Pathways to protection – referral mechanisms and case management for vulnerable children in Eastern and Southern Africa

Lessons learned and ways forward

Keetie Roelen, Siân Long and Jerker Edström

Centre for Social Protection
Institute of Development Studies, Brighton, UK

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1. Introduction

This discussion paper puts forward a set of lessons learned and recommendations for referral mechanisms and case management for vulnerable children in the Eastern and Southern Africa region (ESAR). This paper concludes a regional study that reviewed regional knowledge, understandings and practice with respect to referral mechanisms and case management – exploring what they mean and do at present and what their future potential may be in responding to the multiple risks and needs of vulnerable children. The study was born out of the general recognition that the multiple and complex needs of vulnerable children and families in Eastern and Southern Africa are not sufficiently being responded to, leaving many in vulnerable and/ or destitute situations. As expressed in SADC (2011): *"The current delivery of services in each SADC Member State is too piecemeal, short term or inadequate to respond to the complexity of needs of orphans and other vulnerable children and youth. Most services are delivered through a vertical sector approach, and different service providers do not coordinate their efforts in order to guarantee basic services for children and youth."* (p11) There is a need for a more comprehensive and systematic response, of which referral mechanisms and case management are crucial elements.

The debate on referral mechanisms and case management for vulnerable children, and how they can ensure positive outcomes, is extremely pertinent and timely. Momentum is growing around the need for the responses to vulnerable children to take a systems approach rather than relying on fragmented service delivery. As pointed out in UNICEF (2011): *"A functioning social welfare system – typically inclusive of social protection and child protection services – is a vital safety net for children and families made vulnerable by HIV and AIDS as well as other risks"* (p14). This momentum complements the concurrent recognition by states of the need for inclusion of children's development needs in national budgeting and legislation . This is evidenced by the rapid expansion of social protection in ESAR in the last five years and by the increasing number of Children's Acts being drafted and implemented across the region.

An understanding of childhood vulnerability is imperative when considering how referral mechanisms and case management are to facilitate an appropriate and effective response. We have seen significant success in shifting thinking from narrow and individual understandings of child vulnerability to broader concepts. This includes a shift in focus from a primarily 'welfare' response to broader socio-economic and cultural concepts of vulnerability, as well as shifts from considering individual HIV-affected children to broader notions of vulnerability that link HIV-related to other vulnerabilities. It is now increasingly recognised that childhood vulnerability is multidimensional, complex and dynamic, both across sectors and across a wide range of stakeholders. Nevertheless, practical experience of successfully translating this more complex analysis of child vulnerability into policy and practice in a coordinated and systematic fashion remains limited.

Effective referral mechanisms and case management systems are essential in ensuring that vulnerable children and/or households are identified, their needs correctly assessed and that they receive cross-sectoral support, until there has been a positive outcome for that child and/or family. Having strong case management systems are a practical demonstration of commitment towards ensuring that interventions have a positive *impact* on children – that is, having a strong referral and case management system is a commitment to accountability to

vulnerable children at all levels. A strong case management system offers a framework within which all sectors playing a role in meeting the needs of vulnerable children are required to communicate and act together, so that the dynamic, multidimensional and complex nature of children's vulnerabilities – and that of their families - are met.

No clear consensus currently exists about what referral mechanisms entail or case management means, specifically in the ESAR context of limited availability of statutory services and the important social role of community networks. Therefore working definitions for the purposes of our discussion are provided in Box 1.[1]

Definitions: Working definitions of referrals and case management

Referral is the process of noticing a concern about a child or family, deciding that action needs to be taken and reporting that concern to someone who with the relevant responsibility. This might be directly, or by giving information to the family about where they should go for further help.

Referral mechanisms are essential both to managing services within sectors (such as health, education or justice systems) and for supporting referrals across services. In particular, effective referral systems are necessary to support effective case management by skilled service providers responding to complex individual child or family vulnerabilities.

These types of mechanisms cut across different ways in which referrals are made, including self-referral (Child Helpline, for example), family referrals (a mother taking a child to a health clinic when ill, for example), community-based referrals (a community committee providing basic needs such as blankets or food or providing emotional and moral support through spending time assisting the family with domestic chores to a child-headed household, for example) and referrals by local service providers (a teacher referring a child to another service, for example).

Case management encompasses referral mechanisms and requires an individualised and time-sensitive perspective from early detection, management of referrals across sectors and services and follow-up. ***Community case management*** refers to mechanisms building on the community as being the main entry and focal point for case management, referring to identification of vulnerable children, detection of needs, referrals to services and following up. ***Case management with a family focus*** emphasises that the needs and vulnerabilities are not independent of those from other family members and that the response to the individual child should go hand-in-hand with a response to the family as a whole.

Figure 1 illustrates the interaction between our understanding of child vulnerabiilty with those working definitions of referrals and case management. It illustrates that case management: (i) is a multidimensional response over time, nuanced to the different age-specific physical, emotional and developmental needs of the child; (ii) recognises the environment and context the child lives in; and (iii) provides a multi-layered response from prevention through to rehabilitation.

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[1] These definitions have been drawn together by the authors of this report from definitions provided primarily by interviews with regional stakeholders and field visits.

Figure 1 Contextual vulnerability and resilience of children in need of protection, over time
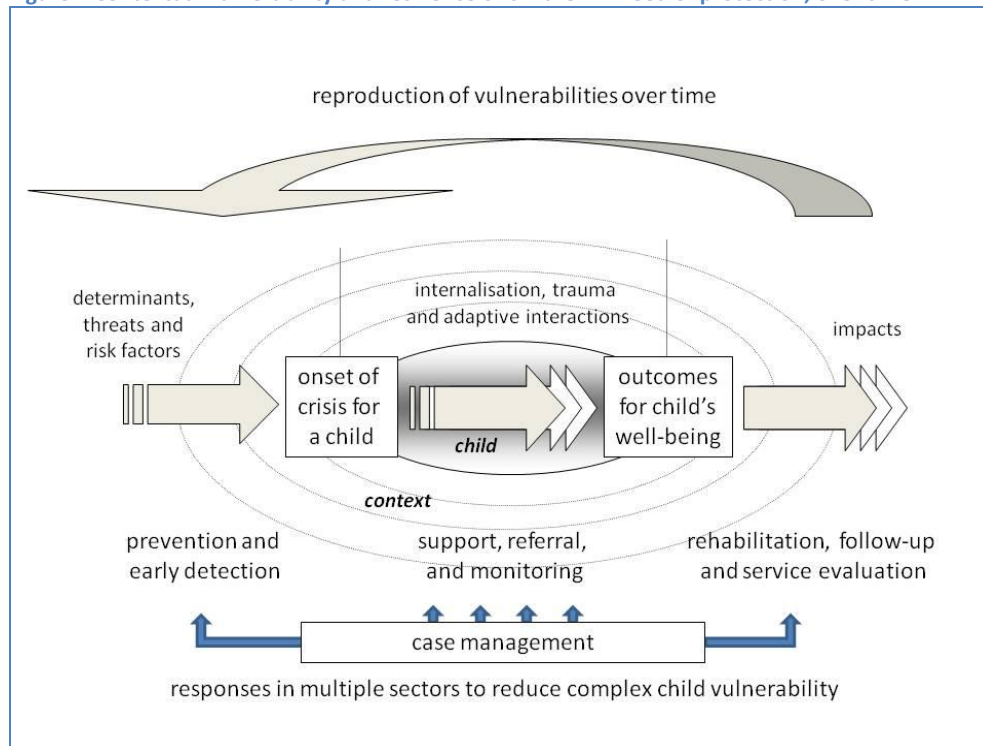
Against the backdrop of this framework, this report sets out lessons learned and ways forward for thinking about referral mechanisms and case management for vulnerable children in ESAR, and for putting such thinking into practice towards the improvement of the response to child vulnerability. The discussion in this report is based on: (i) a desk review using literature on OVC and social protection responses in the region that specifically referred to case management and referral systems; (ii) long-distance interviews with key informants from the global and regional policy sphere, UNICEF Country Offices and key informants from government and civil society at the country level; (iii) and three country visits (Tanzania, Mozambique and Namibia).[2]

2. Lessons learned

Overall, the study found strong commitment to identification of vulnerable children and referral mechanisms to address their needs. Nevertheless, active translation into more rigorous mechanisms that meet the multiple needs of *most of the vulnerable children* and particularly *those most vulnerable* was found to be largely missing. However, interest across the region for strategic 'case management' thinking as a way to enhance outcomes for children who are currently falling through the cracks and, crucially, of providing support over time is growing. As a result, new mechanisms for addressing the current gaps in referral processes are emerging across the region. The sections below distil regional lessons learned and outline priority considerations for developing a policy and programming environment that is conducive to a

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[2] A stocktaking report, *Protecting most of the vulnerable children, and protecting those most vulnerable:*
A stocktaking report of case management to strengthen child and social protection in Eastern and Southern Africa, and three country case studies from Mozambique, Namibia and Tanzania informed this final report. See bibliography for full details.

system in which child and family vulnerability is addressed effectively across sectors and over time.

2.1.   Policy environment

The response to vulnerable children requires accountability and responsibility

The complex, multidimensional and dynamic situation of child vulnerability makes it difficult to pinpoint responsibility to one particular body or agency and thereby to foster accountability. Child vulnerability, and its links into different sectors and services, needs to be understood comprehensively and thus to be seen as a national development priority to create the required level of accountability and sense of shared responsibility across all stakeholders.

Responding to the complex reality of child vulnerability requires a 'systems-approach'; i.e. working across multiple sectors (not just within one sector such as education, health or child protection) and with multiple stakeholders (not just with social workers, but also community volunteers, para professionals or auxiliary workers at community level). Deliberately designing a referral or case management system, with clear roles and functions and required outcomes is not merely about making referrals work, but also about restating the problem in terms of a responsibility for ensuring that there is a positive outcome. The various actors involved in providing the response to vulnerable children, from the identification through to follow-up and tracking of provision services, are all duty-bearers and should be able to be held accountable for their part in the response to vulnerable children.

There must be a clear and agreed national definition of what referral mechanisms and a case management system for vulnerable children seek to achieve and a common understanding of how they will function
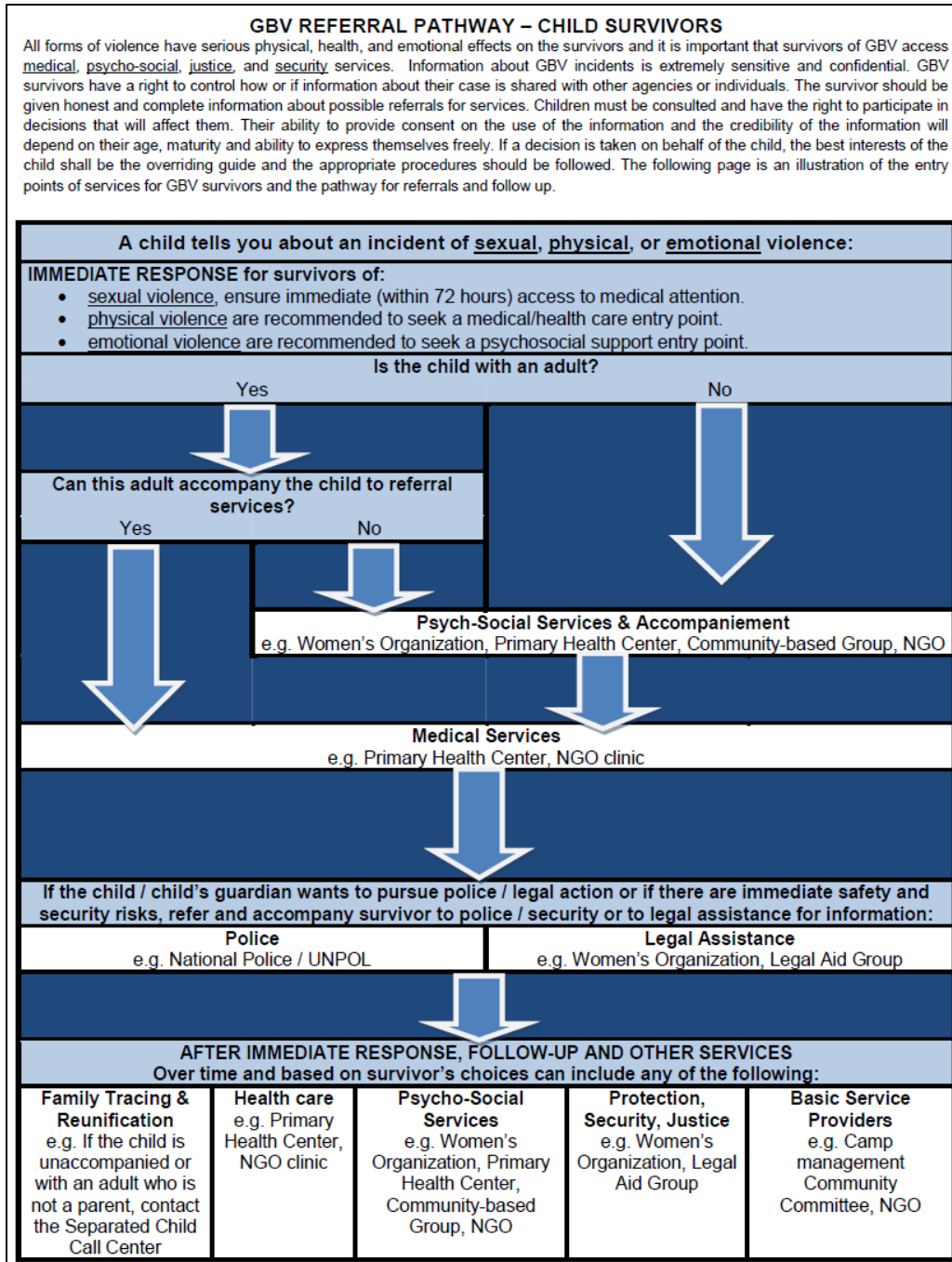
Definitions of what referral mechanisms and case management mean and how they function in the ESAR context are few and far between. A lack of such a common understanding has far-reaching consequences for creating a conducive policy environment, and for being able to put policy into practice. As commented by one key informant: *"Referrals are not spelled out at all. Apart from specific case management protocol for sexual abuse for all service providers, there is no such thing put in writing about other categories."* (see box below) Regional informants felt that often 'referral' and 'case management' were used interchangeably without a clear definition that means they could be translated into action and assessed to ensure that they are achieving the stated purpose.

Where there has been progress towards a common understanding of case management, there has been a strong emphasis on getting collective understandings from all actors, including families and communities. *"The strength of a case management system is its collaborative nature which oversees the process of assessment, planning, facilitation, coordination and advocacy for services to meet the individual care, protection and justice needs of children vulnerable to violence, abuse, exploitation, and neglect."* (UNICEF Malawi, 2012).

Box 2

Promising practices: Generic referral pathways for local adaptation

The growing recognition of the importance of addressing violence against women and children has been coupled with the acknowledgement of the need for clear and consistent guidance for referrals in cases of violence. The following generic referral pathway is being developed and is being used as a template for the development of national flowcharts that clearly guide the response to cases of violence. (Key informant interview).

GBV REFERRAL PATHWAY – CHILD SURVIVORS

All forms of violence have serious physical, health, and emotional effects on the survivors and it is important that survivors of GBV access medical, psycho-social, justice, and security services. Information about GBV incidents is extremely sensitive and confidential. GBV survivors have a right to control how or if information about their case is shared with other agencies or individuals. The survivor should be given honest and complete information about possible referrals for services. Children must be consulted and have the right to participate in decisions that will affect them. Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding guide and the appropriate procedures should be followed. The following page is an illustration of the entry points of services for GBV survivors and the pathway for referrals and follow up.

A child tells you about an incident of sexual, physical, or emotional violence:

IMMEDIATE RESPONSE for survivors of:
- sexual violence, ensure immediate (within 72 hours) access to medical attention.
- physical violence are recommended to seek a medical/health care entry point.
- emotional violence are recommended to seek a psychosocial support entry point.

Is the child with an adult?

Yes   No

Can this adult accompany the child to referral services?

Yes   No

Psych-Social Services & Accompaniement
e.g. Women's Organization, Primary Health Center, Community-based Group, NGO

Medical Services
e.g. Primary Health Center, NGO clinic

If the child / child's guardian wants to pursue police / legal action or if there are immediate safety and security risks, refer and accompany survivor to police / security or to legal assistance for information:

Police	Legal Assistance
e.g. National Police / UNPOL	e.g. Women's Organization, Legal Aid Group

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES
Over time and based on survivor's choices can include any of the following:

Family Tracing & Reunification	Health care	Psycho-Social Services	Protection, Security, Justice	Basic Service Providers
e.g. If the child is unaccompanied or with an adult who is not a parent, contact the Separated Child Call Center	e.g. Primary Health Center, NGO clinic	e.g. Women's Organization, Primary Health Center, Community-based Group, NGO	e.g. Women's Organization, Legal Aid Group	e.g. Camp management Community Committee, NGO

Much of the existing understanding of what referral mechanisms and case management for vulnerable children could or should entail draws on the health and child protection sectors, as described in Box 3. Although useful, these examples of referral and case management largely relate to an individual, statutory sector and rarely make links across sectors or between non-formal and formal services. There is widespread concern that current thinking of referral mechanisms and case management for vulnerable children is too heavily biased towards a Western model of thinking, which often includes an individualised focus on children, a sector-specific approach and little involvement of non-formal services. As one respondent pointed out: *"Case management is being used more and more as a buzz word, also in ESAR, in recent years. But has it been thought through appropriately? I haven't seen any of that thinking on what it means for a US understanding of social work or case management to be placed in other specific contexts like ESAR".*

Definitions: Experiences from health and child protection, and how they shape current understandings of referral mechanisms and case management for vulnerable children

Case management is generally considered to denote a system that follows an individual child (or family) across referrals, either within a particular sector or across sectors. In practice, the phrase 'case management for children' appears most frequently in the health and child protection sectors. In the health sector, HIV care or Integrated Management of Childhood Illnesses programmes, for example, have strong and formalised mechanisms from community through to tertiary services, with clear guidance on what each actor must do, when to make a referral and what action to take at each stage. Similarly, clear definitions of case management have been formalised within the statutory child protection sector, holding the following key elements (McCormick, 2011):

i) identification and assessment of children (with clear referral mechanism between agencies, stating clear roles & responsibilities);

ii) design of individual support plans, coordinated by one overall focal point ('case worker') with clearly defined results of support for the child and what actions are required to achieve this result, by who and by when;

iii) a referral pathway that outlines the various support and referral services, that involve ongoing support from a case worker; and monitoring and review through regular case conferences including all who are involved. There should be an agreed point at which the child stops receiving specialist 'case management' assistance.

Another concern expressed by many stakeholders was the largely reactive, rather than proactive, approach to the response for vulnerable children, and thereby the focus on response rather than early detection or prevention of harm to the child. There is a need for more critical thinking about appropriate models for case management in the various contexts in ESAR, ensuring that definitions are fit-for-purpose. Common understanding, firstly at national level and secondly at regional level, of the rationale for and application of any particular referral mechanism or case management system is a pre-condition for making them appropriate and effective.

Implementation of national policies must address issues of universality and equity for all vulnerable children, including those most excluded
National policies and responses to the risks faced by children are becoming more sensitive to particular needs, and more holistic in scope, as they respond to the growing acknowledgement

that child vulnerability is multidimensional, complex and dynamic. In addition to the shift from HIV-specific to HIV-sensitive approaches in the region, social protection initiatives offer scope for greater focus on children. The African Unions call for "[…] *a minimum package of essential social protection [that] should cover: essential health care, and benefits for children, informal workers, the unemployed, older persons and persons with disabilities*" (African Union, 2008), thereby building a strong case for increasing the scope and scale of national social protection programming. Although great strides have been made towards increasing universal access to basic services such as education and health care for children, the most vulnerable fail to be reached and benefit from mainstream service provision. A complex and interlinked set of factors, relating to intra-household dynamics, livelihoods and resilience and issues of cultural, social or economic exclusion make it hard for those children to benefit from increased coverage of basic services (UNICEF, 2010). Issues of equity are relevant in all countries across the region, ranging from low-income to middle-income. Middle-income countries with relatively high service provision, such as South Africa, Botswana and Namibia, struggle with a small but significant proportion of children who cannot access services. The focus on delivery of services at scale in low-income countries makes it even more likely that the barriers for the most vulnerable children remain hidden (UNICEF, 2010). Key-informant interviews suggested that despite the recognition that vulnerability is multifaceted, policies still tend to take the 'short cut' by focusing on narrowly defined groups or by applying rigid socio-demographic data (e.g. double orphan, granny-headed household) or assuming that providing services will automatically lead to access for all.

Policies for referral mechanisms and case management require an explicit consideration of how to apply principles of universality and equity, which need to move beyond tokenism and translate into actual action. The MVC definition in Tanzania, for example[3], may be more inclusive in terms of the types of vulnerabilities referred to, but it is not very different in terms of application and implications for policy (Brooks, 2011).

A regional understanding of referral mechanisms and case management must put family and community support for children at the centre
The large majority of children live within families and families are part of communities that are generally the first, and certainly the largest, source of support for vulnerable children in Eastern and Southern Africa. However, current practices do not take the family and community role significantly into account. The term 'case management' in and of itself was felt to be inconsistent with a family or community-focused approach, as voiced by one respondent: *"I am not very comfortable with the phrase 'case management' as it is seen as very much an individual child and not the process of collective action around that child's vulnerability.",* and *"I don't like to use the word case management because it refers to a piece of paper rather than a child. In our project, we refer to care management. And that is really what it is, the management of care for children."*

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[3] The Tanzanian MVC definition states that a *most vulnerable child* is a child who experiences any of the following conditions: lives in extreme poverty; is affected by a chronic illness and lacks adequate care and support; lives without adequate adult support; lives outside of family care (e.g., in institutional care or on the streets); is marginalised, stigmatised or discriminated against; has disabilities and lacks adequate support. This does not differ significantly from other socio-demographic 'OVC' definitions.

The lack of clarity about what case management or referrals actually mean in the ESAR context, coupled with unease in adopting a Western social work model, has led to growing interest in new concepts, such as 'community case management' (see Box 1 for working definitions). As such, this is an opportune moment for regional, or national, definitions of a child referral mechanism and case management system to consider the family as a 'unit', as opposed to the individual child, and to recognise the community as an inherent and supported element of such a system. This is not just a matter of having an agreed understanding at policy level, but means stressing the active role that children, families and their communities can play, whilst retaining the value of the core 'case management' principles of mandate, accountability and continuity until the family or child no longer require intensive care, protection or support.

Referral mechanisms and case management need a clear and strong mandate and protocols
Mandates and related protocols that stipulate clear roles and responsibilities of service providers and community members, are largely absent. A lack of clarity about who is responsible for what rings through in all levels of policy making and implementation. It was suggested that a vision of 'systems approaches', and the role of referrals and case management within those, is missing: *"The lack of an idea of a child protection 'system' is partly why there are weak referrals, because no system means no case management [...]"*. The link between such a vision and a mandate runs both ways; a vision is crucial for spelling out mandates but a clear mandate is also key in terms of feeding and developing such a vision.

A referral mechanism requires that children or families can be introduced into the 'system' at the correct time and consequently be referred to the right services. Case management requires that needs are assessed on a continuous basis and that referrals meet the different needs of the child and/ or family over time. Protocols that spell out roles and responsibilities for making such referral mechanisms and case management systems work are missing across the region. Where protocols are developed, it is generally for just one sector. As a consequence, different stakeholders end up with a different understanding of roles and responsibilities. Examples include the child protection sector, with sometimes overlapping or contradictory responsibilities for police and social workers in case of child abuse or neglect, or in the health sector, where it is unclear whether it is the health worker or midwife who checks whether a child has a birth certificate (Key informant interviews, September 2011). Confusion of roles and responsibilities create the most challenges at community level, where multiple factors (such as lack of human capacity, resources, transport and available services) compound an unclear division of roles and responsibilities. This is discussed further in Section 2.2 below.

Box 4

Promising practices: Memoranda of agreement for improving referrals between ministries in Namibia

Namibia had low coverage of birth certificates until recently as they were not required of Namibians prior to independence in 1990. The Ministry of Home Affairs and Immigration (MHAI) is expanding birth registration by using mobile outreach services to remote areas and upgrading its facilities. Progress has been achieved more rapidly since the introduction of a Memorandum of Understanding between the MHAI, the Ministry of Gender Equality and Child Welfare (MGECW) and the Ministry of Health and Social Services (MOHSS) which aimed to identify and refer children from marginalised households. The establishment of hospital-based facilities has rapidly improved early birth registration (the majority of children are born in hospital). The MOU has been essential to demonstrate to staff working in the three ministries that they all have a responsibility to work together for a joined-up approach. Nurses are expected to refer women who have delivered for birth registration and this was slow at start. With the MOU in place, it has been possible to actively ensure that service providers at hospital level have a clear set of responsibilities and carry these out. (Verbal report, Namibia)

Resource mobilisation is vital for operating referral mechanisms and case management

Lack of resources is a crucial constraint in current implementation of referrals and case management. The lack of such resources comes in two forms: (i) an overall lack of financial resources at all levels of implementation; and (ii) a lack of human resources, with low numbers and relevant capacities of key individuals identifying, assessing and responding to the complex needs of the most vulnerable children. The squeeze on HIV-related funding and overall reductions in revenues in the least resourced countries and donor countries may compound such constraints even further, calling for a need to demonstrate impact for the money invested and gauge the 'return-on-investment'.

To be able to gain insight into 'value-for-money' and thereby convincingly argue the case for more resources, we need more information about the cost and benefits of investing in referral mechanisms and case management. Much of the literature focusing on HIV-affected children, 'OVC' or child protection does not provide much information about budgets or expenditures, with the exception of donor implementation reports, notably PEPFAR. In addition, there is an absence of data on the economic cost of widespread child abuse, neglect and exploitation or other child protection violations. It is also noticeable that the OVC and child protection sectors seem to have paid limited attention to the need for strong evidence about which interventions work than in, for example, the health, education or social protection sector, resulting in lack of evidence to assist countries in designing the most appropriate child protection interventions for their context.

The growing interest in social protection interventions across the region provides interesting opportunities for accessing a new source of resources. Without a clearer sense of the cost and benefits (the 'added value') of an effective referral and case management system that can demonstrate positive outcomes for national development indicators, it remains hard to build the business case for investing in such a system that links different sectors, including child protection and social protection. Some countries, including South Africa, Malawi, Tanzania and Zimbabwe, have undertaken or are in the process of undertaking budget analysis to see where child protection resources come from, where budget decision making is placed and what is needed. This would appear to be an essential step. An effective referral and case management system can be a strong lever for more effective resources, if able to demonstrate that it is more

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effective to respond through a system than through individually resourced, small-scale component parts.

Investments in referral mechanisms and case management need to go hand-in-hand with investments in services

The lack of resources pointed out above translates into limited availability of services or low quality of services for vulnerable children. For referrals to be effective and case management to work, they need to interact with responsive and viable services that are able to process and act upon the referrals in an adequate way. The unavailability of quality services, coupled with the lack of sufficient trained human resources, is a key barrier in current functioning of referrals and case management. Mandates may be clearly stipulated and protocols well established, clearly defining roles and responsibilities, but if there are no viable services in place, referral mechanisms and case management systems will still not be able to adequately respond to and address children's needs. This is endorsed by key informants and in the literature (McCormick, 2011): *"The relative lack of success or difficulty in referrals is partly due to referral mechanisms and systems not being sufficiently developed and formalised. Another compounding element is the lack of available services within appropriate reach of children and families or the quality of the services that are available."* (p. 18)

Box 5

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Promising Practices: Maximising outreach to make the most of scarce services

Whilst a referral mechanism can direct children to necessary services, this is only possible when services are available. Maximising outreach is one way in which services can cover more children in a context of constrained resources. In Swaziland, a partnership between the Ministry of Health and Swaziland Positive Living (SWAPOL), a national NGO for people living with HIV, has addressed this by providing family-based health care, linked to other forms of care and support for vulnerable children. SWAPOL and the Ministry of Health conduct monthly outreach mobile clinics at a Neighbourhood Care Point (NCP) in remote or hard to reach areas. One NCP is visited and children from 'feeder' NCPs in the area are referred by NCP staff or volunteers, and other community members. Caregivers in the main and feeder NCPs have been trained on health-related assessments in preparation for monthly outreach. They screen children before for minor ailments so that by the time the SWAPOL health team arrives, the children have already been screened and referred for minor treatment. The health teams respond to more complex health cases and other care providers are present, so that health care is complemented with counselling as well as other non-health referrals. HIV treatment is provided. As the initiative has developed, other children and adults who have not yet used the NCP are also presenting for referrals. There are now 20 centralised and 67 feeder NCPs participating in the initiative. (Verbal report, UNICEF Swaziland)

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Referral mechanisms and case management need strong monitoring and evaluation

Accurate and timely data is essential in the response to vulnerable children for two reasons, in the crudest terms: (i) tracking individual children or families across different sectors over time to ensure that the identified problem or problems are being solved; and (ii) monitoring the system itself and holding accountable those responsible for taking action. The first reason refers to a monitoring system as a case management tool in and of itself. The second reason refers to the need for a monitoring system to have up-to-date and accurate information about standard of response provided to vulnerable children. 'Referral systems' are often included in OVC action plans or similar documents, but lack specific indicators to measure their success – this is

indicative of the challenges faced in this area, often related to lack of locally available technical and human capacity to work with tracking and monitoring systems.

Data collection and analysis pose several challenges. One of the biggest priorities is an information system that can be used by community-based workers, given their central role in identification and referral of vulnerable children. Literacy is an issue, as well as motivation and an understanding of the need to keep records up to date. Few examples have been found that address these challenges, although pilot initiatives are underway across the region, for example in Mozambique and Malawi. Secondly, the types of technology used in tracking and monitoring systems are often not suitable, as people do not have the capacity to use them or to maintain them (such as computers). Although the innovative use of technologies is being explored across the region in various sectors to support programme monitoring (see IDS, 2012), experiences in child protection are still largely paper- and computer-based.[4] More careful assessments are required about the extent to which users at various levels can work with and support a particular technology, before choosing which technology to use. Finally, data has to be stored in a way that the case worker can access information for individual follow-up, i.e. to serve as the practical tool in making referrals and doing case management. However, it also needs to be gathered so that macro-level information is available and presented to policy makers in such a way that it can be used to adapt interventions and allow for improvements to the overall response to vulnerable children. A crucial priority in monitoring and tracking case management is to more clearly define what information is needed and by who, so that data collection at local level links and that at national level are aligned.

Box 6

> **Promising Practices: Referrals made simple**
>
> In Namibia, Development Aid People to People (DAPP) have designed a simple referral system. Trained community volunteers conduct home visits to identify and support vulnerable children, If they find a household where a child needs a locally available service – birth certificate, social work support, Child Welfare Grant, for example – the volunteer notes the referral on a form using a number, gives a card (below) to the caregiver which has the number on it. The card is placed in a box in the reception area of the relevant service and once a month the volunteer collects the cards and matches the number on the card with the list that he or she has. In this way, DAPP can track which referrals have been followed up on by the family, go back to the family to find out if they were supported and also monitor overall service uptake.

2.2.   Putting policy into practice

This section provides a number of recommendations in reference to the case management process and all its elements, including referral mechanisms.

The recommendations provided in this section do not aim to suggest a 'one-size-fits-all' model, but rather provide a number of pointers for providing a comprehensive and coherent response to children and families. A particular issue to keep in mind is that of context; options open to

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[4] This study actively sought to identify examples where mobile phones are used for referrals for vulnerable children. Although there are several promising examples in the field of HIV treatment or maternal and child health, there are far fewer examples for other types of referral.

different countries across the region may vary considerably against the backdrop of human and financial capacity, institutional arrangements and political commitment. Options are likely to differ most between middle-income countries versus low-income countries and in urban/peri-urban areas versus rural areas, particularly in terms of financial and human resources.

Linkages between sectors and across services need to be clearly spelled out
As discussed above, cross sectoral coordination is largely absent in the response to vulnerable children, with unclear mandates and few protocols to coordinate cross-sectoral efforts. Referral *across statutory sectors* is possibly the most challenging element of implementing a referral system and case management. The lack of a well-defined mechanism is a large impediment in ensuring that statutory workers *work together,* or feel a sense of responsibility for the response to the child and family beyond their own sector. The lack of clearly defined expectations between different sectors, lack of knowledge by personnel within a sector of their core responsibilities for children, and (perceived) differential levels of financial and human resources across sectors all contribute to lack of alignment between services. Formal memoranda of agreement between specific sectors, with clearly outcomes such as increased civil registration, appear to be interesting opportunities to stimulate greater cross-sectoral engagement.

A lack of formally spelled out cross-sectoral linkages does not mean that cooperation cannot and does not currently take place. In the absence of formal requirements for cross-sectoral referrals, collaboration for effective referrals appears possible where peers from different sectors have a chance to meet together regularly and where there is a sense that one's own work load reduces by collaborating with others. The informal, face-to-face contacts offered by regular (e.g. three monthly) forums for sharing were reported as successful in several countries, including Tanzania, Namibia and South Africa. Regular meetings and information sharing opportunities can help to clarify roles and responsibilities, and support greater mutual accountability. As stated in SADC (2011): *"No longer can services be delivered in isolation; they must be designed with a keen awareness of all the potential links to other services. All service providers should understand what's available across other service areas; regular engagement across the service areas is essential to promote and maintain the linking relationships."* (p22)

Box 7

Promising practices: More meetings, less work

In Tanzania, a newly formed child protection coordination model at district level has found that the most significant success factor is the group's multisectoral nature, and that regular contact and communication fosters collaboration across sectors. The diverse factors that lead to the risk of abuse can be addressed simultaneously when different actors work together. This approach has reduced individual case loads. At a monthly meeting held by the District Child Protection Team, a representative from the Ministry of Home Affairs explained the birth registration process and fast tracked the system for children in residential care. A social worker in a children's home brings the documents in bulk to the meetings and hands them to her colleague in Home Affairs. Team members report that *"as a team we work together. Whenever we need transport we have requested assistance from the planning office. When there have been hygiene issues (when inspecting residential homes) health has assessed hygiene and sanitation." "The secret of success is that the team is from different sectors. We share information back in our sector, so all members of the sectors know the issues and it is easier to advocate for resources. These members reinforce messages between different members."* (Community Development Officer & DCPT member)

Community initiatives are central, and need to be more firmly included in the response to vulnerable children

In addition to lack of inter-sectoral cohesion, clear guidance about linkages between the formal and non-formal sectors is largely absent. The non-formal, or community-based, sector plays a crucial (and often primary) role in the response to vulnerable children in ESAR. Non-formal actions include both activities conducted by NGOs and CBOs as well as the array of activities conducted by community initiatives or simply neighbours or local leaders. For example, when asked how children are being identified and by whom, most respondents discussed community-based processes. Community-based identification takes place either spontaneously, by community members picking up on problems faced by their children in their community, or more systematically through committees that have often been established by outside non-government initiatives with donor funding available (Wessels, 2009).

Placing community initiatives at the centre of referrals and case management for vulnerable children in ESAR is essential, both in recognition of the limited resources in the formal sector, but also, and more importantly, because of their potential ability to provide a culturally sensitive, family-oriented, comprehensive and high-quality response. A 'Western model' of case management, with a highly individualised case load, will be untenable and too costly for most countries, but is also unlikely to meet the issues raised by having problems across a range of issue. This includes, for example, household economic support, confidence and competence in providing a nurturing setting for children who need additional developmental support for children experiencing health or other problems.

However, although community initiatives to care for children are generally considered to be culturally appropriate and often more sustainable, there are a number of challenges. Community initiatives tend to rely on community goodwill and, whilst the HIV pandemic has demonstrated strong and creative community goodwill, research has shown that community members also often struggle to identify and address the more hidden and complex challenges faced by families. Cultural taboos, lack of training in key child development issues, community power and gender dynamics all play a part in making it hard to identify vulnerable children and provide the experienced technical inputs that some families and children need – management of abuse and violence within the family, disability and other issues are usually the most difficult to respond to (Wessels, 2009). Due recognition of the role of community initiatives in case management is a crucial first step towards addressing such community-level challenges because it is only once the role of such initiatives is linked more explicitly with the 'system' (i.e. health, education, social protection, child protection) that a coherent and smooth response to families and children can be made.

Box 8

Promising Practices: Community volunteers at the forefront of the response to vulnerable children

In Mozambique, Child Protection Community Committees (CPCCs) across the country are tasked with identifying, and providing a response to the needs of, vulnerable children. In several regions across the country, Community Case Management (CCM) and Minimum Standards of Care are being piloted to support and streamline the work of the CPCCs. Through these pilots, the Ministry of Women and Social Affairs (MMAS) supports the community-based and community-led committees that are responsible for the identification of vulnerable children and their households, the assessment of their needs, provision of and referral to services and follow-up on delivery and impact of services. Despite challenges of capacity, both human and financial, availability of services to refer to and support from statutory social welfare officers, a bottom-up model with community members at the forefront of identification, assessment and referral was considered the most appropriate and feasible option in a country with limited statutory services.

Case management needs a focal person with responsibility for overseeing the overall process

There is a need for a focal person to link all the different actors – to promote cooperation between different services and across sectors once a 'case' or a formal referral has been made. Based on the limited evidence available and perspectives of key informants, it would seem necessary to have such a person at the lowest coordination point, usually at district level.

In the case of a formal 'case management' approach, in which a complex case has been identified and it is clear that a child and/or family will need professional support over time and across different sectors, it is necessary to have a 'focal person' with the statutory mandate and responsibility so that he or she can be held accountable for:
- ✓ being aware of prevention, response and redress (follow-up);
- ✓ accurately identifying which type of intervention is likely to be necessary and referring to the correct person(s) for fuller risk assessment in a timely way;
- ✓ tracking children or families across services and across time, according to the responses identified by the key actors;
- ✓ being objective;
- ✓ providing quality supervision and holding service providers to account – or having the authority to facilitate that sector-specific supervision is implemented so that individual service providers fulfil their mandate.

This 'focal person' needs to be available to ensure that individual vulnerable children and families receive the minimum standard of care and protection and ensure that all children have access to it. They need to act as a resource, guide or focal point for those that may make the actual referrals or act as the 'shepherd' to guide children through the system. This is not the same as being responsible for 'solving the problem' for the child, which needs to be left in the hands of service providers, or even for correctly planning the required response but for getting the right people around the table to talk to each other, and ensuring that action is taken. Of most importance is that it is someone who can supervise, coordinate and follow cases through from beginning to end.

The process of making such decisions, and attempting to hold others to account, is essential but appears to be largely absent, especially in the 'OVC' sector. There is a need for clear agreement on the roles of different players, transparent decisions about remuneration and strong supervision of both formal and non-formal actors and service providers across sectors – and there is no evidence that this is happening where there is no formal mandate for one person to take this leadership and accountability role at local level. Such a function would enable more effective tracking of outcomes for individual children and families, and more effective monitoring of the key elements of support (for example, which types of interventions offered by which actors in which sequence) in order to generate a clearer evidence base of effective referrals for children.

Clearly, there is not one 'model' or a particular professional sector that should provide this role. Whilst there is some value to having a person with social work training fulfil this function, particularly given that one of the biggest gaps is responding to violence and abuse, this is unlikely to be feasible because of staffing constraints and also might skew the focus to child protection alone, rather than the broader range of responses to vulnerability. That said, such a focal person with the required level of responsibility is likely to be a statutory worker. This does not mean that communities shouldn't be involved in the case management system; however, it seems inappropriate to put this level of responsibility on the community. Alternative options could include para professionals to act as such focal persons, or to share responsibilities. Again the most appropriate solution will differ from country to country and be dependent on human capacity, financial resources and institutional arrangement.

Promising Practices: Case workers and community committees as focal persons

Countries such as Malawi, Namibia and Tanzania are developing a statutory sector child protection referral system, and exploring the appropriate shape and form of focal persons.

In *Malawi*, the suggestion is that there will be 'family case worker' volunteers who manage cases and refer them onto formal structures if the matter cannot be resolved at the community level.

In *Namibia*, all state and non-state actors at constituency level meet in Constituency Child Care and Protection Forums. The committees are expected to identify and monitor progress for vulnerable children. Committee guidelines outline key tasks, roles and responsibilities, including guidance on running effective meetings so that people are supported to have a clear sense of purpose. There is a clear role for the District Social Worker to ensure that meetings are convened and that key agenda items are addressed.

In *Tanzania*, statutory sector and civil society workers with a child protection role meet together monthly at district level, and report that the process of meeting regularly ensures mutual accountability. The district social worker is responsible for coordinating but they are exploring other ways of promoting mutual accountability. A magistrate in the team reports: *"The value of the district child protection team is that they hold me accountable because I know I am going to be asked about my work at the next monthly meeting."*

Social workers are a key element of referral systems and case management

Social workers are considered the most important actors in referral mechanisms and case management for vulnerable children in contexts of a well-established formal social work and child protection sector, such as reported in Botswana, Namibia, Mozambique, Tanzania and Zimbabwe. That said, it is clear that providing fully qualified social workers with the type of

statutory responsibility that they have in the West is not tenable in the majority of countries in ESAR, given both the types of vulnerabilities faced by children in the region and the large proportion of children experiencing these vulnerabilities.

Yet what a social worker should do in the ESAR context, particularly in acknowledgement of the need of a 'focal person', remains unresolved. At the formal level, the roles and responsibilities of social workers and social welfare staff are often diffused and unclear (AIDSTAR-Two, 2011). Social workers are stretched in terms of the workload and the wide variety of tasks they are expected to undertake. Whilst many social workers and social welfare staff are trained as social workers, they end up doing routine administrative tasks, especially administrative work related to cash transfers (Roelen et al., 2011). Much more clarity is needed about their role in processing applications for social protection and welfare programmes, and to what extent this informs or detracts from the technical aspects of assessment of complex cases. This concern is increasingly being recognised in changes in statutory functions, e.g. kinship care and introduction of auxiliary social workers, across the region. The time spent by qualified staff on routine administrative tasks begs the larger question of where this leaves the responsibility for overall coordination of tracking of outcomes for vulnerable children.

To relieve the social workers and spread their workload, a number of options are being explored across the region. Para social workers are being introduced in various countries across the region, but there is little yet that has been documented about remit of responsibilities, criteria for recruitment and training and appropriate remuneration. An extension of the mandate to make referrals or do case management to civil society is under discussion as well, for example in Mozambique, Namibia and Zimbabwe. A particular challenge with this option may be tensions between the formal/statutory service provider and civil society. Another emerging challenge is that response may create further demand as auxiliary workers become more skilled at identifying problems.

Promising Practices: Civil society responding to the needs of vulnerable children

Whilst the government of Botswana implements large-scale social protection programmes, including cash transfers, the response to children's non-material needs such as trauma and grief following the loss of a parent is largely in the hands of the civil society. NGOs can be considered the main implementing partners in terms of psycho-social support for children having lost parents to HIV, and the youth wilderness retreats by Ark 'n Mark provide a particular example showcasing the value of interventions that consider children's non-material needs. The wilderness retreats target orphaned children between primary and secondary school, building on traditional rites of passage customs but utilising various psychological counselling techniques. In combination, these methods enable orphans to process grief and loss, to build social skills and friendships, as well as practical life-skills and relationship skills for growing up. Discussions with boys and girls having attended the retreats recently (i.e. one or two years before) or longer ago (i.e. five or six years ago) point towards the large and beneficial impact that these retreats have had on their lives. (see Roelen et al., 2011)

The role of volunteers and their levels of responsibility require more consideration
Given the importance of community initiatives in terms of initiating and maintaining a response to vulnerable children in the region, a minimum level of staffing across both formal and informal sectors is essential for effective referrals and case management.

At community level, guidelines that spell out what community volunteers should do to identify and refer vulnerable children and what actions they can and "should" take at community level are available in most countries. For example, many training manuals for OVC or child protection committees, based on volunteers, have been nationally developed and endorsed. With respect to assessment of child-specific needs, the Child Status Index and Child Support Index are currently being piloted across the region to assess a range of economic, physical and child protection needs, although a recent survey has highlighted the lack of evidence about impact with these tools (Sabin, Tsoka, Brooks and Miller, 2011). However, these guidelines and tools do not seem to be well aligned with other elements of a referral and case management system, with at best only partial links into the formal sector. That is, community guidelines provide information about how a community volunteer could advise a family on how to get an HIV test, but does not spell out the consequent division of roles and responsibilities between the volunteer and statutory health worker in working together to support any treatment or follow up following a positive or negative HIV diagnosis.

In addition to lack of system-wide guidelines, community members acting as volunteers are massively overburdened. Resources are scarce, training is often minimal and the emotional impact large given the need to deal with highly complex cases. Community volunteers are often the first to identify vulnerable children, but consequently have nowhere to send them and lack the appropriate means to provide follow-up. Tracking systems are too complex with a reliance on high standards of education and detailed data collection. Basic resources such as means of transport are often missing. This overburden on volunteers is widely recognised. For example, the 2008 evaluation of PEPFAR OVC initiatives noted that: *"The vast majority of programs rely heavily on volunteer efforts. Overworking volunteers may threaten sustainability. More work is needed on identifying strengths of and opportunities for older children, young people, and guardians to engage more directly with programs"* (PEPFAR, 2008, p43).

The over-reliance on unpaid and overworked volunteers, and the challenges in terms of capacity to deliver effective referrals and case management, was a frequent theme in the interviews and in the literature. Yet there has been very little debate at national level about the challenges of volunteerism at the community level, or the appropriate balance of tasks between community volunteers and statutory sector workers or civil society employed staff. Across the SADC region, there has been a move towards a greater call for adequate reimbursement for HIV-related care volunteers, but there is no coherent national or regional debate on the need for formal recognition for volunteers working with vulnerable children, with the exception of the growth of the new auxiliary child care worker recognised as a government cadre in some countries, such as Malawi, Tanzania and Namibia. There has been some growth in investment in capacity of community volunteers, such as through the distance learning programme for youth and community volunteers supported by REPSSI and UNICEF, but this has not yet translated into a clear statement of mandate, role, recognition, minimum standards of training and support.

2.3. Working with children and families

This section discusses findings pointing towards the need to actively involve children and their families in making referrals and case management work. Social welfare officers, community volunteers and extension workers should be working *with* children and families, rather than for

them. Although integral to the practical aspects discussed in the previous section, these issues merit a distinct section to ensure they receive the appropriate level of attention

Informal care and intra-household dynamics need to be recognised and more firmly included in referral and case management systems

As stated in the previous section, communities are generally the first, and certainly the largest, source of support for vulnerable children in ESAR. Children live within families, and families are part of communities. However, 'families' vary enormously in terms of household composition, roles and responsibilities and their economic and social position within communities. This is known to affect individual outcomes for children, yet this appears an area where there is least guidance in terms of response. Whilst some socio-demographic categories, notably 'granny headed households' and child- or youth-headed households are already recognised as being potentially vulnerable, there is little evidence about whether this affects access to children's services and, if so, in what way. And even less is known about other family and community dynamics and how they would affect service access and access to and uptake of referrals.

Notable gaps pertain to the role of male caregivers and household decision makers in relation to effective referral and case management and to the differences in rural and urban settings. These differences include both external factors (the extent to which particular types of household are more or less likely to access support) and internal factors (intra-household dynamics and how this impacts on the risks faced by individual children of different age and sex).

Promising Practices: Assessing the needs of children and their family members

A country-wide and community-based response to vulnerable children in Ethiopia is currently being implemented by PACT Ethiopia (USAID-funded) and has explicitly taken the needs of children and their family members into account in its needs assessment. The identification of vulnerable children is a two-step process, whereby (1) children in 'obvious categories of vulnerability', including disability, orphanhood, living with elderly caregiver, are identified, and (2) the needs of these children are consequently assessed by means of the Child Support Index to consider whether a child and his or her family needs support and if so, what kind of support. The Child Support Index has been developed for Ethiopia specifically, although it was suggested that it will probably not look very different in other countries - most of the questions refer to the 'standard' criteria of vulnerability. An important distinction from the Child Status Index (which has been used in other countries in the past) is that the Child Support Index explicitly includes questions on potential needs of other household members. If the needs assessment concludes that the particular child may not have a particular need for support, but another family member does, the family as a whole will be included in the programme (Key informant interview).

Child and family participation is necessary across all stages of the case management process

A child may not 'enter' a referral mechanism or case management system, either because his or her needs are not identified as 'problems' (for example, if early marriage is the norm in a particular society or if a potential disability is not recognised at an early stage), or because they are not noticed by anyone (for example, sexual abuse may remain hidden) or due to unavailability of services. Lack of children's agency, traditional beliefs and norms and limited knowledge of child rights and development may compound incomplete or failed identification

and assessment processes. There is currently not enough focus in the existing identification and referral tools on the importance of listening to both children and caregivers.

Across the region, children are expected in general to be submissive to adults' decisions. However, when a child is facing challenges within the family – abuse, denial of a right such as access to information – he or she needs to be able to access support directly, either from a trusted adult or peers in the community or from a service provider, such as a teacher. The options for self-referral across the region were limited, with little scope for children to have their voices heard. That said, where there has been investment in Child Helplines, the results are very encouraging (see Bazan, 2011).

Equally important is listening to caregivers' voices. A range of assessments across the region show that caregivers have clear ideas about what might be best for their family and child and usually have a clear idea of their main caregiving challenges. Lack of information for children and caregivers about their rights and how to realise them remain a problem, despite growing investment in public information campaigns about, for example, access to birth certificates or free primary school. Lack of confidence and, at times, negative attitudes from service providers make it even harder to for those facing complex problems to realise their rights. More needs to be done to ensure that children and caregivers' voices are being heard and taken into account across the whole process of case management, from identification through to follow-up.

Box 12

Promising Practices: Child Helplines getting children's voices heard

Child Helplines are grounded in principles of self-referral by children. Child participation is a core element of responding to vulnerability and risk, and yet has not featured much in either the literature or information from key informants. Several recent studies have shown that adults do not always identify some of the most extreme abuse and violence issues (The Cradle, 2007; Wessels, 2008; Columbia Group for Children in Adversity, 2011). Data collected on cases from Child Helplines worldwide shows that violence and abuse has consistently been the number one reason across the board why children contact a child helpline. *"In countries where the child protection system is porous, Child Helplines often also step up and provide direct interventions, shelter, mediation and rehabilitation services to children and young people reaching out for help... In fact, Child Helplines are in the singular position of being privy to children's true voices, as they themselves choose to express them"* (Bazan, 2011). This is confirmed by the example of Childline Zimbabwe, with the majority of their calls by children themselves. As such, Childline plays an important role in identification of children in need, which appears recognised by the Government as Childline is able to operate across the country and complement its activities with community-based drop-in centres and support by social workers.

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3. Conclusion and way forward

There is a broad consensus that complex interactions of factors can make children especially vulnerable. This is increasingly being reflected in national legislation, emerging policies and a shift in focus by many programme implementers from narrow targeting to broader vulnerability responses. This paper has argued for the importance of effective referral mechanisms and case management as an essential component of this exciting shift in focus. By 'effective referral mechanisms', we mean those that ensure that those children and families who are most

vulnerable get identified and their needs, correctly assessed, that the right forms of support are provided (both formal and informal support) and that this support continues (and is, if required, adapted) until there is a positive outcome and no additional support is required. Such support should be available for most of the vulnerable children, and particularly for those that are most vulnerable.

This concluding section translates the study findings into key recommendations for the way forward, thereby establishing the necessary pre-requisites for effective referrals and case management, and a number of specific action points to act upon those recommendations.

Recommendation #1: Achieve national policy consensus and translate this into an accountability framework

Consensus should be reached on a common understanding of what effective referrals and case management are, should do and should achieve for vulnerable children in ESAR. Such a consensus provides the fundamental basis and can be considered a pre-condition to provide a solid basis for systems building. This should first and foremost happen at the national level, given stark differences across the region in terms of financial, human and institutional capacity. It requires:

- *An overarching supportive framework:* to ensure that national policies on children (including OVC or MVC policies, national action plans on children, sectoral plans) have a consistent definition of vulnerability, ideally developed through national consensus and based on evidence of the economic, social and developmental risks faced by children.

- *A sound evidence base*: to identify the exact nature of the challenges faced by children locally, and to demonstrate which approaches or innovations achieve positive change. In the process of building consensus around priority challenges and responses, it should be possible to highlight any underlying tensions between 'social' and 'economic' vulnerabilities, or addresses popular assumptions about vulnerability, such as orphanhood, for example. The outcome must be clarity about what is known, what needs to be known and what will be measured to achieve a desired outcome.

- *Strong partnerships:* to understand who the core actors and identify relationships between the many individuals and sectors that provide care and support to vulnerable children, including family members, non formal support and statutory services. An effective referral system needs to be clear what role different actors play in order to achieve the desired outcome. Clarity on role and function is necessary to design a referral mechanism that has a desired outcome.

- *Oversight and enforcement of accountability:* to ensure that people can be held accountable for their role in the response to vulnerable children. This is essential at all levels, but starts with clarity at all levels about who should be doing what, and with investment in ensuring that those with the mandate to act are enabled to do so. Given the multisectoral nature of the response, this requires people at senior level to work closely with counterparts in other sectors to enforce action.

Recommendation #2: Translate consensus into mandates and protocols for all actors

The articulation of clear mandates is vital to translate common understandings of referral mechanisms and case management into practical roles and responsibilities. This requires:

- *Clearly articulated roles and responsibilities:* to enable those involved in referral mechanisms and case management for vulnerable children, both paid and unpaid, to take action with confidence and for them to be held to account. Referrals are currently failing in part because of the different resources, levels of training and status between different actors in the referral chain. Roles and responsibilities need to be spelled out at all levels in order to give legitimacy to key actors for the action that they take (such as clarity about the mandate of NGO staff vis-à-vis government staff, what a volunteer child care worker can and should do when there are concerns about family abuse or neglect, or evidence of discrimination against a child or groups of children by service providers); provide a clear pathway so that all actors know who they should take information to and what is expected of each person, both state and non-state employed; and enable supervision and holding actors to account for fulfilling their mandate (for example ensuring that a health worker *does* provide the necessary slip to enable a mother to register her newborn for a birth certificate). Referral pathways and case management guidance need to be able to spell out who should do what and what action can be taken where this does not happen. This will have to be relevant to the local context, bearing in mind locally available skills and resources as well as local constraints to service delivery.

- *Capacity building:* to ensure that actors can fulfill their roles and responsibilities and deliver on mandates. Shared learning and exchange has been found to be a way of understanding the importance of working together for referrals. Training and investment in human capacity is required at all levels, across all sectors and for statutory professionals as well as volunteer community workers.

- *Equal investment in both prevention and response:* to make the response to vulnerable children more pro-active and effective. Prevention and response work both ways; prevention messages work better when people know that there will be a response in cases of emergencies. By the same token, response works better when people feel able to also address some of the causes of the crisis. It is important to provide the space for statutory workers to participate in the prevention sphere, for example through oversight of services to identify potential risks for children. It is equally important for non-statutory and community-based actors to know that they have a clear role in a response when a crisis occurs, even if this is primarily knowing where to go in an emergency and being able to insist on a response from that statutory service on behalf of the child and/or family.

Recommendation #3: Develop a monitoring and evaluation framework

Strong M&E systems and accountability frameworks are crucial for tracking children over time and over different sectors. The concurrent information is to be used as a practical tool for case management and for further systems strengthening, but also for improving accountability. This requires:

- *Alignment of data collection efforts with national priorities:* to ensure that the available information is in line with the key priorities of vulnerability and commitments in terms of the response to vulnerable children. The introduction of common indicators across the whole country (and ideally region) will reflect progress towards those priorities and commitments. Reliable data will allow for sharing of results and holding political and technical leadership to account. In order to promote mutual accountability between different sectors, at management and service delivery level, data and information sharing across these different sectors is crucial, requiring harmonized sets of indicators and data collection systems.

- *A simple but sound tracking system:* to track cases across services and over time in a way that is manageable for those feeding information into the system as well as those using the information to provide care to children. This requires for data collection to be kept simple, particularly at community level. The expanding experience with new technologies could provide exciting and appropriate opportunities for putting such systems in place, although use should be made of what is already in place, seeking to avoid duplication and increase harmonization across systems. Regardless of the tool or technology used, it is crucial that the system can track progress to an individual child and his or her family over time.

- *Two-way information flow at all times:* to ensure a transparency and space for feedback at all levels. Managers – policy makers at state level and technical managers at implementation level – have an obligation to provide feedback to those acting for vulnerable children. Feedback enables action and, importantly, is part of investing in actors' capacities, making it easier for people to see what they are achieving and which parts of the referral mechanism need greater attention or possibly resources. Likewise, a mechanism should be in place that feeds back data to those in touch with children and families on a regular basis and for feeding back to those who are coordinating information at the lowest administrative level to be able to review progress and consider alternative actions. This is true for both individual cases and also for tracking progress across the entire body of potentially vulnerable children in the area. Finally, children and caregivers should also be part of this two-way information flow, and receive feedback from care providers.

Recommendation #4: Mobilise resources

Effective referral mechanisms and case management systems need resources, including financial resources and human capacity. Although the squeeze on HIV-funding and development in general makes access to resources more difficult, the recent interest and funds towards supporting social protection interventions and systems-strengthening efforts more broadly allow for new opportunities to tap into. This requires:

- *A sound investment case*: to clearly demonstrate the 'return-on-investment' and substantiate the value-added of investing in effective referral mechanisms and case management The regional investment in social welfare workforce systems strengthening is contributing to this case significantly. However, the 'OVC sector' or those working with HIV-affected children or child-sensitive social protection, can equally advance this investment case by more clearly costing and evaluating interventions that enhance effective identification and follow up within their own programmatic areas.

- *Strong linkages to broader policy debates*: to tap into resources available that are not exclusively linked to child protection or support to OVC but do have strong links to the response to vulnerable children. This includes debates around social protection, HIV response, and emergency planning, amongst others. Whilst OVC programming, which has been the main driver behind case management initiative, largely followed from HIV funding, the response is by no means limited to HIV. The increased interest, and concurrent availability of funding, in the field of social protection may offer similar opportunities for shaping and integrating case management as a response for vulnerable children.

Action points

We propose a number of concrete and specific actions that serve as steps to be taken towards making referrals and case management more effective.

✓ *Do scoping or mapping of referral mechanisms and case management* within countries to formulate a context-specific definition that is based on current understandings and practice and fit-for-purpose. This must include consultation with children and families to verify key barriers to service access.

✓ *Define minimum standards* to agree on common understanding about the types of services and the way in which they should be delivered to all children. These should recognise both government and non-government service provision. For those countries in the Southern Africa Development Community (SADC), there is already a set of draft common standards and guidelines for improving the delivery of basic services for orphans and other vulnerable children and youth. A Minimum Package of Services for Orphans and Other Vulnerable Children and Youth has been developed in order to put into action the regional Strategic Framework and Programme of Action for OVCY, 2008–2015 (SADC, 2011).

✓ *Establish referral protocols* involving both government and civil society and verifying with children and adults what the key barriers to their access to services are. Such referral protocols could take the form of MoUs between different service providers, flow diagrams spelling out roles and responsibilities for different actors at different stages in the case management process or formal guidelines.

✓ *Define a results framework* to translate national definitions of vulnerability into measurable and concrete indicators, based on results for vulnerable children that can reasonably be expected from effective referrals and case management. Tracking and monitoring information in light of this framework will help to identify gaps and need for services within the case management system as well as across other services in terms of response to referrals.

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