poor families use financial tools: 1) generating useful lump sums of cash, 2) weathering bad times, and 3) funding day-to-day expenses.[111,112] The evidence for the important role of savings is solid and growing. Several experimental studies show that access to savings increases household investments in different domains, including agricultural inputs,[113] small businesses,[114] and health.[115] These findings are consistent with many other studies that have used less rigorous methods,[116] suggesting that the benefits of savings for poor households may be generalizable across contexts. Other experimental studies have investigated the impact of credit on household welfare, with mixed results.[117] There are potentially good reasons for this, in particular because families may use (and benefit from) credit in very different ways.[118] This makes it difficult to discern generalizable impacts across a population, but it does not mean that access to credit is a poor strategy. Instead, it suggests that context matters and that credit may be a less appropriate strategy for some families or outcomes than for others.

Evidence from specific contexts has also shown that cash transfers can have infection outcomes by reducing risky sexual behavior among adolescent girls.

While traditionally a common HES approach, interventions to promote income generation have the weakest evidence base for OVC programming. There are many different ways to foster income

[105] Adato, M, Bassett, L. (2008). *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates.* Joint Learning Initiative on Children and HIV/AIDS.
[106] U.K. Department for International Development (DFID). (2011). *Cash Transfers: Evidence Paper*. DFID.
[107] Hagen-Zanker J, McCord A, Holmes R, Booker F, Molinari, E. (2011). *Systematic Review of the Impact of Employment Guarantee Schemes and Cash Transfers on the Poor.* Overseas Development Institute.
[108] Baird S et al. (2009*). The Short-Term Impacts of a Schooling Conditional Cash Transfer Program on the Sexual Behavior of Young Women.* The World Bank Development Research Group: Poverty and Inequality Team October 2009. Impact Evaluation Series No. 40
[109] Sabates-Wheeler R, Devereux S. *Transforming Livelihoods for Resilient Futures: How to Facilitate Graduation in Social Protection Programmes.* Centre for Social Protection Working Paper No. 003. Future Agricultures Consortium.
[110] Hashemi SM, de Montesquiou A. (2011). *Reaching the Poorest: Lessons from the Graduation Model*. Focus Note No. 69. Consultative Group to Assist the Poor.
[111] Rutherford S. (1999). *The Poor and Their Money.* Oxford, U.K.: Oxford University Press.
[112] Collins D, Morduch J, Rutherford S, Ruthven O. (2009). *Portfolios of the Poor: How the World's Poor Live on $2 a Day.* Princeton, N.J.: Princeton University Press.
[113] Duflo E, Kremer M, Robinson J. (2010). *Nudging Farmers to Use Fertilizer: Theory and Experimental Evidence from Kenya.* Working Paper No. 15131. National Bureau for Economic Research.
[114] Dupas P, Robinson J. (2011). *Savings Constraints and Microenterprise Development: Evidence from a Field Experiment in Kenya.* Working Paper No. 14693. National Bureau for Economic Research.
[115] Dupas P, Robinson J. (2011). *Savings Why Don't the Poor Save More? Evidence from Health Savings Experiments.* Working Paper No. 17255. National Bureau for Economic Research.
[116] Barber A. 2011. *Transforming Lives: Can Savings and Credit Group Membership Work for People Affected by HIV/AIDS? A South African Case Study.* Universitas Forum.
[117] Duvendack M, Palmer-Jones R, Copestake JG, Hooper L, Loke Y, Rao N. 2011. *What Is the Evidence of the Impact of Microfinance on the Well-Being of Poor People?* EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
[118] Banerjee AV, Duflo E, Glennerster R, Kinnan C. (2010). *The Miracle of Microfinance? Evidence from a Randomized Evaluation.* Abdul Latif Jameel Poverty Action Lab at the Massachusetts Institute of Technology.

generation (access to credit, business skills training, enhancing productivity, or improving market access), which complicates research and confounds findings. However, of all HES interventions, family income promotion has the most distant causal links with child well-being. The impact pathways have not been adequately explored beyond descriptive studies. The implications are that traditional approaches may only work for some families, while others require alternative approaches or longer time horizons.[119, 120,121] Careful analysis and highly capable implementing partners are prerequisites for success, and further rigorous research is necessary to better understand what works and why.

The impact of HES interventions on child well-being depends greatly on the response of the family.[122] Household behavior in this regard is determined by its current vulnerability profile, intra-household decision making,[123,124] and prevailing sociocultural norms.[125] HES approaches are therefore highly contextual and must be grounded in a coherent hypothesis for how family responses to HES interventions are likely to result in measurable improvements in child well-being. It is often easier to observe how families are spending or investing their money than how they are earning it. These observations enable certain inferences about a family's wealth status and other factors affecting their purchasing decisions. As shown in Table 3 (below), this can indicate key intervention strategies that are appropriate for a family's current situation, responsive to their immediate needs and desires, and aligned with key outcomes associated with child well-being. In most contexts, money management interventions are the highest HES priority for OVC families.

6.2.1 Consumption support

Consumption support interventions are direct transfers of resources, usually in the form of cash, to families in order to support basic needs of household members, particularly children. These transfers may come with conditions, with households engaging in specific behaviors to continue accessing the transfers.[126] Consumption support is most appropriate for the most vulnerable families ("families in destitution") and aims to build their capacity to pay for basic necessities. PEPFAR OVC programs should prioritize supporting governments to initiate, expand, or be innovative in their social protection initiatives to better serve the needs of OVC families.

6.2.2 Money management

OVC partners and programs should integrate money management and/or income promotion interventions to help OVC families transition to more stable and self-sustaining economic circumstances. Money management interventions introduce mechanisms for saving financial and other assets, accessing prudent consumer credit, and fostering the knowledge and behaviors families need to better match their expenses with their income. Formal financial services tend to be available only from a

[119] de Mel, S. McKenzie D, Woodruff C. (2008). Returns to Capital in Microenterprises: Evidence from a Field Experiment. *Quarterly Journal of Economics* 123(4), 1329-1372.
[120] Duflo E, Kremer M, Robinson J. (2008). How High Are Rates of Return to Fertilizer? Evidence from Field Experiments in Kenya. *American Economic Review* 98(2), 482-488.
[121] Fafchamps M, McKenzie D, Quinn S, Woodruff C. (2011). *When Is Capital Enough to Get Female Enterprises Growing? Evidence from a Randomized Experiment in Ghana.* Policy Research Working Paper No. 5706. The World Bank.
[122] Barrientos A, DeJong J. *Child Poverty and Cash Transfers.* CHIP Report No. 4. Childhood Poverty Research and Policy Centre.
[123] Anderson S, Baland J. (2002). The Economics of Roscas and Intrahousehold Resource Allocation. *Quarterly Journal of Economics* 117(3), 963-995.
[124] Duflo E. (2011). *Women's Empowerment and Economic Development.* Working Paper No. 17702. National Bureau for Economic Research.
[125] Conning J, Udry C. (2005). *Rural Financial Markets in Developing Countries.* Economic Growth Ctr Discussion Paper 914. Yale University.
[126] Fiszbein A, Schady N. (2009). *Conditional Cash Transfers: Reducing Present and Future Poverty.* The World Bank.

limited number of financial institutions, usually located in urban areas and targeting less vulnerable clients. Accordingly, more informal mechanisms independent of financial institutions are often more appropriate and accessible for more rural or vulnerable households. Such mechanisms[127] use self-selected groups of individuals or households to mutually pool and guarantee each other's savings, and they are derived from traditional arrangements easily understood by most households.[128] These interventions are helpful and appropriate for many families, particularly those with access to some income sources but still unable to invest adequately in their children ("families struggling to make ends meet"). In many contexts, these families likely make up the majority of potential participants in OVC programs and, accordingly, savings-led money management interventions should be a core focus of PEPFAR programs and partners.

6.2.3 Income promotion

Income promotion helps families invest in appropriate low-risk activities to diversify and stimulate moderate growth in household income. Because these interventions require families to invest some of their own resources, they are most appropriate for households who have adequate mechanisms to manage risk and more access to lump sums of money ("families prepared to grow"). Multiple, diversified, reliable, and frequent income streams tend to receive higher priority than simply maximizing profit from an individual activity.[129] Moreover, households will tend to seek activities that require a low investment and have a low risk of failure, although such activities feature relatively low returns.[130] Microenterprise activities, where families operate their own businesses or farms, are a frequent focus. However, labor-based opportunities (such as formal employment or casual labor) are equally, if not more, important because they may be less risky for families to engage in. Effective interventions should yield self-sustaining outcomes: families should be equipped to finance their ongoing participation in these income opportunities and to manage the natural evolution of the markets they are operating in. PEPFAR programs need access to highly specialized expertise to design and carry out these interventions, so programmers should be judicious and strategic about how they incorporate these interventions into their OVC portfolio.

6.2.4 Integration of HES with other child-focused interventions

HES is a necessary but potentially insufficient intervention to achieve impacts for children affected by HIV/AIDS. It is critical to integrate HES approaches with other complementary interventions to maximize scale and OVC-related outcomes. Within an OVC portfolio, there are effective models for integrating HES interventions with psychosocial, protection, education, and health activities. A well-documented example is the Urwaruka Rushasha program in Burundi, funded by USAID's Displaced Children and Orphans Fund, which demonstrates how saving groups combined with discussion sessions on parenting can accelerate outcomes for children.[131]

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[127] These mechanisms are known generically as accumulating savings and credit associations (ASCAs) or informally as "savings groups." Some common methodologies, which share many of the same features, include village savings and loan associations (VSLAs), savings and internal lending communities (SILCs), and self-help groups (SHGs).

[128] Ritchie A. (2007). *Community-Based Financial Organizations: A Solution to Access in Remote Rural Areas?* Agriculture and Rural Development Discussion Paper No. 34. The World Bank.

[129] Chen M, Dunn E. (1996). *Household Economic Portfolios.* USAID AIMS Project. Management Systems International.

[130] , Knorringa P. (2012). 'Helping a Large Number of People Become a Little Less Poor': The Logic of Survival Entrepreneurs. *European Journal of Development Research.* Advance online publication, 19 January.

[131] Bundervoet T, Annan J, Armstrong M. (2011). Urwaruka Rushasha: A Randomized Impact Evaluation of Village Savings and Loans Associations and Family-Based Interventions in Burundi. Evaluation Brief. International Rescue Committee.

HES programs should also support and integrate with PEPFAR's prevention and treatment programming (for instance, through bidirectional referral mechanisms) and wrap around relevant USG initiatives outside of PEPFAR. Within PEPFAR, care and support activities (in particular food and nutrition efforts) and prevention activities for adolescents frequently employ similar HES interventions. Outside of PEPFAR, there are frequent wraparound opportunities with:

- Social protection initiatives led by governments and other donors
- The USG's Feed the Future initiative targeting families vulnerable to food insecurity
- USAID activities attributed to the microenterprise earmark
- U.S. Department of Labor programming to combat child labor

Table 3: FAMILY SITUATIONS AND IMPLICATIONS FOR PROGRAMMING

Families in destitution	
Characteristics Trouble providing/paying for basic necessities (like food) No discernible or predictable source of income but potentially a lot of debt they cannot pay Very few liquid assets (e.g., cash savings, livestock, food/crop stores, and personal belongings that could be sold or traded for money) Probably classified as extremely food-insecure *Take care to understand whether this situation is chronic, transient, or acute*	**Resilience outcomes** Recover assets and stabilize household consumption **Purchasing power outcomes** (Re)build short-term capacity to pay for basic necessities **Evidence-based strategies** Consumption support
Families struggling to make ends meet	
Characteristics Usually paying for basic needs (like food) but not regularly paying for other needs (like school fees), especially if they require lump-sum payments One or more predictable sources of income Some liquid assets (as described above), which may fluctuate throughout the year as they are accumulated and liquidated Seasonal fluctuations in income/expenses, especially due to agricultural calendar (i.e., they do well for one part of the year but poorly for another part of the year) Probably classified as moderately food-insecure	**Resilience outcomes** Build self-insurance mechanisms and protect key assets Expand income and consumption **Purchasing power outcomes** Strengthen family capacity to match income with expenses **Evidence-based strategies** Money management
Families prepared to grow	
Characteristics Usually paying for both basic needs (like food) and other needs (like schooling and basic health care) on a regular basis; possibly struggling, but usually managing, to make lump-sum payments Some liquid assets that fluctuate less throughout the year than for struggling families Seasonal fluctuations in income/expenses, but probably not as dramatic as for struggling families Probably classified as mildly food-insecure	**Resilience outcomes** Smooth income and promote asset growth Smooth consumption and manage cash flow **Purchasing power outcomes** Grow family income to enable more/larger investments **Evidence-based strategies** Income promotion

6.3 Prioritization of Recommended Interventions

The OVC portfolio aims to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care through the use of global best practices and evidence-based interventions. PEPFAR programs should prioritize within their country context and target populations the following HES interventions:

1) Money management interventions for savings, access to consumer credit, and fostering knowledge and behaviors for better family financial management
2) Integration of HES activities with complementary interventions, such as parenting skills
3) Income promotion using low-risk activities to diversify and stimulate growth in household income

7. SOCIAL PROTECTION

7.1 Background

The HIV pandemic strains the economic and social fabric of families and communities, magnifying economic vulnerabilities and social marginalization to such a degree that they can persist or even grow from one generation to the next. While this directly influences the capacity of families to provide for the children in their care, it can also trap children in a cycle of poverty and social exclusion. Many governments invest in measures to protect vulnerable families, prevent the intergenerational transmission of poverty, and overcome marginalization. Supporting, leveraging, and strengthening these country-led initiatives need to be a part of the continuum of response to provide sustainable assistance to vulnerable children and their caregivers.

"Social protection" is an umbrella term encompassing an array of government-led policy instruments for reducing vulnerability and risks faced by disadvantaged groups. Cash transfers may be the most widely known instrument, but social protection includes other measures to reduce risks, foster human capital development, and interrupt the transmission of poverty from one generation to the next.

There is no single accepted definition for social protection, which prevents many programmers from understanding and leveraging interventions that use this term. However, social protection offers an important systemic and country-owned approach that can sustain and scale up a family-centered response for children in the epidemic. With support from other donors, most lower-income countries with generalized epidemics are investing in new or expanded social protection strategies. PEPFAR OVC programs should engage, align with, and leverage these schemes to the greatest extent possible, recognizing that other donors have the expertise to support social protection broadly while PEPFAR has a comparative advantage to ensure its target populations are included and its HIV-related outcomes are achieved. Refer to Annex A for definitions of terms, explanation of concepts, and further review of evidence cited in this section.

The most common social protection instruments seek to stimulate at least one of the following effects:

- ***Social transfers,*** which provide resources to boost household consumption (especially for basic goods and services), reduce risk exposure, and facilitate investment in activities with higher-risk investments (such as income generation) or delayed-return investments (such as education)
- ***Equitable access to services,*** which overcomes "market failures" for essential goods and services (such as food, health, and education) where adequate supplies are available but target families cannot or do not access them at a level commensurate with less vulnerable families

A recent systematic review of evidence on social transfers conducted by the U.K Department for International Development (DFID) concluded that 80 percent of the reviewed programs had a positive effect on reducing family poverty in economic terms.[132] Cash transfers in particular have the most robust evidence base, which reflects the relative prevalence of these interventions, their suitability for experimental research, and the push for rigorous evidence to justify ongoing public investment in them. Cash transfers are direct, noncontributory resource transfers to poor people aimed at reducing

[132] Hagen-Zanker et al. 2011.

vulnerability and increasing consumption.[133] Depending on how they are structured (e.g., with or without conditionalities), cash transfers can produce different effects that link to relevant outcomes for family strengthening and HIV mitigation.

The Joint Learning Initiative on Children and HIV/AIDS (JLICA) asserts that cash transfers – with or without conditionalities – are a sensible investment for families affected by HIV/AIDS because of their low input requirements and rapid scale-up relative to other social protection interventions. [134] JLICA synthesized the evidence on impacts for children, especially those affected by HIV/AIDS. They find positive impacts on family spending and resilience that correlate with marked improvements in child health, nutrition, and education.[135] Following Mexico's successful experience with conditional cash transfers, many middle-income countries have integrated them into their social assistance policies, and, notably, many of these programs have been subjected to intensive and rigorous evaluation. Low-income countries are now ramping up investments in cash transfers, but weak government capacity and limited public financing raise new questions on how to structure appropriate instruments for this context.[136]

In addition to the conditionalities of some cash transfer interventions, social protection can include other instruments to overcome market failures for essential services. These interventions typically take the form of government-backed waivers or vouchers that lower or eliminate the costs of accessing key services, especially health and education, for vulnerable children. The issue is important for OVC programming since many countries adopt user fees to offset weak or unpredictable public financing that can introduce significant inequities for poorer or more vulnerable families in then accessing services.

While governments have experimented widely with waivers and exemptions for user fees, the evidence of impact is scattered and mixed.[137] Some debate remains on whether user fees are an appropriate instrument for rationing scarce services and whether waivers are an appropriate policy instrument for ensuring equitable access. Most of the literature, however, focuses instead on the mechanics of targeting, managing, and financing subsidies for such a system of waivers and exemptions.[138]

7.2 Evidence-based Implementation Recommendations

The evidence for social protection instruments is quite strong for outcomes important to OVC programming, and it is clear that the USG should include support to social protection as an integral part of PEPFAR system strengthening and sustainability strategies. However, PEPFAR's role and modalities to support social protection are less straightforward. Other donors (such as DFID and various United Nations agencies) have a long history of providing direct assistance for establishing, strengthening, and scaling up social protection. USG support should seek to complement and fill in the gaps of existing assistance rather than crowd out other donors.

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[133] Fiszbein and Schady. 2009.
[134] Joint Learning Initiative on Children and HIV/AIDS (JLICA). (2009). *Home Truths: Facing the Facts on Children, AIDS, and Poverty.* JLICA.
[135] Adato and Bassett. 2008.
[136] Devereux S, Marshall J, MacAskill J, Pelham L. (2005). *Making Cash Count: Lessons from Cash Transfer Schemes in East and Southern Africa for Supporting the Most Vulnerable Children and Households.* Save the Children UK; HelpAge International; Institute for Development Studies, University of Sussex.
[137] Kivumbi G, Kintu F. (2002). Exemptions and Waivers from Cost Sharing: Ineffective Safety Nets in Decentralized Districts in Uganda. *Health Policy and Planning* 17(Suppl 1), 64-71.
[138] Bitrán R, Giedion U. (2003). *Waivers and Exemptions for Health Services in Developing Countries.* Social Protection Discussion Paper No. 0308. The World Bank.

As a relatively new area of programming, PEPFAR OVC support for social protection is an area of experimentation and innovation. Compared to the OVC portfolio as a whole, a limited proportion of resources should be invested in these efforts until clear evidence of effectiveness is demonstrated. Strategic alliances with the host-country government, DFID, UNICEF, the United Nations Development Programme, the International Labour Organization, and the World Bank are also critical to success. Direct funding to government agencies may be considered when consistent with PEPFAR agency policies and country assistance strategies.

The following illustrative interventions indicate both the range and types of assistance to social protection. Selection of appropriate interventions is highly dependent on country context and the role of other donors.

7.2.1. Policy-level interventions

- ***Plan:*** Support the development of new social protection policies, regulations, and instruments that will yield benefits for families and children targeted by PEPFAR.
- ***Advocate:*** Promote social protection policies and instruments that are child-sensitive and HIV-sensitive. This might include providing benefit levels that are aligned with the number or ages of children supported by eligible families or ensuring that eligibility is not conditioned on labor capacity (which is often diminished for people living with HIV/AIDS).
- ***Coordinate:*** Invest in platforms and mechanisms that facilitate coordination between the lead government ministry in charge of social protection and allied ministries that need to align with, support, or perform specific functions required for effective social protection coverage and performance.
- ***Innovate:*** Build country-specific evidence for how appropriate social protection policies and instruments might yield improved OVC-related outcomes or perform more efficiently. This might include pilot efforts (in collaboration with governments and likeminded donors) to test new approaches, explore the effects of new modalities, or quantify impacts of existing schemes.

7.2.2 Operational level

- ***Scale up:*** Actively support the rollout and expansion of social protection schemes through service-delivery programs funded by PEPFAR. The USG has a history of supporting interventions in this area, which may include identifying and assisting eligible families to enroll and referring families to social protection services rather than providing these services directly through bilateral implementing partners.
- ***Build infrastructure:*** Strengthen allied systems to accommodate increased demand for services from social protection interventions and develop a cadre of qualified frontline workers and managers to administer social protection schemes.
- ***Complement:*** Design and implement interventions that intentionally complement existing social protection policies. This might include HES interventions that support families to graduate from social protection assistance.

7.2.3 Integration

Social protection efforts provide an outstanding platform for integration, especially since an explicit goal is often to increase access to and utilization of essential services. Within an OVC portfolio, this creates opportunities for leveraging complementary investments in education, health, and nutrition. Social and

parasocial workers are frequently the primary frontline agents of social protection efforts, helping to identify eligible families, deliver assistance, and manage casework.

There are opportunities to integrate social protection initiatives with PEPFAR's prevention and treatment programming and to wrap around relevant USG initiatives outside of PEPFAR. Within PEPFAR, other care and support activities as well as prevention activities for adolescents are interested in similar efforts. Outside of PEPFAR, there may be wraparound opportunities with the following initiatives:

- Social protection initiatives led by government and other donors
- The USG Feed the Future initiative targeting families vulnerable to food insecurity
- U.S. Department of Labor programming to combat child labor

7.3 Prioritization of Recommended Interventions

The OVC portfolio aims to reduce vulnerability and risks, foster human capital development, and interrupt the transmission of poverty from one generation to the next through the use of global best practices and evidence based interventions. PEPFAR programs should prioritize within their country context and target population the following social protection interventions:

1) Supporting host-country governments to initiate, expand, or be innovative in their social protection initiatives at both the policy and operational levels

8. HEALTH AND NUTRITION

8.1 Background

In addressing health and nutrition interventions within the context of OVC programming, this section focuses on the complementary integrating role OVC programs can play in combination with other health investments. The comparative advantages of OVC programs for health and nutrition include:

- A massive community presence
- A focus on the underlying socioeconomic factors that determine uptake of health care services and behavior
- The potential to bridge clinic-based health care with community and home care

Because of these advantages, OVC programs are uniquely poised to expand and extend health care knowledge and services to reach women, infants, and children who are less likely to present in clinics. The wide and deep community presence of OVC programs also has strong potential to support tracing of mothers (and infants) lost to follow-up; help in treatment adherence and retention efforts; significantly strengthen malnutrition prevention through early identification of malnutrition risks and referrals to comprehensive clinical care; and strengthen the impact of lifesaving interventions prioritized under child survival, the President's Malaria Initiative (PMI), PMTCT, pediatric treatment, and HIV prevention and reproductive health for youth and adolescents.

Determining child health status in specific epidemic settings always requires a situation analysis. At the same time, programs should note the following general considerations relating to child health at different points in the age span:

- Maternal/neonatal health, nutrition, and hygiene interventions during the first "1,000 days" are critically important to reducing infant mortality and building a strong foundation for a child's lifelong health and developmental outcomes.[139]
- Holistic early childhood development is key for lifelong health outcomes. "A scientific consensus is emerging that the origins of adult disease are often found among developmental and biological disruptions occurring during the early years of life."[140] The presence of "reliable nurturing relationships with adults [that] buffer children from the adverse effects of toxic stress" can affect lifelong outcomes in "immune system competence" and "the early establishment of health-related behaviors" [141] (see Psychosocial section).
- Nutritional intake during a child's first five years is critical to survival and healthy development. In general, differences in nutritional status between boys and girls are negligible from ages 0 to 4 years. As children become adolescents, the risk of nutritional issues, notably anemia, is significantly higher for girls.[142]
- Adolescent girls are at far greater risk of contracting HIV than their male counterparts. This risk is a result of a number of factors, including physiological susceptibility and greater exposure to sexual violence both inside and outside marriage.[143]

[139] Victora C, Adair L, et al. (2008). Maternal and child undernutrition: Consequences for adult health and human capital. *The Lancet*, 371.
[140] Shonkoff JP, Boyce T, McEwan B. (2009). Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention. *JAMA*. 301 (21), 2252-2259.
[141] Center on the Developing Child. 2010. Harvard University.
[142] UNICEF. (2011). *The State of the World's Children 2011: Adolescence: An Age of Opportunity*. New York: UNICEF.
[143] UNICEF. (2010). *Children and AIDS: Fifth Stocktaking Report*. New York: UNICEF.

8.2 Evidence-based Implementation Recommendations

8.2.1 Incorporating health and nutrition in child-focused activities

The strong community and household presence of PEPFAR programs for children provides multiple opportunities to improve children's and families' access to health and nutritional services covering early nutrition screening and referral; malaria, TB, and child pneumonia and diarrhea services; and routine vaccinations. Most often these opportunities result from effective integration with child-focused community- and home-based activities. In particular, programs should continue to incorporate key elements such as water, sanitation, and hygiene (WASH); nutrition; and HIV prevention and care knowledge into child-focused activities. The venues and interventions below can serve as important conduits to health information and services for children and their families:

- ***Home visits:*** Evaluations[144] indicate that home visiting programs have a positive impact on child and family well-being[145] when staff or volunteers regularly visit households and spend adequate time with children and families, especially those at high risk for poor health outcomes who do not present at health centers or at community venues.
- ***ECD:*** ECD programs provide an excellent venue for accomplishing multiple objectives, including nutritional education and supplementation,[146] WASH promotion, early identification of childhood illness and developmental disabilities,[147] and monitoring and support for children on treatment.
- ***Schools*****:** Schools play a key role in health education[148] and can also serve as an important channel for identifying and referring children who need further health services and assistance.
- ***Kids clubs*****:** Kids clubs that meet regularly and feature health messages in curricula have produced positive results.[149] International research indicates that afterschool and other kids clubs are most productive when they involve parents and caregivers. They can provide an entry point for increasing knowledge and health-seeking behaviors, particularly for children who are not in school and are therefore missed in school-based health interventions.
- ***Parenting skills (groups, education):*** Interventions aimed at facilitating child-caregiver bonding and imparting knowledge on child development[150] and positive discipline can also play a key role in promoting basic health and nutritional knowledge.
- ***Health events:*** National or local campaigns to increase coverage of key health interventions, such as insecticide-treated bed nets (ITNs), vaccinations, or micronutrients, should be leveraged for and include children affected and infected by HIV/AIDS. Such campaigns can utilize OVC community volunteers and other OVC program investments to enhance their success.

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[144] Sherr L, Zoll M. (2011). *PEPFAR OVC Evaluation: How Good at Doing Good?* Prepared for PEFPAR through USAID by Global Health Technical Assistance Project.

[145] Richter L, Sherr L, Adato M, et al. (2009). Strengthening families to support children affected by HIV and AIDS. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*. 21 (S1), 3-12.

[146] Shonkoff J, Richter L, van der Gaag J, Bhutta Z. (2012) An Integrated Scientific Framework for Child Survival and Early Childhood Development. *Pediatrics.* 129 (2), 460-472.

[147] Irwin LG, Siddiqi A, Hertzman C. (2007). *Early Child Development: A Powerful Equalizer. Final report for the World Health Organization.* Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization.

[148] Gregson S, Nyamukapa C, Garnett G, et al. (2005): HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 17 (7), 785-794

[149] Nyangara F, Thurman T, Hutchinson P, Oblero W. (2009). *Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania*. MEASURE Evaluation for USAID. New Orleans: Tulane University School of Public Health.

[150] Caspe M, Lopez ME. (2006). *Lessons from family-strengthening interventions: Learning from evidence-based practice*. Cambridge, Mass.: Harvard Family Research Project.

8.2.2 Reducing access barriers

OVC programs should maximize integration opportunities that reduce barriers to health and nutrition services, recognizing that decisions about service access are made at the household level and influenced by communities and the systems through which the services are delivered. Establishing health insurance opportunities, encouraging health-seeking behaviors while providing HES, and facilitating coordination between OVC program volunteers and community health workers are possible areas where integration can serve to reduce access barriers.

OVC programs should identify sustainable approaches to reducing barriers, so that access to health and nutrition services continues beyond the time frame and parameters of the PEPFAR-funded program. These approaches should be family-centered and child-focused, consistent with the overall OVC program approach. Assistance such as insurance opportunities or fees paid through HES earnings should not be limited to a few members of a household. Interventions should positively impact the well-being of all children and caregivers in the household, which is ultimately in the best interest of children infected or affected by HIV/AIDS.

A family-centered approach to health and nutrition also helps strengthen links between community- and facility-based services. This can lead to benefits such as more families knowing their HIV status, more mothers seeking PMTCT services, and more caregivers adhering to treatment regimens that keep them healthy and better able to support the children targeted by the OVC program.

8.2.3 Medical care and commodities

PEPFAR OVC funding does not provide direct HIV-specific medical care, which is covered by pediatric treatment and care funding. It is critical, however, that OVC programs help ensure that children and their caregivers are able to access HIV-specific services. Programs should link with PEPFAR-supported HIV treatment, care, nutrition, and support services in addition to government- and other donor-supported HIV services. As part of the transition from an emergency response to a long-term sustainable response, OVC programs should primarily focus on sustainable interventions that reinforce families' or communities' long-term capacity to respond to the health and nutritional needs of children infected and affected by HIV/AIDS. ***Short-term interventions such as one-off fee payments and distributions of food and other consumables should be a minimal portion of any OVC program, to be used only in extreme and emergency situations.***

At the household and community levels, this translates into a stronger focus on health and nutritional skills building, HES opportunities, negotiating fee waivers or reductions at the facility level, facilitating linkages between community and facility-based services, and improving access to health insurance. At regional and national levels, programs are encouraged to leverage opportunities within child vaccination campaigns, ITN distributions, and other child-focused initiatives through integrated planning and priority setting. PEPFAR support via OVC programs that are integrated with child survival, PMI, and other health and nutrition programs must be proportional based on the number of children infected or affected by HIV/AIDS within a targeted population. These funds should focus on sustainable interventions (e.g., system strengthening) versus commodity procurement already captured under allied GHI programs.

8.2.4 Formal linkages and referral systems

As previously noted, a critical element of OVC programming is to build and maintain formalized linkages and referral systems between community- and clinic-based programs. Through integrated, coordinated systems and advocacy, families can have improved access to health, nutrition, and social services, which will result in better health status and lower vulnerability to HIV/AIDS.

PMTCT programming provides an excellent opportunity for collaborating with OVC programs. Integrating ECD interventions with PMTCT programs can help ensure that women and infant/child pairs remain connected to services between the time a child completes immunizations at 18 to 24 months of age and enters school at age 6 or 7 years. Treatment programming likewise provides important opportunities for OVC program linkages to ensure the continuum of response. While OVC programs are not intended to fund pediatric treatment, they can play a critical supporting role for treatment programming. Examples of collaborative activities with PMTCT and treatment programming include:

- Helping to formalize cross-referral relationships between community worker cadres and local health facilities to ensure continuity of care for mother-infant pairs
- Helping clinic-based programs establish a continuum of care, including referral mechanisms with HES schemes (such as savings groups) to motivate follow-up and care-seeking barriers
- Collaborating with and referring to existing HIV pediatric care and treatment programs
- Providing educational support, vocational training, economic strengthening, and other services to the growing population of children on ART transitioning into adolescence and adulthood
- Providing support for related issues such as disclosure and linkage to testing
- Minimizing delayed care-seeking by promoting discussion and action around seeking skilled care and facility-based delivery, particularly for HIV-positive women and HIV-exposed infants
- Encouraging male partner involvement by emphasizing the importance of partner support to mother and infant health outcomes
- Promoting peer support/treatment buddies for HIV-positive mothers and their families

OVC programs also have many opportunities to improve child and family nutrition by incorporating the

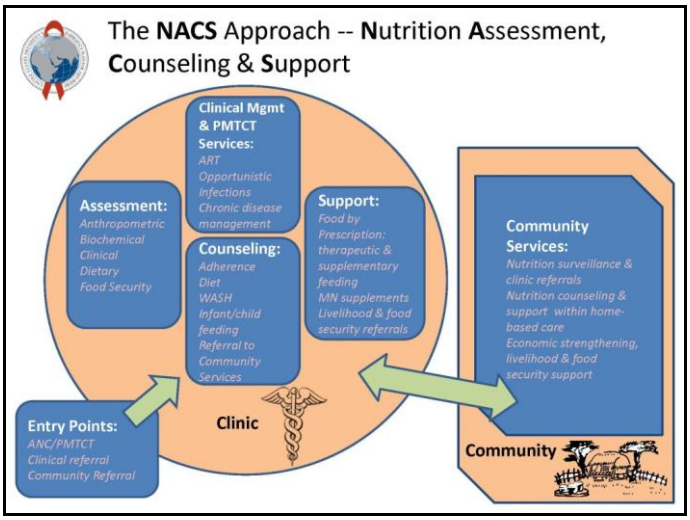

Figure 5

community aspects of the “nutrition assessment, counseling, and support” (NACS) approach into existing activities. As Figure 5 on the preceding page shows, linkages from community services to clinic include not only referrals but also nutritional counseling at the community level by home visitors and economic strengthening for food security and clinic access.

8.3 Prioritization of Recommended Interventions

Health and nutrition programs within the OVC portfolio should prioritize coordinated evidence-based interventions that aim to improve children’s and families’ access to health and nutritional services through the use of global best practices. Coordination with other USG and global donors who are supporting health and nutrition programming, as well as with PMTCT scale-up and pediatric HIV care and treatment services, will help create better health access, prevent loss to follow-up, and ensure a continuum of care between ages and care points. PEPFAR programs should prioritize within their country context the following health and nutrition interventions:

1) A child-focused, family-centered approach to health and nutrition through ECD and school-based programs
2) Effective integration with existing or planned child-focused community- and home-based activities, including PMTCT, treatment, PMI, and child survival
3) Reducing access barriers to health services through HES and social protection schemes, such as health insurance opportunities
4) Establishing linkages and referral systems between community- and clinic-based programs

9. CHILD PROTECTION AND GENDER-BASED VIOLENCE

9.1 Background

Children made vulnerable by HIV/AIDS are frequently exposed to abuse; exploitation; violence (including gender-based violence (GBV); and family separation as a result of the epidemic's effects. These exposures can further increase risks through adult life. For example, a history of "adverse childhood experiences," including abuse, increases risk factors associated with HIV, including injection drug use, promiscuity (having 50 or more lifetime intercourse partners), and ever having an STD, including HIV.[151] While the relationship between GBV, violence against children, and HIV/AIDS is multifaceted, HIV can increase the likelihood of being exposed to violence and violent or forced sex, which increases the risk of HIV infection and other STDs.[152] In addition, HIV puts increased stress on the families, communities, and service systems intended to protect children from violence.[153]

Current estimates of GBV and other forms of violence against children vary widely depending on the country and the research method used. Nonetheless, international studies reveal that approximately 302 million children have experienced severe physical punishment at home;[154] 150 million girls have experienced sexual abuse;[155] and 115 million children are involved in hazardous work.[156] Additionally, many children are subject to emotional abuse and neglect.[157] Every year, there are an estimated 31,000 homicide deaths in children under 15 worldwide. This number underestimates the true extent of the problem, as a significant proportion of deaths is incorrectly attributed to falls, burns, and other causes.[158]

Several factors, including but not limited to gender, may impact risk levels and the types of abuse to which children are vulnerable. A 2006 UNICEF study cited data suggesting that girls are at greater risk of neglect and sexual violence, whereas boys face a greater risk of physical violence.[159,160] Recent violence studies carried out by the Centers for Disease Control and Prevention (CDC) and UNICEF confirm this trend. The UNICEF study revealed that young children are at the greatest risk of physical violence, whereas sexual violence predominantly affects those who have reached adolescence or puberty. [161,162]

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[151] Hillis S, Anda R, Felitti V, Nordenberg D, Marchbanks P. (2000). Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. *Pediatrics* 106 (1), E11.

[152] AIDSTAR-One. (2011). *Introduction: Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs.* Accessible at: http://www.aidstar-one.com/sites/default/files/Intro_AIDSTAR-One_GBV_Guidance_0.pdf

[153] Cluver L, Operario D. (2008). *The Inter-generational Link Between the Impacts of AIDS on Children, and Their Subsequent Vulnerability to HIV Infection: A Study of the Evidence to Inform Policy on HIV Prevention and Child and Adolescent Protection.* Technical report. Joint Learning Initiative on Children and AIDS Learning Group 4: Social and Economic Policies. Oxford, England: Oxford University.

[154] UNICEF. (2007). *A World Fit for Children: A Statistical Review*

[155] United Nations General Assembly Sixty-First Session. (2006). *Promotion and Protection of the Rights of Children.* A/61/299.

[156] International Labour Organization (ILO). (2010). *Acceleration Action Against Child Labour: Global Report under the Follow up to the ILO Declaration on Fundamental Principles and the right to Work.* International Labour Conference. 99th Session. Report I(B). Geneva: ILO. Accessible at: http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/publication/wcms_126752.pdf

[157] WHO Media Centre. (2010). *Child maltreatment.* Factsheet N°150, http://www.who.int/mediacentre/factsheets/fs150/en/index.html

[158] Ibid.

[159] UNICEF. (2010). *Violence Against Children.* Accessible at: http://www.crin.org/docs/UNVAC_World_Report_on_Violence_against_Children.pdf

[160] Child Welfare Information Gateway. *Child Maltreatment Prevention: Past, Present, and Future*. Issue briefs retrieved July 2011. Accessible at: http://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.pdf

[161]. Goldman J, Salus MK, Wolcott D, Kennedy KY. (2003). *A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice*. Office on Child Abuse and Neglect, Children's Bureau User Manual Series. Accessible at: http://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf

[162] UNICEF. (2010). *Violence Against Children – Looking Beyond Experience: Introduction to the Participatory Assessment Tool.* New York: UNICEF.

In addition, children living in extremely impoverished communities may face higher levels of vulnerability to different forms of violence. Likewise, children living outside of family care (in institutions or on the streets) may be more vulnerable due to the absence of parental care[163] (although research also indicates that most child abusers are family members or others close to a family[164]).

Violence may also occur in the context of programs intended to support children, either as a result of poorly planned activities that unintentionally place children at risk or due to abuse perpetrated by program staff or volunteers.[165] Either case represents a serious reputational and legal risk as well as a violation of a child's and family's trust.

9.2 Evidence-Based Implementation Recommendations

Although children affected by HIV/AIDS face significant child protection risks, several strategies have been proven to minimize risks by seeking to:

- Prevent child abuse, neglect, and family separation
- Respond to incidents of abuse
- Safeguard children against abuse by organizations and programming intended to benefit them

These strategies can be pursued through both the formal child protection system and informal systems (see Capacity Building section) and stakeholders such as traditional leaders, religious leaders, parents, neighbors, and young people themselves.

9.2.1 Prevention

Child protection programming occurs at three levels of services: 1) primary prevention of abuse, exploitation, and violence, which is directed at the general population; 2) secondary prevention, targeted to individuals or families in which violence is more likely; and 3) tertiary prevention, targeted to families in which violence has already occurred.[166] Many prevention programs operate at all three levels, following evidence-based models that seek to reinforce the six protective factors that, when present in families or communities, increase the health and well-being of children and families. These six factors are:

- Nurturing and attachment
- Knowledge of parenting and child development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence of children[167]

[163] Ibid.
[164] Asmussen K. (2010). *Key facts about child maltreatment*. Research Briefing. The Institute of Psychiatry, King's College London. Accessible at: http://www.nspcc.org.uk/Inform/research/briefings/Key_facts_child_maltreatment_pdf_wdf76279.pdf
[165] Keeping Children Safe. (nd). *Toolkit*. Accessible at http://www.keepingchildrensafe.org.uk/toolkit
[166] U. S. Department of Health and Human Services, Administration for Children and Famillies, Child Information Gateway. (nd). *Framework for Prevention of Child Maltreatment*. Accessible at: www.childwelfare.gov/preventing/overview/framework.cfm#four
[167] U. S. Department of Health and Human Services, Administration for Children and Famillies, Child Information Gateway. (nd). *The Six Protective Factors.* Accessible at: http://www.childwelfare.gov/preventing/preventionmonth/factors.cfm

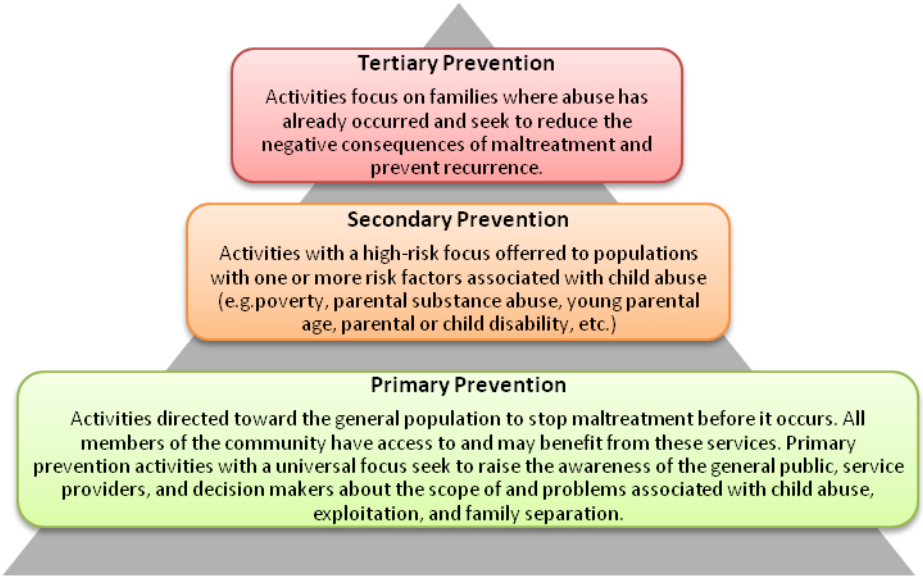

Figure 6: Prevention Pyramid

PEPFAR partners should engage stakeholders in the child protection system in implementing the following evidence-based models[168] and reinforcing the protective factors.

Raising public awareness – Public awareness activities increase knowledge about the dangers of child abuse and about available resources and solutions. They can reach a range of stakeholders critical to creating an environment in which abuse is not tolerated. PEPFAR OVC programs can work with media outlets to develop and disseminate public awareness materials and engage community members and youth in community theatre and other public events.

Educating and supporting parents/caregivers – Parent education programs enhance parental competencies and promote healthy parenting practices. PEPFAR partners can train parent educators and support group facilitators, provide necessary tools and resources, and monitor their progress.

Providing skills-based training for children – Many schools and local community social service organizations offer skills-based curricula to teach children safety and protection skills. PEPFAR partners can work with schools and other organizations to equip facilitators to implement skills training and provide any tools or resources necessary for the training.

Visiting vulnerable homes – Regular home visitation programs offer a variety of family-focused services. PEPFAR partners can engage in structured visits in the family's home to address positive parenting practices, nonviolent discipline techniques, child development, maternal and child health issues, how to access social services, and other relevant subjects.

All prevention activities undertaken under the above models may require some specific technical expertise during the development phase.

All partners should provide some form of child protection activities, which are low-cost, sustainable, replicable, appropriate to all contexts, and feasible. Often they can be offered alongside other interventions. For example, partners might consider offering parent education and support groups to

[168] Mikton C, Butcharta A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin World Health Organization*. 87, 353–361. Accessible at http://www.who.int/bulletin/volumes/87/5/08-057075.pdf

savings and loan groups.[169] Under certain conditions, interventions to raise abuse awareness can be supported. For example, partners may support targeted awareness raising in hard-to-reach areas with high rates of abuse. However, the impact of awareness raising is difficult to measure, and most efforts are too general to justify large investments.

9.2.2 Response

Response strategies are tertiary interventions, appropriate for children and families once abuse has occurred. Many of the casework and short- and long-term care options described below refer to formal system interventions, but PEPFAR partners can also help strengthen informal response mechanisms by collaborating with traditional leaders during investigations and building the capacity of community-based care and justice mechanisms.

Identification and reporting systems – PEPFAR partners can strengthen systems for identifying and reporting concerns by establishing hotlines; disseminating information about reporting mechanisms and reporting processes; facilitating child abuse training and the development of child safeguarding protocols; supporting governments to develop mandatory reporting policies; and supporting community-based committees to monitor child protection concerns on a more active basis.[170]

Individual and family casework – Casework is a foundational but very technical undertaking for child protection response. Many casework functions are statutory and must be carried out by government social workers and/or in coordination with medical personnel, police, and others involved in investigations. PEPFAR partners may facilitate implementation but should avoid taking primary responsibility for statutory functions. Partners should also ensure that when undertaking casework, they have the technical capacity to do so, consult experienced professionals, and follow established standards for all phases of casework. This is especially true when dealing with post-rape care at the clinic or community level. PEPFAR partners can undertake activities to support casework, such as facilitating transport for team members and abuse survivors to services; creating child-friendly spaces in facilities; working with teams to co-locate services in one place; recruiting and equipping multidisciplinary teams to provide medical checkups, HIV testing, formal forensic interviews, trauma counseling, etc.; developing case planning tools and helping with implementation and monitoring of case plans; and working closely with service providers to ensure that ongoing services meet quality standards. [171,172]

Emergency/immediate and interim care options – Emergency care options for child abuse survivors include drop-in centers, and, as a last resort, orphanages, prisons, and rehabilitation centers. Family-based emergency foster care is recommended when feasible and safe. Longer-term options for children in out-of-home care include living in the homes of extended family, foster homes, or group or residential care.[173] PEPFAR partners can improve conditions in short-term facilities and long-term out-of-home care options by training and supporting caregivers and providing appropriate supplies. Partners may also support efforts to scale up emergency foster care, legal guardianship, and adoption by working with

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[169] Bundervoet T, et al (2011). Urwaruka Rushasha project, Burundi, also supported by USAID's Displaced Children and Orphans Fund.
[170] U. S. Department of Health and Human Services, Administration for Children and Famillies, Child Information Gateway. (nd). *Intake, Investigation, and Assessment*. Accessible at: http://www.childwelfare.gov/responding/iia/
[171] Population Council. (2008). *Sexual and Gender-based Violence in Africa: Literature Review.* Accessible at: http://www.popcouncil.org/pdfs/AfricaSGBV_LitReview.pdf
[172] National Quality Improvement Center on Differential Response in Child Protective Services. (nd). *A literature review*. Accessible at: http://tinyurl.com/3kvssht
[173] U.S. Department of Health and Human Services. (2005). *A report to Congress on adoption and other permanency outcomes for children in foster care: Focus on older children.* Washington, D.C.: Children's Bureau.

governments and communities. In addition, they may provide ongoing support to children in permanent placements and/or older adolescents living independently and/or caring for young siblings.[174]

Strengthening justice systems – Holding perpetrators of violence against children and GBV accountable can be an empowering experience for survivors and a deterrent to future abusers. PEPFAR partners can work with legal professionals, train community-based paralegals to bring criminal and civil cases against perpetrators, and guide and support survivors through the legal system. Partners can also work closely with traditional justice systems to address crimes in ways that both seek justice and restore harmony within communities and families. Because many child protection response activities are statutory and require a high level of technical competence, only partners with strong expertise and experience should pursue, in a limited and selective manner, activities in these areas, primarily with the goal of building government capacity to carry out such functions.[175] These activities are sustainable only when supported by government structures, and replicability often depends on the strength of these government structures.

PEPFAR partners should support long-term residential care (orphanages) only as a last resort and include measures that prioritize permanency solutions,[176] such as regular case review and transition to family care.[177,178] In addition, PEPFAR partners should facilitate individual interventions only for children and families requiring secondary and tertiary interventions and/or families that are in immediate danger. Individual interventions should be goal-oriented and time-limited. Once danger has passed, children and families should be encouraged to join group activities. Individual interventions include casework, home visiting, and counseling.[179] Partners should avoid establishing parallel, unlicensed child protection services, e.g., casework or care placement services, which must legally be managed by government.

9.2.3 Community-based protection

Throughout both prevention and response activities, partners should build upon and strengthen existing community-level structures. At the same time, partners must be sensitive to any disconnect between the formal and informal child protection subsystems and how differences in values, beliefs, and expectations between the formal system and community knowledge and practices might create conflict and put children at further risk. In some communities, any formal interventions that are not sanctioned, supported, and carried out in coordination with community leaders may result in the isolation, stigmatization, and in some cases, expulsion of a child and his or her family. At minimum, PEPFAR partners should support efforts to build better collaboration between formal child protection services and informal supports. There is a literature and experience base for community-based child

[174] Oaks EJ, Fruendlich M. (2004). *The Role of Emergency Care as a Child Welfare Service: Summary of Findings and Recommendations*. Children Rights. http://www.childrensrights.org/wp-content/uploads/2008/06/role_of_emergency_care_as_child_welfare_service_sept_2004.pdf

[175] Neudorf K, Taylor TM, Thurman TR. (2011). *A Case Study: The Greater Rape Intervention Program*. New Orleans: Tulane University.

[176] Desmond C, Gow J. (nd). *The Cost-effectiveness of Six Models of Care and Vulnerable Children in South Africa*. Evaluation database. UNICEF.

[177] The rigorous design and implementation of a series of studies of the Bucharest Early Intervention Project (BEIP) provides substantial support for ensuring that infants and young children are placed in family-based care rather than in institutions. They show that infants and young children risk profound harm (e.g., reduced growth, developmental delays) from institutional care. Bos K, Fox N, Zeanah CH, Nelson CA III. (2009). Effects of early psychosocial deprivation on the development of memory and executive function. *Front. Behavioral. Neuroscience*. 3:16, doi: 10.3389/neuro.08.016.2009

[178] Ainsworth M, et al. (1999). *Confronting AIDS: Public Priorities in a Global Epidemic. A World Bank Policy Research Report.* revised edition, 1999. Washington, D.C.: Oxford University Press. See Chapter 4.

[179] Barinbaum R. (2007). *Child, Youth and Family Involvement in Case Planning.* Information Packet, National Resource Center for Family-based Practice and Permanency Planning, Hunter College School of Social Work. Accessible at: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/child-family-youth-involvement.pdf

protection[180] that partners should draw upon in conjunction with child protection experts. The community network of PEPFAR OVC programs is an excellent foundation for this community-based child protection work, but efforts should be undertaken building on past efforts and lessons learned.

9.2.4 Safeguards against organizational abuse

Research indicates that persons with a history of abusing children will often seek positions of power in countries or programs with weak safeguards in order to gain access to vulnerable individuals. In addition, poorly designed projects or those that have not been subject to a rigorous risk assessment may inadvertently put already vulnerable children at further risk by asking children to participate in events without adequate supervision or by organizing school clubs that meet after school and require children to walk home alone.[181] At a minimum, all OVC programs and partners should adopt clear and comprehensive child safeguarding policies. Processes for establishing these policies are low-cost, sustainable, replicable, and appropriate to all contexts. However, partners are encouraged to work with experienced technical experts during the development of policies to ensure they are comprehensive and effective. Partners are also encouraged to collaborate with PEPFAR colleagues working in treatment, care, and GBV to ensure child-centered support is available at post-rape care centers.

9.3 Prioritization of Recommended Interventions

The OVC portfolio aims to develop appropriate strategies for preventing and responding to child abuse, exploitation, violence, and family separation. It also aims to ensure safe, supportive, and permanent family care through the use of global best practices and evidence-based interventions. PEPFAR programs should prioritize within their country context the following child protection and GBV interventions:

1) Implementing child safeguarding policies
2) Integrating child protection activities
3) Supporting communities to prevent and respond to child protection issues
4) Strengthening linkages between the formal and informal child protection systems
5) Building government capacity to carry out and improve child protection responses

[180] Wessells, M. (2009). *What Are We Learning About Community-Based Child Protection Mechanisms. An Inter-Agency Review of the Evidence From Humanitarian and Development Settings*. Inter-Agency Report. Accessible at: http://www.sfcg.org/programmes/children/pdf/Report%20Community%20Based%20Child%20Protection_provisional%20draft.pdf

[181] Keeping Children Safe. (nd). *Toolkit*. Accessible at http://www.keepingchildrensafe.org.uk/toolkit

10. LEGAL PROTECTION

10.1 Background

Legal protection in OVC programs and appropriate strategies are critical for ensuring that children are registered, and, in the event of absent or deceased caregivers, that their assets are protected and they have appropriate guardians. Ensuring children access to basic legal rights, such as birth certificates and inheritance rights, enables them to access other essential services and opportunities, including health, education, legal services, and legal employment when they grow older.

Evidence suggests that birth registration is critical to ensuring that children can access these essential services and opportunities. Many people living with or affected by HIV/AIDS do not access birth registration systems or successfully claim inheritance rights. HIV/AIDS physically and financially deters ill parents or caregivers from registering children and making succession plans. In addition, ill parents fear that registration will induce stigma towards their children.[182] Furthermore, the mechanisms used for establishing the identity of an unregistered child (sworn affidavits, for example) are more difficult to obtain when a child's relatives are deceased.[183]

10.2 Evidence-Based Implementation Recommendations

Although significant barriers prevent birth registration and succession planning, several strategies have been proven to minimize these barriers and facilitate access to basic legal support.

10.2.1 Improving birth registration[184]

Raising awareness about the importance of birth registration – PEPFAR partners can support efforts to organize mass registration to promote the benefits of birth registration. These interventions are low cost and sustainable, replicable, appropriate to all contexts regardless of the type of epidemic, and require limited technical capacity. Partners can develop and disseminate messages through radio, television, film, and existing groups or structures (e.g., health teams, youth organizations, religious institutions, and police), and work with community leaders and celebrity ambassadors to advocate for registration. Messages should incorporate local languages and iconography. Partners can also offer special incentives for those who register births within a certain time period, such as bed nets, and support links with other services, such as prenatal care, immunizations, and educational services.

Supporting efforts to break down geographical barriers – PEPFAR partners can support mobile birth registration units and advocate for the decentralization of birth registration to very local levels and for the authorization of local government officers, chiefs, and health care workers to carry out birth registration functions.

Advocating for reduced fees – PEPFAR partners can advocate for and work with government to temporarily or permanently reduce or abolish fees associated with birth registration.

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[182] Inter-Agency Task Team on Children Affected by AIDS. (2008). *Strategic analysis on civil registration and children in the context of HIV and AIDS*. Working Paper. 5. Accessible at: http://www.unicef.org/Birth_registration_in_the_context_of_HIV_and_AIDS.pdf

[183] Sharp, N. (nd). *Technical consultation of global partners forum on children affected by HIV AND AIDS.* Technical Paper on Birth Registration. Accessible at: http://www.ovcsupport.net/s/library.php?ld=662

[184] Plan International. (2009). *Count every child, the right to birth registration*. Accessible at: http://plan-international.org/birthregistration/files/count-every-child-2009

Facilitating efforts to make registration simple – PEPFAR partners can advocate for extending registration periods to give those who live far away or are waiting to name their child longer to register without having to go through late registration procedures. They can also help develop and deliver manuals and training for civil registrars to reduce costly clerical errors.

Building government capacity and political will to implement better birth registration systems – PEPFAR partners should always emphasize the role of government as leader of birth registration efforts and seek to build the capacity of government through every activity.

10.2.2 Improving succession planning[185]

Raising awareness about rights and inequalities in inheritance practices and the importance of succession planning – PEPFAR partners can develop and translate into local languages messages about the importance of ensuring the financial security of family members through succession planning and about the dangers of failing to create plans. They should also link succession planning with other basic services and offer temporary incentives for completing succession plans. When possible, they can organize targeted training and awareness-raising campaigns for community leaders, police, magistrates and lawyers, who have authority to enforce succession plans or distribute property in ways that benefit women and children.[186]

Supporting caregivers to appoint standby guardians – PEPFAR partners should support all parents and caregivers to appoint a standby guardian to care for a child in their absence or incapacitation. This is especially true for (but should not be limited to) HIV-infected parents and guardians. PEPFAR partners can also offer training to guardians to help them understand and prepare for this responsibility. This activity can be incorporated into parent education and support groups and other services.[187]

Facilitating widows and orphans to build social capital and seek joint title to property – PEPFAR partners can encourage widows and orphans to engage more in community and family activities and recruit allies to support their inheritance claims. This process can begin prior to the death of a head of household and include efforts to seek joint title.[188]

Training and deploying paralegals – PEPFAR partners can work with legal professionals to recruit and train community-based paralegals to provide education about key legal services, watch for cases of disinheritance or land grabbing, and help prepare legal documentation to prevent these incidents. Although paralegals may not be able to perform all of the functions of a legal professional, they may be able to provide low-skill functions at a much lower cost.

Advocating for laws and/or traditions that enable women and minors to own property – In countries that deny women the ability to own property, PEPFAR partners can encourage married couples to seek joint ownership or title of land and property and work with legal advocates to arrange for legal guardians of orphaned children to act as temporary custodians of their parents' land and property.[189]

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[185] Schenk K, et al. (2010). Improving the Lives of Vulnerable Children: Implications of Horizons Research Among Orphans and Other Children Affected by AIDS. *Public Health Reports*. 125.

[186] GROOTS Kenya Association. *The Complementary Role of Community Land and Property Watchdog Groups in Protecting Women's Land Rights in Kenya.* Policy Brief. Accessible at: http://web.idrc.ca/uploads/user-S/12850770631GROOTS_Kenya_Policy_Brief_Complementary_Role_of_WDGs1.pdf

[187] OVCSupport.net. (nd). *Succession Planning*. Accessible at: http://www.ovcsupport.net/s/index.php?c=28

[188] Izumi K, Deshpande C, Larson G, Ragasa C. (nd). *Protecting Women's Land and Property Rights in the Context of AIDS, Module 4, Thematic Note 5*. Accessible at: http://siteresources.worldbank.org/INTGENAGRLIVSOUBOOK/Resources/AfricaIAP.pdf

[189] Petermans Evans R, Day C. (2011). *Inheritance, poverty and HIV/AIDS: Experiences of widows and orphaned youth heading households in Tanzania and Uganda*. Chronic Poverty Research Centre Working Paper No. 185. Accessible at: http://www.chronicpoverty.org/uploads/publication_files/WP185%20Evans-Day.pdf

As with birth registration, PEPFAR partners should also seek to link succession planning with other services, promote succession planning through public campaigns, and disseminate information through existing groups. In addition, partners should ensure that all children enrolled in PEPFAR programs have a standby guardian. These interventions are low-cost and sustainable, replicable, appropriate to all contexts, feasible, and require limited technical capacity. Partners may also organize targeted training and awareness-raising for key partners and for legal guardians.

10.3 Prioritization of Recommended Interventions

The OVC portfolio aims to develop strategies to ensure basic legal rights, especially birth registration and inheritance rights, to improve access to essential services and opportunities through the use of global best practices and evidence-based interventions. PEPFAR partners should note that many of the more systematic birth registration and succession planning interventions listed above require technical expertise and a commitment to large-scale and long-term support for improving the birth registration system and a country's broader legal system, and should be pursued only by partners who can complement PEPFAR support with additional funding and continue support beyond the life of a PEPFAR project. Partners should always be sensitive to any disconnect between the formal and informal child protection and legal subsystems and how differences in values, beliefs, and expectations between these subsystems might create conflict and put children at further risk when seeking inheritance rights or registering a child's identity.

PEPFAR programs should prioritize within their country context and target populations the following legal protection interventions:

1) Raising awareness about birth registration and succession planning
2) Linking birth registration and succession planning to other essential services
3) Improving government birth registration systems and legal mechanisms for enforcing fair and equitable inheritance laws and guardianship

11. BUILDING CAPACITY AND SYSTEMS STRENGTHENING FOR COUNTRY OWNERSHIP

11.1 Background

To ensure strong country ownership and availability of good quality services, PEPFAR must address sustainability and capacity at all levels of society. All of the above sections addressing specific technical efforts should be implemented taking a capacity building and systems strengthening approach. PEPFAR is in the process of developing a broad and flexible capacity-building framework. This framework defines "capacity building" as an evidence-driven process of strengthening the abilities of *individuals, organizations, and systems* to perform core functions effectively, efficiently, and sustainably, and to continue to improve and develop over time.

Within the context of OVC services, "capacity building" means strengthening the social service system, including the technical and operational capacities of its individual actors and organizations. While the other sections in this guidance outline strategies to improve technical capacity, this section outlines strategies for strengthening systems and building operational capacity of actors within the system. For definitions of key terms and concepts, see Annex A.

The goal of an OVC social service system can be understood as ensuring the welfare and protection of children affected by HIV/AIDS. Ensuring *welfare* refers to alleviating poverty (social protection) and facilitating access to essential services, and ensuring *protection* refers to preventing and responding to abuse, exploitation, neglect, and family separation.

OVC Social Service System: Ensures the welfare and protection of children and other vulnerable populations	
Social Protection (Welfare) System	**Child Protection System**
Reduces poverty and vulnerability	Protects children from abuse, neglect, exploitation, and other forms of violence

Social service systems have *formal* and *informal* components, which may not always connect or coordinate. In some countries, coordination between the more "formal" national or government-led elements of the system (e.g., laws, policies, finance, workforce, etc.) and the more "informal" (sometimes referred to as "endogenous family and community practices") is complicated by differences in values, beliefs, and expectations.

At each level of the social service system (and in both its formal and informal components), family, community, government, and civil society actors play vital roles in shaping how the system looks and functions.[190] See Section 2 for an explanation of these roles within the system. Because strategies to

[190] Wulczyn F, Daro D, Fluke J, Feldman S, Glodek C, Lifanda, K (2010) *Adapting a Systems Approach to Child Protection: Key Concepts and Considerations*. UNICEF

build family capacity are discussed throughout this guidance, this section will focus on building the capacity of government (primarily social welfare ministries), civil society, and community actors.

The functions of a social service system include the following:

- Strong leadership and governance
- A well-performing workforce
- Adequate financing
- Effective information management and accountability systems
- Effective coordination and networking mechanisms
- Good service models and delivery mechanisms

At this point, collecting evidence to support capacity building can be challenging, as drawing causation from systems strengthening efforts through to outcomes for children is not usually linear or direct. However, systems strengthening and capacity building are acknowledged logical steps in building sustainable, country-owned processes and responses for children. Case studies and isolated research indicate that investments in key building blocks will enable more effective systems. For example, recent system-mapping and capacity assessments in Kenya have led to an increase in public funding for system strengthening and a dramatic expansion of the public social service workforce. In several countries, a larger and better-distributed workforce with lower caseloads enables workers to address protection concerns more quickly and effectively.[191] A recent technical brief introducing a new organizational capacity-building framework notes that "governments, donors, and NGOs have made significant investments in capacity building, but the term is often vaguely defined and operationalized, and impact is difficult to measure."[192] At the same time, the brief notes that support for capacity building continues to grow as the importance of such efforts is increasingly recognized.[193]

11.2 Evidence-Based Implementation Recommendations

The strength of a system depends on its ability to carry out its functions, which, in turn, is influenced by the capacity and interaction among actors across system levels and across its formal and informal components. The cost of these strategies can vary greatly depending on their intensity. It is possible to carry out significant capacity building at a relatively low cost, but a comprehensive capacity-building approach can be labor- and cost-intensive. If done well, capacity-building strategies can be highly sustainable.[194]

In taking formal capacity-building steps, such as drafting national and organizational policies, standards, guidance, and legal regulations (including OVC quality standards), PEPFAR partners need to engage key stakeholders. At the same time, partners should avoid seconding staff to organizations without clear plans for withdrawing staff or transferring costs. They should also avoid funding recurring costs (e.g., recurring equipment costs) or strategic line items within government institutions, and avoid providing

[191] The National Association for Social Workers Foundation--Social Work Policy Institute. (2010). *High Caseloads: How Do They Impact Health and Human Services?* Research Brief. Accessible at:
http://www.socialworkpolicy.org/wp-content/uploads/2010/02/r2p-cw-caseload-swpi-1-10.pdf
[192] AIDSTAR 2. (2011). *Organizational Capacity Building Framework: A foundation for Stronger, more Sustainable HIV/AIDS Programs, Organizations and Networks*. Technical Brief No. 2.
[193] The World Bank. (2009). *The Capacity Development Results Framework – A Strategic and Results-Oriented Approach For Capacity Development.*
[194] Sklaw K. (2012). Presentation. PEPFAR Partners Meeting

equipment or infrastructure that cannot be maintained unless they have a clear management and maintenance plan.[195] In addition, partners should keep training scholarships to a minimum. Rather, partners should invest in building the capacity of training institutions and of individuals and households to fund their own education.

11.2.1 Building strong leadership and governance

At minimum, PEPFAR partners should engage in strategies to improve the leadership and governance of social service ministries, CSOs, and communities*.* Engaging in these activities will establish a foundation for capacity-building activities in other function areas.

Government level – Social service ministries need strong senior leadership that is able to communicate clear ministry goals and to convene processes for agreeing on strategic plans and regulations. Leadership needs processes for engaging stakeholders in decision making and a sound organizational structure that clearly identifies responsibilities and lines of communication between different departments.[196]

Civil society/NGO level – Strong, well-run, and responsive NGOs need boards of directors and well-articulated vision and mission statements. They also should have coherent strategic plans, participatory planning processes, and a clear and functional organizational structure and administrative policies.

Community level – Community leadership structures should be organized around common community goals and involve representation from a diverse range of constituencies, including equal representation from less powerful segments of the population, such as women and young people.[197,198]

Approaches that PEPFAR partners can take to support leadership and governance include:

- Helping to carry out child protection mapping exercises to better understand protection concerns and the capacity of various actors to address them
- Supporting vision and mission statements and community goals
- Respectfully challenging belief and value systems that endorse harmful cultural practices
- Facilitating strategic planning to inform action plans
- Supporting capacity building of leadership bodies and government and community leaders
- Assisting the drafting and/or review of technical and operational policies, practice standards, program guidance, and legal regulations, including OVC quality standards
- Strengthening lines of communication and feedback channels
- Facilitating participatory planning processes

11.2.2 Building a well-performing workforce

As a second priority, OVC partners should pursue strategies to strengthen the social service workforce employed by the government, NGOs, and community. Most services in this sector are human resources-heavy and require a number of highly skilled professionals and paraprofessionals.

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[195] PEPFAR COP Guidance. 2012.

[196] Play Therapy Africa and Training Resources Group. 2012.

[197] Zaharah H, DaudSilong, A. (2008). Women leadership and community development*. European Journal of Scientific Research*. 23 (3), 361-372. Accessible at: http://www.eurojournals.com/ejsr_23_3_02.pdf

[198] House RJ, Hanges PJ, Ruiz-Quintanilla SA, Dorfman PW, Javidan M, Dickson M, et. Al. (nd). *Cultural Influences on Leadership and Organizations: Project Globe*. Accessible at http://t-bird.edu/wwwfiles/sites/globe/pdf/process.pdf.

Government level – Social service ministries need accurate human resource data, clear job descriptions, and staffing plans that include recruitment and deployment mechanisms. They should also have a good understanding of staff skills and qualifications and access to training opportunities for professional development. In addition, a strong workforce requires competitive salary scales and incentives, good supervision, clear professional codes of conduct, licensing mechanisms, and professional associations.

Civil society/NGO level – Human resources plans and policies should at minimum reflect the standards outlined for the government social service workforce. In addition, NGOs must have mechanisms for managing nonpaid volunteers.

Community level – Each member of a community should have a role that complements his or her capacities and interests and is well understood by others. Community leaders and members should be able to identify individuals to fill capacity gaps and provide them with the support required to do their jobs well. Communities should also identify ways to compensate members for their contributions.[199]

Approaches that PEPFAR partners can take to support the workforce at each of these levels include:

- Working with ministries and NGOs to do capacity assessments and develop human resources information systems and recruitment and deployment plans
- Training and mentoring supervisors and developing performance improvement tools and resources
- Working with communities, they can support regular assessments of community members' roles and responsibilities
- Establishing systems for supporting volunteers
- Encouraging community members to provide frank and constructive performance feedback to government workers, NGO staff, and other community members

11.2.3 Building adequate financing

OVC partners should support strategies to improve financing. This is the third most-requested area of operational support and has implications for other functions.

Government level – Social service ministries must know the financial costs and benefits of services, and make a strong case to ministries of finance and other donors to secure necessary funding. Ministries should have complete and effective financial management systems. If relevant, organizations should have clear policies and procedures for managing grants and contracts, including policies and guidance for providing regular supervision and support to grantee and contractors.

Civil society/NGO level – NGOs should have well-defined business development plans and, ideally, multiple funding sources. Like social service ministries, NGOs should have complete, up-to-date, and well-understood and well-documented financial management systems.

Community level – Communities should support a diverse economy with a range of activities that succeed and decline at different rates over time. As the economy improves, the entire community may benefit through increased tax revenues, tithes, or donations by community members. Overdependence on agriculture or a specific industry, such as mining, may leave a community vulnerable to changes in weather and external markets.

[199] International Finance Corporation (IFC) Environment Division. (2000). *Investing in People: Sustaining Communities through Improved Business Practice: A Community Development Resource Guide for Companies.* Washington, D.C.: IFC. Accessible at: http://www.ifc.org/ifcext/enviro.nsf/AttachmentsByTitle/p_comdev/$FILE/CommunityGuide.pdf

Approaches that PEPFAR partners can take to support financing at each of these levels include:

- Working with social service ministries and communities to do costing analyses and develop budget requests for the ministry of finance (or, for communities, for district and local government funds)
- Helping ministries, NGOs, and communities develop business plans, draft donor proposals, and establish private-public partnerships
- Providing training to ministry and NGO accountants and other budget staff to better track expenses and improve cost estimates and systems for managing sub-grants and contracts
- Encouraging community members to provide support or in-kind donations to vulnerable families

11.2.4 Building effective information management and accountability systems

OVC partners should also strengthen information management and accountability mechanisms. Much of the data generated by information systems is used to support other functions. Improvements within data collection, analysis, and dissemination will contribute to improvements in other key areas.

Government level – Social service ministries must have strong systems for generating accurate social service data as well as for coordinating relevant data with other ministries (e.g., education statistics, birth and death registration, criminal cases involving children, health data, etc.). This information helps identify child protection trends and estimate the impact of social service programming. This data can also be used to improve existing policies, plans, and laws.

Civil society/NGO level – NGOs should have systems for providing up-to-date data on program activities to inform follow-up monitoring, program adjustments, planning, and progress reports, and for sharing and verifying data with relevant partners and clients. Monitoring and evaluation (M&E) systems should document both quantitative and qualitative data and facilitate the collection of lessons learned and best practices.

Community level – Communities can be valuable sources of data and should have a good system for monitoring their progress toward community goals. They can also use data to hold community leaders and service providers accountable for poor performance.

Approaches that PEPFAR partners can take to support information management and accountability systems at each of these include:

- Advising and helping to create or strengthen national M&E plans, systems, and databases
- Helping government agencies and NGOs establish realistic performance expectations and address performance gaps
- Launching or supporting ministries in launching independent research studies and assessments and disseminating research findings and lessons learned through appropriate media
- Facilitating community-based focus group discussions to verify data, identify new research questions, launch research efforts, and use data to advocate for change

11.2.5 Building strong coordination and networking mechanisms

OVC partners should also support coordination and networking. In many ways, these functions can occur spontaneously, but coordination can also require some level of intervention.

Government level – Social service ministries must have complete information about all actors working in the social service field. In many cases, government is the only actor with the mandate to plan multiyear, sector-wide initiatives; to direct service providers to the geographic and technical areas that

require their assistance; and to authorize the activities of nongovernmental actors. Where appropriate, they should have collaborative agreements, mechanisms for regularly engaging with stakeholders, and strong linkages with other ministries and government offices.[200]

Civil society/NGO level – NGOs should likewise have information about social service actors, particularly those operating in the same geographic and technical area. They should also have collaborative agreements, mechanisms for engaging with stakeholders, and processes for both referring clients for services and ensuring that services meet quality standards.

Community level – Community members should have a good sense of their roles, responsibilities, and relationships with one another. They should know where to go for specific services and supports, how to access these, and how to offer support to other community members.

Approaches that PEPFAR partners can take to support coordination and networking include:

- Helping to identify services and supports within a country or region and to develop or strengthen service directories and referral mechanisms
- Negotiating memoranda of understanding and organizing regular meetings with key partners
- Carrying out community assessments to identify and better understand the capacities and needs of vulnerable families in specific communities
- Helping to form stronger community relationships and, where appropriate, creating or strengthening existing community child-focused committees
- Helping communities form relationships with other communities, NGOs, and government actors to broaden their sources of support and protection in the event of future shocks
- Connecting the formal and informal components of the social service system

11.3 Prioritization of Recommended Interventions

The OVC portfolio aims to strengthen the social service system and operational capacity of partners through global best practices and evidence-based interventions. PEPFAR programs should prioritize within their country context the following capacity-building and systems-strengthening interventions:

1) Building strong leadership and governance
2) Strengthening the social service workforce
3) Improving financing for social service systems
4) Strengthening information management and accountability mechanisms
5) Supporting coordination and networking within the social service system

[200] Mendizabal E. (2008). *Supporting Networks: Ten Principles.* Overseas Development Institute. Accessible at: http://www.odi.org.uk/opinion/docs/1734.pdf

12. CRITICAL ISSUES IN MONITORING AND EVALUATING OVC PROGRAMS

Strong M&E systems are an essential foundation to improving the effectiveness of OVC programs. Quality monitoring (routine tracking of inputs, activities, and outputs) and evaluation (using data to assess effectiveness, relevance, and impact of achieving program goals) provide the evidence and essential information for strategic planning, program improvement, accountability of funds and effort, and advocacy.

This section highlights a few of the critical issues facing the monitoring and evaluation of PEFPAR OVC programs. It brings attention to lessons learned related to M&E from the early years of PEPFAR implementation and stresses areas of needed improvement, drawing heavily on the recent analysis of key PEFPAR program evaluations.[201]

12.1 Improving the Quality of OVC M&E Systems

Figure 7 represents the 12 components of a national M&E system proposed by UNAIDS and graphically illustrates the central and primary purpose of an M&E system – to use data for effective decision making. The middle ring focuses on the mechanisms through which data are collected, verified, and analyzed while the outer ring represents the planning and human resources needed to support data collection and use.[202] While each of these components is important in a fully functioning M&E system, this section will focus on a few of these components that are particularly critical to improving the quality of OVC M&E systems.

Figure 7: Organizing Framework for a Functional National HIV M&E System – 12 Components

- **Allocate Sufficient Funds:** OVC programs have often lacked robust program evaluations and, at times, adequate monitoring and data tracking systems, in part due to a lack of funds committed to this area. To combat this deficit, programs are advised to allocate at least 10 percent of their program budgets to ensure adequate funds for M&E activities.

[201] Sherr L, Zoll, M. (2011). *PEPFAR OVC Evaluation: How Good at Doing Good?* Prepared for PEFPAR through USAID by Global Health Technical Assistance Project.
[202] UNAIDS. (2009). *12 Components Monitoring and Evaluation Systems Assessment, Guidelines to support preparation, implementation and follow-up activities.* Accessible at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/1_MERG_Assessment_12_Components_ME_System.pdf.

- **Link with National M&E Systems:** All PEPFAR M&E activities should align with national M&E mechanisms in order to support an efficient care management and monitoring system. Implementing agencies and their partners are expected to harmonize program indicators and reporting systems with national OVC response management information systems (MIS) and are advised to support operationalization of OVC MIS at local, regional, and national levels. Registration and case management data for OVC households are best coordinated through government ministries responsible for orphans and vulnerable children. Coordination of referrals, service delivery, and follow-up with other relevant ministries (health, justice, and education, for example) is also essential.
- **Use M&E Field Experts**: While it is important to have M&E staff within the implementing partners, the complexity of both OVC programs and of the evolving field of monitoring, evaluation, reporting, and learning (MERL) demand sophisticated skill levels. Programs are therefore urged to engage professional experts, particularly drawing upon universities or research institutions, to design M&E systems and conduct program evaluations while generally using internal M&E staff for monitoring, reporting, and facilitating the use of data for decision making.
- **Develop M&E Capacity:** Based upon assessments of community, NGO, and government capacity in M&E, implementing agencies should promote the development of MERL capacity. Capacity development may address routine program monitoring and reporting, data quality assessments, data feedback loops at household and community levels, and data use for decision making, resulting in increased M&E skills and leadership within institutions and organizations at all levels.
- **Promote Quality Assessment and Improvement:** Promoting the establishment, adoption, and implementation of national OVC standards for service delivery and for program M&E can serve to improve the quality of OVC programming. Supporting governments and NGOs to conduct quality assessment and improvement activities will also further quality services.

12.2 Improving Program Evaluations

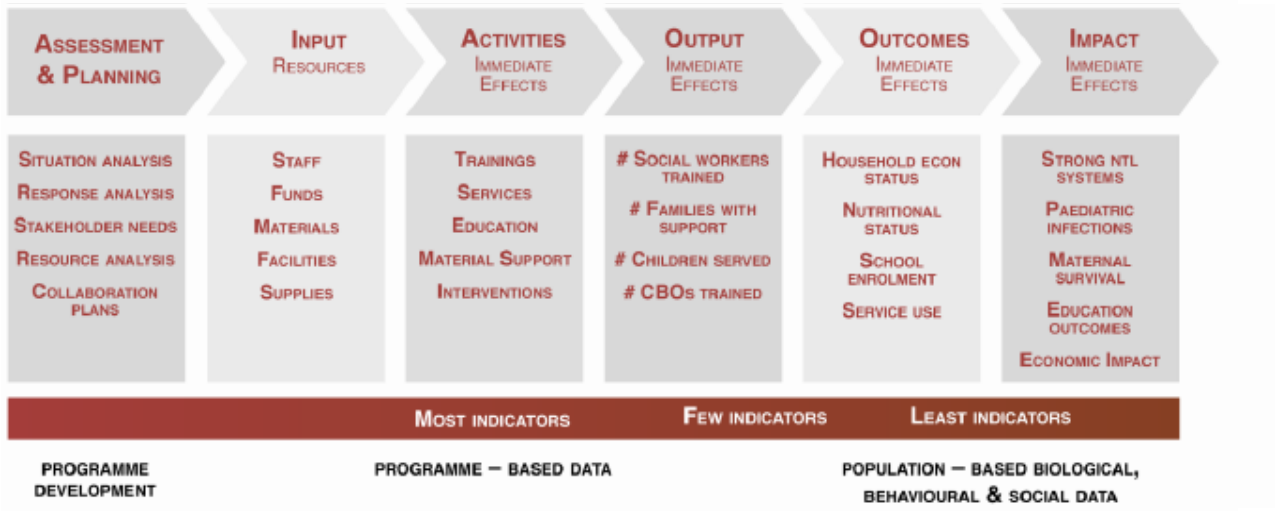
Well-designed program evaluations are needed to confirm that OVC programs are achieving the desired results and that those results can be associated with the interventions. Evaluation data also enable better understanding of the ramifications of these interventions. The entire discipline of program evaluation has evolved with multifaceted attention to methodology in order to maximize the confidence with which outcomes can be associated with interventions. Strong evidence with statistical significance requires strong design.[203] Many of the elements needed to improve M&E systems, such as adequate funding and use of external M&E experts, are also important in improving program evaluations. Additional avenues for enhancing program evaluations include:

- **Base Evaluation Design on Theory**: Theory-based evaluation is founded on careful articulation of the program model and use of this model as a guiding framework for evaluation. By mapping out the determining or causal factors proven to be important for success, and how they might interact, it can then be decided which elements to monitor and evaluate, to see how well they are in fact supported. A lack of theory-based design can result in invalid conclusions such as equating attendance with knowledge and knowledge with behavior.
- **Develop M&E Plans in Tandem with Program Plans**: Ideally, M&E plans and designs are developed in tandem with program designs and plans. Once program goals and objects are established,

[203] Sherr and Zoll. 2011.

indicators should be chosen that reflect and measure those desired outcomes. Baselines and comparison groups need to be established prior to program implementation.

- **Qualitative and/or Quantitative**: When utilized with rigor, qualitative methods provide descriptive insights into program results, issues, concepts, and experiences. This approach can drive theory, understanding, and explanation, and holds weight and integrity when done well. Poor qualitative methodology (for example, simple quotations from recipients and descriptions of programs) do not substitute for rigorous qualitative methodology and provide limited insights. Descriptive studies with no or poor methodology add little definitive evidence.[204] Rigorously designed quantitative methods are needed to understand impact and demonstrate cause and effect of program implementation. Often a combination of well-designed qualitative and quantitative methods provides maximum understanding of a program's effects.
- **Indicator Choices**: Indicators are used to capture data and to measure the degree of change. A first step in determining indicator choice, and thus the information to be gathered, is clarifying what data are needed by whom and for what purpose. Most indicators are used for monitoring programs while fewer indicators are generally used for evaluation (see Figure 8). International and national standard indicators should be chosen whenever possible. Indicators need to be well validated, high quality, and sensitive to a number of variations, such as cultural bias, test-retest bias, and situational applicability. Individually, indicators should have validity, integrity, precision, reliability, and timeliness. Taken together, they should give a clear picture of what is being accomplished and how well the targets are being achieved. Optimally, program design, including goals, objectives, and activities, must be decided first, and then corresponding indicators can be chosen. For example, whether an OVC program should link with a PMTCT program should be a strategic decision and not based on indicator choice.



Source: Adapted from Rugg et al., Global Advances in HIV/AIDS Monitoring and Evaluation: New Directions for Evaluation, Wiley Periodicals, Hoboken, NJ, 2004. **Source of adaptation**: Taking Evidence to Impact, UNICEF, 2011.

Figure 8: Monitoring and Evaluation Pathway

[204] Ibid.

- **Next Generation Indicators (NGIs) -** PEFPAR NGIs are primarily output indicators (e.g., C.1.1.D Care Umbrella) and, while necessary for general accountability, are not intended to be sufficient for M&E of OVC programs. The desire to contribute to this indicator should not drive program design or practice. The indicator is a simple, quantitative reflection of program effort.
- **Focus on Child and Household Outcomes -** Child and household outcome indicators (which measure the results) are essential to assessing whether programs are measurably improving child well-being. In addition to PEPFAR NGI OVC indicators (e.g., C.1.1.D Care Umbrella), M&E plans should include child and household outcome indicators (examples below[205]). In an effort to standardize such indicators, the PEPFAR OVC Technical Working Group is working to develop "Core Indicators for OVC Program Evaluation"[206] made up of key child well-being and household indicators.
- **Rigorous Design:** Rigorous program evaluation designs are essential to determine program effectiveness. To ensure high-quality evaluations of complex OVC projects, implementing agencies are advised to enlist highly skilled, independent evaluators for OVC programs. Compliance with evaluation policies of the source of funding (e.g., Department of State, USAID, or CDC) must also be adhered to. Design models vary in strength of attribution. Randomized controlled trials (RCTs) are seen in the scientific community as the "gold standard" intervention to attribute causal links and effective outcomes. The role of RCTs in complex programs and applied settings is subject to some debate,[207] and novel ways of adapting good standards[208] to challenging evaluation situations are being formulated. When RCTs are not used or possible, other designs can be employed to capture and describe some outcomes, with the caveat of supplying weaker evidence. Such methods cannot provide definitive causal pathway information but will show associations, correlations, predictions, change, and other outcomes. These methodologies do allow for controlled trials (even if allocation is not random) or comparison groups in the design. High-standard controlled evaluations need to have high-quality sampling and be sufficiently powered as well.[209] A longitudinal design can strengthen an evaluation by revealing how programs contribute to sustained improvement of child and household well-being.
- **Comparison and Controlled Groups -** At a minimum, PEFPAR OVC program evaluation designs should include comparison or controlled groups and baselines. Comparison and controlled groups are viewed as the minimum requirement for studying difference and drawing conclusions with some level of confidence. Controlled trials or those with a comparison group are enhanced if there is baseline data. Such designs are considered solid within the scientific community, even if not as definitive as the RCT. The purpose of these comparison groups is to demonstrate the 'counterfactual' – in other words, what would have happened in the absence of the specific intervention. A counterfactual may be established by measuring differences between recipients and nonrecipients of assistance. It is often possible to use future beneficiaries as the control group who will benefit from a later phase of the project, thereby reducing ethical issues of withholding benefits from an equally needy group.

[205] For example, percent of children who have completed immunization; percent of children who are malnourished; percent of children with a birth certificate/registration; percent of children demonstrating attachment with a primary caregiver; percent of children enrolled in school, attending regularly, and progressing to next grade; percent of children tested for HIV and percent of HIV-positive children on treatment; percent of children with basic shelter; percent of children who are inactive/withdrawn or disobedient/aggressive; percent of children able to reach developmental milestones.

[206] *Standardized Evaluation Indicators*. PEPFAR through USAID by Measure Evaluation (forthcoming).

[207] Connelly JB. (2007). Evaluating complex public health interventions: theory, methods and scope of realist enquiry. *J Eval Clin Pract.* 13 (6), 935-941.

[208] Tones K. (2000). Evaluating health promotion: a tale of three errors. *Patient Educ Couns.* 39 (2-3), 227-236.

[209] Sherr and Zoll. 2011.

- **Conduct Baseline Assessment -** Baseline assessments are essential for determining whether later program outcomes and impacts are a result of program exposure. Baselines are also helpful in determining programming needs and adjusting program design. Sufficient lead time is necessary to accomplish pre-baseline activities, such as building consensus among relevant stakeholders around the appropriate evaluation questions to be asked, developing protocols, and training in order to implement the baseline before the program activities commence. At times, institutional review board process approvals may be needed. This lead time should be built in by program planners and allowed by USG program managers.

12.3 Improving Data Analysis and Usage

- **Thoroughly Analyze the Data**: Data must be adequately analyzed in order to provide evidence of and confidence in outcomes. Rigorously designed studies with poor analysis add little definitive evidence. Quality evaluations need to provide power calculations to ensure that the sample is sufficient to capture a possible result. Complex analysis of data is then required to ensure that variables are controlled for and differences reach statistical significance. Evaluation reports that carry out such analyses, providing appropriate statistical tests (rather than simplistic descriptive statistics) together with significance levels, provide the strongest evidence. Using a vast number of data points allow for broad inclusion of a variety of outcomes but may have statistical implications for data management. Despite complex data gathering of many OVC evaluations, simplistic analysis reduces the value that could be gained from those evaluations.
- **Gender and Age Analysis:** While most OVC programs track sex and age, few programs adequately analyze this data to find differing program effects, limiting the full effect of having done an evaluation. In all cases, gender and age disaggregation of data is critical to fully understand the specific needs of boys and girls across the lifecycle.
- **Other Data Sources - Specialized Studies or Research:** In addition to program evaluations, special studies or intervention-linked research may be needed to collect information on specific populations or interventions. For example, national household surveys are a primary means of collecting data for strategic planning, but they are generally insufficient for establishing priorities for a national response to vulnerable children since household surveys miss children outside of family environments. For such children, such as those on the street, in residential care, or migrant and displaced children, special studies are needed to ascertain the type and magnitude of their needs.
- **Use the Data:** As stated at the beginning of this section, the purpose of M&E programs is to create knowledge for decision making. Even with excellently designed evaluations, unless the resulting evidence is used to improve systems, households, and children's lives, there is no point in developing M&E systems and collecting data. But data well used can serve to generate high-quality programs that effectively address the needs of children and households affected by HIV/AIDS and help bring a stop to AIDS and its devastating impact on lives.

ANNEX A

Key Terms and Concepts

Block Grants: Sums of money given to a school/community for major projects, such as adding a classroom, buying desks, or purchasing school supplies in exchange for a number of selected students attending school tuition-free.

Caregiver: A person who cares for a child inside the home.

Care Worker: A paid or unpaid person who provides services to support orphans and vulnerable children on the individual, family, and/or community levels.

Cash Transfers, Unconditional: Direct, noncontributory resource transfers to poor people aiming to reduce vulnerability and increase consumption. Participants are deemed to be eligible based on objective criteria (such as age or poverty status) that can be independently verified or that were identified through a participatory process.

Cash Transfers, Conditional: Cash transfers that require participants to engage in specific behaviors as a condition of eligibility (above and beyond other attributes such as poverty status). These conditions are intended to overcome "market failures" that affect a household's access to or utilization of services that are critical to their long-term development. Typically, investments in human capital (such as school attendance or clinic visits for young children) are a major focus.

Child Abuse: A deliberate act of ill treatment that can harm a child's safety, well-being, dignity, and development. Abuse includes all forms of physical, sexual, psychological, or emotional ill treatment.

Child Development and Early Child Development: Child development has been defined as "the physical, cognitive, social, and emotional maturation of human beings from conception to adulthood, a process that is influenced by interacting biological and environmental processes."[210] It has also been described as "a multifaceted, integral, and continual process of change in which children become able to handle ever more complex levels of moving, thinking, feeling, and relating to others."[211] One of eight key themes established by the WHO Commission on the Social Determinants of Health is "early child development," in recognition of the critical importance of "early life factors and experiences that are underlying social determinants of health."

Child Protection: All activities associated with preventing and responding to child abuse, exploitation, neglect, and family separation. Abuse, exploitation, and neglect are often practiced by someone known to the child, including parents, other family members, caretakers, teachers, employers, law enforcement authorities, state and nonstate actors, and other children. They can occur in homes, families, schools,

[210] **Harden, B. (2004) Safety and Stability for Foster Children: A Developmental Perspective**. **Children, Families, and Foster Care** Volume 14 Number 1 Winter 2004

[211] http://workfamily.sas.upenn.edu/glossary/c/child-development-definitions

care and justice systems, workplaces, and communities across all contexts, and also as a result of conflict and natural disasters.

Child Safeguarding: All activities intended to protect children from harm and address incidents of abuse, exploitation, and neglect in a timely and appropriate manner, including incidents involving orphans and vulnerable children project staff, subcontractors, subgrantees, and volunteers.

Continuum of Response (CoR): The CoR approach addresses the lifetime needs of target populations to ensure adequate access to a wide range of prevention, care, and treatment services that are based on the changing needs and circumstances of the families being served. The primary goal of a CoR approach is to provide clients and their families with essential prevention, care/support, and treatment services to reduce HIV transmission and disease progression and to maximize health outcomes.

Consumption Support Interventions: Direct transfers of resources, usually in the form of cash, to families in order to support basic needs of household members, particularly children.

Educational Access: A learner's access to appropriate educational institutions, materials, and personnel.

Educational Attainment: Years of schooling completed.

Family Separation: Any situation in which children are separated from their legal caregiver. Separation can result from legal removal of a child due to allegations of abuse; disasters or conflict; trafficking; the institutionalization of children in residential care centers or detention centers; or children living outside of their families on the street or elsewhere.

Gender-Based Violence (GBV): Violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. In this sense, GBV interventions are similar to other child protection interventions yet child protection refers specifically to those interventions intended to prevent and respond to abuse of children under the age of 18 years. GBV, however, takes on many forms and can occur throughout the lifecycle, from the prenatal phase through childhood and adolescence, the reproductive years, and old age. Types of GBV include female infanticide; early and forced marriage; "honor" killings; female genital cutting; child sexual abuse and slavery; sexual coercion and abuse; neglect; domestic violence; and elder abuse. Women and girls are the most at risk of GBV. Consequently, the terms "violence against women and girls" and "gender-based violence" are often used interchangeably. However, boys and men can also experience GBV, as can sexual and gender minorities, such as men or boys who have sex with men and transgender persons.

Health: According to the World Health Organization, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Household Economic Strengthening (HES): A portfolio of interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children they care for, rather than rely on external assistance. Defining features are a focus on families as direct beneficiaries, with success measured by a family's ability to invest in the education, nutrition, and health

of the children they care for. HES tends to focus on shorter-term outcomes, especially around how families accumulate and spend their money.

Income Generation: Activities aimed at increasing income at the family level such as access to credit, business skills training, enhancing productivity, or improving market access.

Income Promotion: Interventions that help families invest in appropriate low-risk activities to diversify and stimulate moderate growth in household income.

Money Management Interventions: Interventions that introduce mechanisms for saving financial and other assets, accessing prudent consumer credit, and fostering the knowledge and behaviors families need to better match their income with their expenses.

Permanency: A legal permanent family living arrangement, including, for example, reunification with the birth family, living with relatives, guardianship, or adoption. The goal of emancipation is not included in this definition of permanency because it does not provide for a legal permanent family for the child (although the child may have a long-term emotional connection with a family).

Social Protection: Social protection is an umbrella term encompassing an array of government-led policy instruments for reducing vulnerability and risks faced by disadvantaged groups. Compared with HES (see above), social protection promotes greater focus on longer-term outcomes as well as a greater need for systemic and government-led initiatives to sustain interventions. It emphasizes investments in human capital (e.g., education and health) to deal with long-term poverty and vulnerability issues, especially to interrupt the transmission of poverty from one generation to the next.

Toxic Stress: Toxic stress has been described as "…physiologic disruptions precipitated by significant adversity in the absence of adult protection" that "can damage the developing brain and other organ systems and lead to lifelong problems in learning and social relationships as well as increased susceptibility to illness."[212] Toxic stress is differentiated from positive or tolerable stress experienced by infants and young children who are "buffered by relationships with adults that help the child to adapt." However, in the absence of such relationships and the presence of "extreme and long-lasting stress, the result can be damaged, weakened systems and brain architecture, with lifelong repercussions."[213]

[212] Shonkoff JP, et al. (2012).
[213] Center for the Developing Child (2011). Toxic Stress: The Facts. Harvard University. http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

ANNEX B

Evidence Matrix

This annex contains a matrix of some of the evidence referenced in the guidance document. The matrix includes a description of the methodologies used and the locations and titles of the studies. It also includes links to abstracts and texts of articles wherever possible. It is important to note that not all relevant evidence is included in this matrix, as it is meant to be an illustrative rather than an exhaustive list. However, it provides a useful place to start for readers interested in getting a sense of the justification and evidence base for many of the interventions the guidance recommends.

Authors	Year	Title	Source/Journal	URL	Methodology	Location	Sample Size (n)
Adato M and Bassett L.	2009	Social protection to support vulnerable children and families: The potential of cash transfers to protect education, health and nutrition.	AIDS Care, 21(S1): 60–75.	Link to abstract	Literature Review	Global	
Ainsworth M and Mead O.	1997	Confronting AIDS: Public Priorities in a Global Epidemic.	World Bank Policy Research Report. Washington, DC: Oxford University Press: 1999. Ch. 4.	Link to abstract	Literature Review	Global	
Akwara P, Noubary B, Lim Ah Ken P, Johnson K, Yates R, Winfrey W, et al.	2010	Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS.	AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 22 (9): 1066-1085.	Link to abstract	Meta-analysis of data from the Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Surveys (MICS), and the AIDS Indicator Survey (AIS)	Global	60 household surveys from 36 countries

Anda R, Felitti V, Bremner J, Walker J, Whitfield C, Perry B, et al.	2006	The enduring effects of abuse and related experiences in childhood: a convergence of evidence from neurobiology and epidemiology.	European Archives of Psychiatry and Clinical Neuroscience, 256, 174-186.	Link to abstract	Observational, Cross-sectional surveys	United States	17,337
Anderson S and Baland J.	2002	The Economics of Roscas and Intra-household Resource Allocation.	Quarterly Journal of Economics, 117(3): 963-995.	Link to abstract	Qualitative, Semi-structured interviews	Kenya	520 households
Andrews G, Skinner D, Zuma K.	2006	Epidemiology of health and vulnerability among children orphaned and made vulnerable by HIV/AIDS in sub-Saharan Africa.	AIDS Care: Psychological and Socio-medical Aspects of HIV/AIDS, 18(3): 269-276.	Link to abstract	Literature Review	Africa	
Apinundecha C, Laohasiriwong W, Cameron M, Lim S.	2007	A community participation intervention to reduce HIV/AIDS stigma, Nakhon Ratchasima province, northeast Thailand.	AIDS Care, 19: 1157-1165.	Link to abstract	Quasi-experimental, Pre- and post-test control group design	Thailand	199 PLWHA, 31 caregivers and 195 other community members
Asmussen, K.	2010	Key facts about child maltreatment: Research Briefing.	National Society for the Prevention of Cruelty to Children and The Institute of Psychiatry, King's College London.	Link to abstract	Literature Review	Global	
Attanasio O, Kugler A, and Meghir C.	2011	Subsidizing Vocational Training for Disadvantaged Youth in Colombia: Evidence from a Randomized Trial.	American Economic Journal: Applied Economics, 3(3): 188–220.	Link to abstract	Randomized Controlled Trial	Colombia	4,353
Atwine B, Cantor-Graae E, Bujunirwe F.	2005	Psychological Distress among AIDS Orphans in Rural Uganda.	Science & Medicine, 61(3):555-564.	Link to abstract	Observational, Cross-sectional self-report surveys	Uganda	123 children (aged 11-15)

Bachmann M and Booysen F.	2003	Health and economic impact of HIV/AIDS on South African households: A cohort study.	BMC Public Health, 3:14.	Link to abstract	Observational, Controlled Cohort study	South Africa	1913 (in 404 households)
Baird S, McIntosh C, and Ozler B.	2009	The Short-Term Impacts of a Schooling Conditional Cash Transfer Program on the Sexual Behavior of Young Women.	The World Bank Development Research Group: Poverty and Inequality Team. Impact Evaluation Series No. 40.	Link to abstract	Randomized Controlled Trial	Malawi	2691 women (aged 13-22)
Baird S, McIntosh C, Ozler B.	2011	Cash or Condition: Evidence from a Cash Transfer Experiment.	The Quarterly Journal of Economics, 126 (4): 1709-1753.	Link to abstract	Randomized Controlled Trial	Malawi	2,907
Banerjee A, Duflo E, Glennerster R, and Kinnan C.	2010	The Miracle of Microfinance? Evidence from a Randomized Evaluation. Working Paper.	Abdul Latif Jameel Poverty Action Lab at the Massachusetts Institute of Technology.	Link to abstract	Randomized Controlled Trial	India	6856 house-holds in slum areas
Barber A.	2011	Transforming Lives: Can Savings and Credit Group Membership Work for People Affected by HIV/AIDS? A South African Case Study.	Universitas Forum.	Link to abstract	Qualitative, Semi-structured Interviews	South Africa	53 savings group members
Binagwaho A, Noguchi J, Senyana-Mottier M, Smith Fawzi M.	2008	Community-Centered Integrated Services for Orphans and Vulnerable Children in Rwanda.	Joint Learning Initiative on Children and HIV/AIDS (JLICA).	Link to abstract	Program Evaluation Report, including semi-structured interviews	Rwanda	
Blackett-Dibinga K, Anah K, Matinhure N.	2006	Innovations in Education: The role of the education sector in combating HIV/AIDS.	Africare: Office of Health and HIV/AIDS.	Link to abstract	Case Study	Zimbabwe	

Bolton P, Bass J, Neugebauer R, Verdeli H, Clougherty K, Wickramaratne P, et al.	2003	Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial.	JAMA, 289(23):3117-3124.	Link to abstract	Randomized Controlled Trial	Uganda	224
Bos K, Fox N, Zeanah C, and Nelson C.	2009	Effects of early psychosocial deprivation on the development of memory and executive function.	Frontiers in Behavioral Neuroscience; 3 (16).	Link to abstract	Randomized Controlled Trial	Romania	141
Bronfenbrenner U.	1986	Ecology of the family as a context for human development: Research perspectives.	Developmental Psychology, 22:723–742.	Link to abstract	Literature Review	USA	
Brown D, Anda R, Henning T, Felitti V, Edwards V, Croft J, et al.	2009	Adverse childhood experiences and the risk of premature mortality.	American Journal of Preventative Medicine, 37 (5), 389-96.	Link to abstract	Observational, Cohort Study	USA	17,337
Brown L and Lourie K.	2000	Children and adolescents living with HIV and AIDS: A review.	Journal of Child Psychology and Psychiatry, 41 (1): 81-96.	Link to abstract	Systematic Review	USA	
Bruce J and Hallman K.	2008	Reaching the girls left behind.	Gender and Development, 16 (2): 227-245.	Link to abstract	Literature Review	Global	
Bryant M, Shann M, Brooks B, Bukuluki P, Muhangi D, Lugalla J, et al.	2011	Evaluating the Effectiveness of Educational Block Grants to Orphans and Vulnerable Children.	USAID Project SEARCH Research Report: Boston University OVC-CARE Project.	Link to abstract	Program Evaluation Report	Tanzania and Uganda	5738

Bundervoet T, Annan J, and Armstrong M.	2011	Urwaruka Rushasha: A Randomized Impact Evaluation of Village Savings and Loans Associations and Family-Based Interventions in Burundi.	USAID and International Rescue Committee.	Link to abstract	Impact Evaluation Report of a Randomized Controlled Trial	Burundi	
Busza J, Walker D, Hairston A, Gable A, Pitter C, Lee S, et al.	2012	Community-based approaches for PMTCT in resource poor settings: A social-ecological view.	Journal of the International AIDS Society, 15 (Suppl.2): 17373.	Link to abstract	Literature Review	Global	
Card D, Ibarraran P, Regalia F, Rosas-Shady D, Soares Y.	2011	The Labor Market Impacts of Youth Training in the Dominican Republic.	Journal of Labor Economics, 29(2): 267-300.	Link to abstract	Randomized Controlled Trial	Dominican Republic	5801
Caspe M. and Lopez M.	2006	Lessons from family-strengthening interventions: Learning from evidence-based practice.	Cambridge, MA: Harvard Family Research Project.	Link to abstract	Program Evaluation Report and Literature Review	Global	
Child Protection in Crisis Network Livelihoods and Economic Strengthening Task Force.	2011	The Impacts of Economic Strengthening Programs on Children: A Review of the Evidence.	Child Protection in Crisis Network.	Link to abstract	Literature Review	Global	43 impact evaluation studies included
Cho H, Hallfors D, Mbai I, Itindi J, Milimo B, Halpern C, Iritani B.	2011	Keeping Adolescent Orphans in School to Prevent Human Immunodeficiency Virus Infection : Evidence From a Randomized Controlled Trial in Kenya.	Journal of Adolescent Health, 48(5):523-6.	Link to abstract	Randomized Controlled Trial	Kenya	105 children (aged 12-14)
Cluver L and Gardner F.	2007	The mental health of children orphaned by AIDS: A review of international and southern African research.	Journal of Child and Adolescent Mental Health, 19 (1): 1-17.	Link to abstract	Systematic Review	5 studies in USA, 19 in Africa	

Cluver L, Gardner F, and Operario D.	2007	Psychological distress amongst AIDS-orphaned children in urban South Africa.	Journal for Child Psychology and Psychiatry, 48 (8): 755-763.	Link to abstract	Observational, In-person interviews with demographic questionnaire and self-report surveys	South Africa	1025
Cluver L, Operario D, Lane T, Kganakga M.	2011	"I can't go to school and leave her in so much pain." Educational shortfalls among adolescent 'young carers' in the South African AIDS epidemic.	Journal of Adolescent Research, 26 (5):543-669.	Link to abstract	Observational, Quantitative surveys and qualitative interviews	South Africa	659 adolescents (aged 10-20)
Cluver L, Orkin M, Boyes M, and Gardner F.	2012	AIDS-orphanhood and caregiver AIDS-sickness-status: Effects on psychological symptoms in South African youth.	Journal of Pediatric Psychology.	Link to abstract	Observational, Longitudinal Cohort Study	South Africa	1025
Cluver L, Orkin M, Boyes M, Gardner F, and Meinck, F.	2011	Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty.	Journal of Acquired Immune Deficiency Syndromes, 58: 336-342.	Link to abstract	Observational, Longitudinal Cohort Study	Global	723 children
Crampin A, Floyd S, Glynn J, Madise N, Nyondo A, Khondowe M, et al.	2003	The long-term impact of HIV and orphanhood on the mortality and physical well-being of children in rural Malawi.	AIDS, 17(3): 389-97.	Link to abstract	Observational, Retrospective Cohort study	Malawi	593 adults, 1106 children
de Mel, S. McKenzie D, and Woodruff C.	2010	Returns to Capital in Microenterprises: Evidence from a Field Experiment.	Quarterly Journal of Economics, 123(4): 1329-1372.	Link to abstract	Randomized Controlled Trial	Sri Lanka	408 self-employed workers (aged 20-65)
Desmond C and Gow J.	2001	The Cost-Effectiveness of Six Models of Care and Vulnerable Children in South Africa.	UNICEF Evaluation Database, South Africa.	Link to abstract	Program Evaluation Report	South Africa	

Dong M, Anda R, Felitti V, Dube S, Williamson DF, Thompson T, et al.	2004	The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction.	Child Abuse and Neglect, 28:771-784.	Link to abstract	Observational, Cross-sectional surveys	United States	8629
Duflo E, Kremer M, and Robinson J.	2010	Nudging Farmers to Use Fertilizer: Theory and Experimental Evidence from Kenya. Working Paper No. 15131.	National Bureau for Economic Research.	Link to abstract	Randomized Controlled Trial	Kenya	877 farmers
Duflo E, Michael Kremer M, and Robinson J.	2008	How High Are Rates of Return to Fertilizer? Evidence from Field Experiments in Kenya.	American Economic Review, 98(2): 482-488.	Link to abstract	Randomized Controlled Trial	Kenya	663 farmers
Dupas P and Robinson J.	2011	Savings Constraints and Microenterprise Development: Evidence from a Field Experiment in Kenya. Working Paper No. 14693.	National Bureau for Economic Research.	Link to abstract	Randomized Controlled Trial	Kenya	331 self-employed workers
Dupas P and Robinson J.	2011	Why Don't the Poor Save More? Evidence from Health Savings Experiments. Working Paper No. 17255.	National Bureau for Economic Research.	Link to abstract	Randomized Controlled Trial	Kenya	771 ROSCA members
Duvendack M, Palmer-Jones R, Copestake J, Hooper L, Loke Y, and Rao N.	2011	What Is the Evidence of the Impact of Microfinance on the Well-Being of Poor People?	EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.	Link to abstract	Systematic Review	Global	58 studies included
Evans R and Day C.	2011	Inheritance, poverty and HIV/AIDS: Experiences of widows and orphaned youth heading households in Tanzania and Uganda.	Chronic Poverty Research Centre Working Paper, No. 185.	Link to abstract	Qualitative interviews	Tanzania and Uganda	85 women with HIV

Fafchamps M, McKenzie D, Quinn S, and Woodruff C.	2011	When Is Capital Enough to Get Female Enterprises Growing? Evidence from a Randomized Experiment in Ghana. Policy Research Working Paper No. 5706.	The World Bank.	Link to abstract	Randomized Controlled Trial	Ghana	793 self-employed workers (aged 20-55)
Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al.	1998	Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study.	American Journal of Preventative Medicine, 14 (4): 245-258.	Link to abstract	Observational, Mailed self-report surveys	USA	9508
Fox M, Rosen S, MacLeod W, Wasunna M, Bii M, Foglia G, et al.	2004	The Impact of HIV/AIDS on Labour Productivity in Kenya.	Tropical Medicine and International Health, 9 (3): 318-324.	Link to abstract	Observational, Retrospective Cohort Study	Kenya	54
Gregson S, Nyamukapa C, Garnett G, Wambe M, Lewis J, Mason P, et al.	2005	HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe.	AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 17(7): 785-794.	Link to abstract	Observational, Population-based cohort survey	Zimbabwe	1523
Guo Y and Sherr L.	2012	The impact of HIV/AIDS on children's educational outcome: A critical review of global literature.	AIDS Care, 24(8):993-1012.	Link to abstract	Systematic Review	Global	
Hagen-Zanker J, McCord A, Holmes R, Booker F, Molinari, E.	2011	Systematic Review of the Impact of Employment Guarantee Schemes and Cash Transfers on the Poor.	Overseas Development Institute.	Link to abstract	Systematic Review	Global	37 studies included

Hillis S, Anda R, Felitti V, and Marchbanks P.	2001	Adverse childhood experiences and sexual risk behaviors in women: A retrospective cohort study.	Family Planning Perspectives, 33(5): 206–11.	Link to abstract	Observational, Retrospective Cohort study	USA	5060
Hillis S, Anda R, Felitti V, Nordenberg D, Marchbanks P.	2000	Adverse childhood experiences and sexually transmitted diseases in men and women: A retrospective study.	Pediatrics, 106 (1):E11.	Link to abstract	Observational - Retrospective Cohort study	USA	9,323
Horizons/USAID	2007	Psychosocial Benefits of a Mentoring Program for Youth-headed Households in Rwanda.	USAID: Horizons Research Summary.	Link to abstract	Quasi-experimental, Intervention and comparison groups	Rwanda	692
Khumalo-Sakutukwa G, Morin S, Fritz K, Charlebois E, Van Rooyan H, and Chingono A.	2008	Project Accept (HPTN 043): A community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand.	Journal of Acquired Immune Deficiency Syndrome, 49(4): 422-431.	Link to abstract	Randomized Controlled Trial	Sub-Saharan Africa and Thailand	48 communities
King E, De Silva M, Stein A, Patel V	2009	Interventions for improving the psychosocial well-being of children affected by HIV and AIDS.	Cochrane Database of Systematic Reviews 2009, Issue 2, CD006733.	Link to abstract	Systematic Review	Global	
Kivumbi G and Kintu F.	2002	Exemptions and Waivers from Cost Sharing: Ineffective Safety Nets in Decentralized Districts in Uganda.	Health Policy and Planning, 17 (Suppl.1), 64-71.	Link to abstract	Observational (Semi-structured interviews and focus groups)	Uganda	29 interviews and 13 focus groups

Kukamech E, Cantor-Graae E, Maling S, Bajunirwe F.	2009	Peer-group support intervention improves the psychosocial well-being of AIDS orphans: Cluster randomized trial.	Social Science & Medicine, 68: 1038-1043.	Link to abstract	Randomized Controlled Trial	Uganda	298
LaLonde, RJ.	1995	The Promise of Public Sector-Sponsored Training Programs.	Journal of Economic Perspectives, 9(2): 149–68.	Link to abstract	Literature Review	USA	
Leventhal T and Brooks-Gunn J.	2000	The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes.	Psychological Bulletin, 126(2): 309-337.	Link to abstract	Literature Review	USA	
Mikton C and Butcharta A.	2009	Child Maltreatment Prevention: A systematic review of reviews.	Bulletin of the World Health Organization, 87, p. 353-361.	Link to abstract	Systematic Review	Global; primarily USA/Canada	
Murphy J, Pagano M, Nachmani J, Sperling P, Kane S, Kleinman R.	1998	The relationship of school breakfast to psychosocial and academic functioning.	Archives of Pediatric & Adolescent Medicine, 152: 899-907.	Link to abstract	Observational, Cross-sectional and longitudinal data	USA	133
Nelson C, Zeanah C, Fox N, Marshall P, Smyke A, and Guthrie D.	2007	Cognitive Recovery in Socially Deprived Young Children: The Bucharest Early Intervention Project.	Science Magazine, 318 (5858): 1937-1940.	Link to abstract	Randomized Controlled Trial	Romania	136 children
Neudorf K, Taylor T, and Thurman T.	2011	A Case Study: The Greater Rape Intervention Program (GRIP).	USAID South Africa and Tulane University.	Link to abstract	Qualitative Interviews and Focus Groups	South Africa	

Nyangara F, Kalungwa Z, Obiero W, Thurman TR, Chapman J.	2009	Promoting a Home-Based Program Model for Supporting Children Affected by HIV/AIDS: Evaluation of Tumaini Project in Iringa Region, Tanzania	USAID MEASURE Evaluation Project.	Link to abstract	Program Evaluation Report, post-test study design with comparison group	Tanzania	1104 children (aged 8-14) and 845 caregivers
Nyangara F, Obiero W, Kalungwa Z, Thurman T.	2009	Community-Based Psychosocial Intervention for HIV-Affected Children and their Caregivers: Evaluation of The Salvation Army.	USAID MEASURE Evaluation Project.	Link to abstract	Program Evaluation Report, Post-test study design	Tanzania	564 children (aged 8-14) and 488 caregivers
Nyangara F, Thurman T, Hutchinson P, Oblero W.	2009	Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania.	MEASURE Evaluation for USAID, Tulane University School of Public Health.	Link to abstract	Program Evaluation Review (intervention and comparison groups, post-test only design)	Kenya and Tanzania	
Nyblade L, MacQuarrie K, Kwesigabo G, Jain A, Kajula L, Philip F, Henerico W, et al.	2008	Moving Forward: Tackling Stigma in a Tanzanian Community, a Horizons Final Report.	Washington, D.C., Population Council.	Link to abstract	Program Evaluation Report (baseline and endline community surveys, post-intervention qualitative interviews and focus groups)	Tanzania	baseline n = 978; endline n = 910
Oaks, E and Fruendlich M.	2004	The Role of Emergency Care as a Child Welfare Service: Summary of Findings and Recommendations.	Children's Rights.	Link to abstract	Qualitative Interviews	USA	
Operario D, Underhill, K, Chuong C, Cluver L.	2011	HIV Infection and Sexual Risk Behavior Among Youth who have Experienced Orphanhood: Systematic Review and Meta-Analysis.	Journal of the International Aids Society, 14:25.	Link to abstract	Systematic Review and Meta-analysis	Global	19140

Richter L, Sherr L, Adato M, Belsey M, Chandan U, Desmond C, et al.	2009	Strengthening families to support children affected by HIV and AIDS.	AIDS Care, 21:S1: 3-12.	Link to abstract	Literature Review	Global	
Schenk K, Michaelis A, Sapiano T, Brown L, Weiss E.	2010	Improving the lives of vulnerable children: Implications of Horizons research among orphans and other children affected by AIDS.	Public Health Reports, 125: 325-336.	Link to abstract	Literature Review	Sub-Saharan Africa	
Sherr L, Mueller J, and Varrall R.	2009	A systematic review of cognitive development and child human immunodeficiency virus infection.	Psychology, Health and Medicine, 14(4): 387-404.	Link to abstract	Systematic Review	Global	
Shonkoff J, Boyce T, McEwan B.	2009	Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention.	JAMA. 2009, 301(21):2252-2259.	Link to abstract	Literature Review	Global	
Shonkoff J, Boyce W, McEwen B.	2012	An integrated scientific framework for child survival and development.	Pediatrics, 129 (2), e460-472.	Link to abstract	Literature Review	Global	
Simbaya J, and Brady M.	2009	Understanding Adolescent Girls' Protection Strategies against HIV: An Exploratory Study in Urban Lusaka.	The Institute of Social and Economic Research, University of Zambia, and The Population Council.	Link to abstract	Observational, Cross-sectional surveys; qualitative interviews and focus groups	Zambia	821
Smith R, Malee K, Leighty R, Brouwers P, Mellins C, Hittelman J, et al.	2006	Effects of Perinatal HIV Infection and Associated Risk Factors on Cognitive Development Among Young Children.	Pediatrics, 117(3): 851-862.	Link to abstract	Observational, Longitudinal Cohort Study	USA	539 children

Stene A, Chandani T, Arur A, Patsika R, Carmona A.	2009	Economic Strengthening Programs for HIV/AIDS Affected Communities: Evidence of Impact and Good Practice Guidelines.	Private Sector Partnerships- One project, Abt Associates Inc. Bethesda, MD.	Link to abstract	Literature Review	Global	
Thurman T, Jarabi B, and Rice J.	2012	Caring for the caregiver: evaluation of support groups for guardians of orphans and vulnerable children in Kenya.	AIDS Care, 24 (7): 811-819.	Link to abstract	Post-test study design with intervention and comparison groups	Kenya	1794 (766 caregivers, 1028 children)
Thurman T, Rice J, Ikamari L, Jarabi B, Mutuku A, Nyangara F.	2009	The Difference Interventions for Guardians Can Make: Evaluation of the Kilifi Orphans and Vulnerable Children Project in Kenya.	USAID MEASURE Evaluation Project.	Link to abstract	Post-test study design (quantitative) and focus groups (qualitative)	Kenya	1036 children (aged 8-14) and 771 guardians
Thurman T, Snider L, Boris N, Kalisa E, Nyirazinyoye L, and Brown L.	2008	Barriers to the community support of orphans and vulnerable youth in Rwanda.	Social Science Medicine 66(7):1557-67.	Link to abstract	Observational, Mixed Methods (focus groups and structured interviews)	Rwanda	832 youth and 171 adults surveyed 32 youth and 61 adults in focus groups.
UNICEF Tanzania	2011	Violence against Children in Tanzania: Findings from a National Survey, 2009.	UNICEF Tanzania, CDC, and Muhimbili University of Health and Allied Sciences. Dar es Salaam, Tanzania.	Link to abstract	Observational - cluster household surveys	Tanzania	3729 (ages 13-24)
Victoria C, Adair L, Fall C, Hallal P, Martorell R, Richter L, et al.	2008	Maternal and child undernutrition: Consequences for adult health and human capital.	The Lancet, 37: 340-57.	Link to abstract	Meta-Analysis of 5 prospective cohort studies	Brazil, Guatemala, India, the Philippines, and South Africa	

Williams P, Marino M, Malee K, Brogly S, Hughes M, Mofenson LM, et al.	2010	Neurodevelopment and in utero antiretroviral exposure of HIV-exposed uninfected infants.	Pediatrics: 125 (2), e250-260.	Link to abstract	Observational, Multi-site Cohort Study	United States	1840
Zaba B, Whitworth J, Marston M, Nakiyingi J, Ruberantwari A, Urassa M, et al.	2005	HIV and mortality of mothers and children: Evidence from cohort studies in Uganda, Tanzania, and Malawi.	Epidemiology, 16(3):275-80.	Link to abstract	Meta-analysis of 3 longitudinal cohort studies	Tanzania, Uganda, Malawi	
Zaharah H and DaudSilong, A.	2008	Women leadership and community development.	European Journal of Scientific Research. 23 (3): 361-372.	Link to abstract	Qualitative, Semi-structured interviews	Malaysia	3 women