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

A stocktaking report

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List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
CABA	Children Affected by HIV and AIDS
CARI	Children and AIDS Regional Initiative
CBCC	Community Based Care Centre
CBCPM	Community-Based Child Protection Mechanism
CBT	Community-Based Targeting
CDC	US Centers for Disease Control and Prevention
CPMIS	Child Protection Management Information System
ECD	Early Childhood Development
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office
GBV	Gender-Based violence
HIV	Human Immunodeficiency Virus
MVC	Most Vulnerable Children
NCP	Neighbourhood Care Points
NPA	National Plan of Action
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PSA	Programa Subsídio de Alimentos
VAC	Violence against children
WCARO	West and Central Africa Regional Office
WVI	World Vision International

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1. Introduction

Programming and policies for responding to child vulnerability have largely focused on reaching as many vulnerable children as possible in as short a period of time, for example universal birth registration and free primary education. Services that broaden access to basic needs are essential for all children, especially those that are most at risk of ill health, poverty and abuse. However, children who are the most vulnerable are often those who fall between the cracks of even the best sectoral programmes. A key challenge for eliminating children's exclusion from social protection, child protection, education and health programmes, is that of identifying such children and managing their complex needs across a range of sectors, and over time. Even high-quality and child-sensitive universal services and protection schemes must therefore be complemented by child-specific management and monitoring.

Case management and referral mechanisms have increasingly become 'buzz-words' in discussions on coherent and consistent responses to vulnerable children. However, there is little consensus as to what these concepts actually mean in the context of Eastern and Southern Africa and how they play out in practice. Experiences of cross-sectoral referrals and case management are new and sketchy. This study aims to fill this gap by collecting available experiences and drawing lessons learnt and recommendations for future work. It does so at an opportune moment in debates around child and social protection. Momentum is growing around the awareness that services for children need to be linked up and respond to each other. Referral mechanisms and case management are key to linking such services and strengthening systems for children. This study investigates current understandings in the region of how referral mechanisms and case management do or should take shape and considers current practice on the ground to distill lessons learned and recommendations for the way forward.

This report maps and documents understandings and experiences and builds on a wide range of literature, secondary data and information from key informants in Eastern and Southern Africa Region (ESAR), in particular, drawing on programmes and projects supported within the Children and AIDS Regional Initiative (CARI).[1] This analysis aims to broaden and deepen our overall understanding of referral mechanisms and case management in the region, what they mean and do at the moment and what their potential are for the future in responding to the multiple risks and needs of vulnerable children. This stocktaking report is followed by three country case studies and a discussion paper focusing on lessons learned and policy recommendations.

1.1 Background

There is a growing evidence base of what may work in supporting vulnerable children in Eastern and Southern Africa, derived from a myriad of initiatives aimed at realising the rights of individual children and their families. This evidence has been generated from community initiatives that have been carried out without any external support, from the actions of local service providers and local government administrators who are trying to bring various

[1] The Children and AIDS Regional Initiative (CARI) was a five-year programme (2006-2011) to improve the wellbeing of orphans and children made vulnerable by HIV. Nine countries within ESAR were part of this initiative - Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and Tanzania. It was funded by DFID and AusAID. In this study, we consider these nine countries as well as other countries in the region, including Zimbabwe and Ethiopia, to ensure relevance across ESAR.

stakeholders together to talk to each other and from the catalytic energies of policy makers who are pushing for global policies (JLICA 2008, UNICEF 2011). The growing pool of social protection[2] and systems strengthening[3] initiatives are challenging the belief that countries with limited resources cannot guarantee a basic means of survival for their children and thus offer an opportunity to look at investment, at scale, in child welfare and poverty reduction. However, the exact nature of how this is to be done in a way that is sustainable and reaches children at scale remains unresolved. Resources are limited, especially given the ongoing global financial crisis. Children in poor countries remain low in the pecking order for resource allocation.

Children in the Eastern and Southern Africa region face some of the most complex challenges imaginable. This region is at the epicentre of the global HIV epidemic. With only 2% of the global population, there were approximately 1.1 million new infections in 2009, representing about 51% of all infections in Africa and about 37% of the global total (UNICEF 2011). Half of all under-five deaths globally occur in the region, although less than a quarter of births each year are in this region (UNICEF ESARO, 2011). Food insecurity remains persistent across the region, with the number of malnourished children and adults having risen from 88 to 203 million between 1970 and 2002 and a current level of malnourishment of 30% (Martins and Yablonski, 2011).

Despite the evidence of widespread child poverty and vulnerability in ESAR, only a minority of vulnerable children are receiving external support. *"An estimated 11% of households caring for OVC receive any form of external care and support."* (UNICEF, 2011, p.4) Amongst the small percentage receiving some form of external support, the majority of efforts are still largely focused on material care (Roelen et al. 2011) and there is limited evidence of long-term impact and the extent to which interventions address underlying causes and drivers of vulnerability (Roelen, 2011). The available data shows that in general the 'easier to reach' children are those that are benefiting. For example, an evaluation of PEPFAR's large OVC portfolio across the region found that, despite high coverage and some quality examples of care, *"[...] the initial push for numbers of children reached resulted in some partners offering the services with the least cost attached or to the most accessible audiences".* This included focus on services which were relatively easy to deliver to large numbers (such as psychosocial support) but that had limited evidence of long-term impact and delivery of services to particular age groups of children, notably primary school age children (PEPFAR, 2008, p11). A detailed study of community responses in Uganda endorses this view, showing that only 18% of beneficiary children were of preschool age and almost all provision was for education and basic health or psychosocial support, with no provision of social protection, legal support or addressing the impacts of armed conflict (Nshakira & Taylor, 2010).

[2] In their social policy framework, the African Union has defined social protection as *"[…] a set of interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people".* (African Union, 2009) This includes initiatives that provide income (cash) or consumption (food) transfers to the poor; protect the vulnerable against livelihood risks; and enhance the social status and rights of the excluded and marginalized.

[3] Although there is no commonly accepted definition of a 'systems approach', a working definition can be applied: *"System based programs are those that adopt a global perspective on child vulnerability and seek to promote actions that will strengthen coordination within and across systems (social protection and/or child protection) and ensure that all together, they respond to the distinctive needs of the children vulnerable. They also promote complementarities and establish linkages amongst universal basic services (birth registration, health, and education), social protection and child protection services."* (UNICEF WCARO, 2010, p. 9).

Children have multiple needs and are at exposed to multiple shocks at the same time (UNICEF, 2011). Yet growing evidence shows that children's needs and vulnerabilities are not delineated by clear sectoral lines but strongly overlap and interact and that, therefore, interventions to reduce children's risks and vulnerabilities need to be coordinated. Sectoral responses like health and education increasingly recognise the need to extend beyond traditional facility-based service delivery. This includes health centres providing medical care and schools delivering lessons to integrated health and social service support for the entire family. Nevertheless, ensuring a joined-up link between fixed services, such as a health centre or primary school, and the often complex interventions needed at community level to enable the child to benefit from a variety of services, has proven to be difficult.

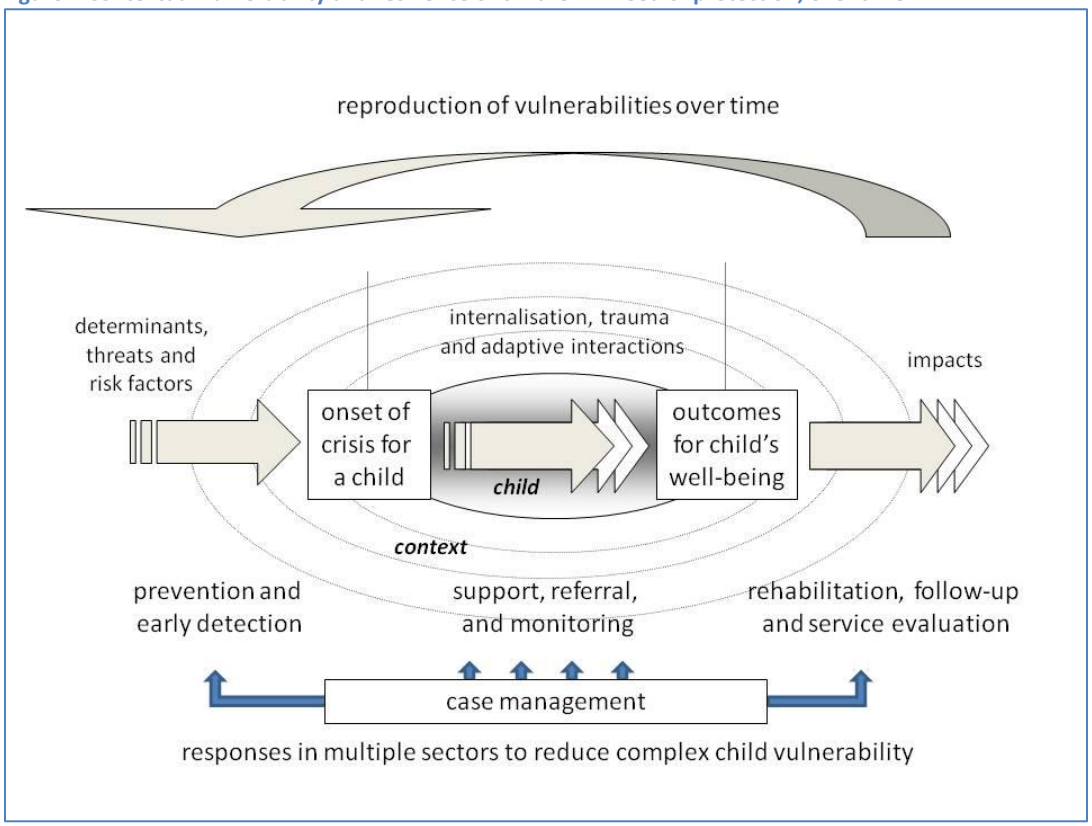
Integration needs to be done at multiple levels – from appropriate identification of vulnerable children within the household and family, correct assessment of the often multiple child and family support needs, to both formal and non-formal service provision (UNICEF, 2011; JLICA, 2008), necessitating a means of ensuring that those children most in need of external support – often the most invisible and excluded – are identified and have their needs assessed correctly.

1.2 Rationale for this study

Against this backdrop, this report aims to gain an insight into one important element of this practice – the process of referrals and case management. That is, the identification of vulnerable children, the assessment of their needs and ensuring that they get access to necessary support that leads to longer-term improvement. Any effective response requires that the particular needs of children at most risk are identified, that the child and caregivers can access the support identified, that care or support is provided in an appropriate way and that the support is followed-up so that it makes a real and lasting difference and the risk is prevented or removed.

The value of a case management approach for children with complex needs is illustrated in Figure 1. The literature on psycho-social support clearly illustrates the necessity of providing long-term support for children who have experienced emotional crisis (Richter et al, 2006). This holds true for all complex vulnerabilities and needs, such as in the case of child malnutrition where multiple sectors need to intervene to provide not only immediate health care but also livelihoods support for the caregiver, possibly a social safety net for the household, health care and potentially more specialist education support to mitigate the impacts of poor nutrition. Whilst not all children need this level of support, the challenge for those working with children is knowing who to refer, where to refer them to and knowing whether their needs are being met.

Figure 1 Contextual vulnerability and resilience of children in need of protection, over time



The debate on effective referral mechanisms and how they can ensure positive outcomes for children is timely. First, there is increasing momentum around the need for the responses to vulnerable children to take a systems approach rather than provide 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"* (p. 14). An effective referral mechanism is part and parcel of such a systems approach.

Second, there is increasing emphasis on and acceptance of state budgeting and legislation specifically for children, especially so in the fields of social protection and, more recently, child protection. Social protection in ESAR has seen a rapid expansion in the last five years with cash (or food) transfer programmes being piloted or implemented in countries across the region. Whilst some are strongly government-owned and funded (e.g. South Africa, Namibia and Botswana), others are more relient on external resources (e.g. Malawi and Mozambique), but all suggest a particular level of state responsibility and government involvement in terms of organising, administering and implementing such programmes (Blank et al, 2010). Blank, Devereux and Handa (2010) argue that rights-based arguments for social protection in particular imply that states have a clear obligation to guarantee social protection. *"The political momentum behind social protection represents an important opportunity to advance the progressive realization of the rights of children"* (p. 26).

Finally, there is a move towards a recognition of state obligations towards the child in the field of child protection. An increasing number of Children's Acts are being drafted and implemented

across the region, national child protection systems and potential responses are being mapped and there are initiatives to strengthen the social welfare workforce (AIDSTAR-Two, 2011). And although national plans may not have been useful as strategic tools for mobilising institutional resources for action in the past, they have increased verbal commitment and stakeholder involvement (Davis, 2009). Much of this has been complemented by a shift in dialogue around the HIV response, with ambitious universal access targets and the need for such responses to be nationally owned and sustainable (UNICEF, 2010a; UNICEF, 2011).

In combination, there is a growing acceptance that the state, together with other stakeholders, has a financial, legal responsibility not only for coordinating but also delivering social and child protection services. A careful balancing of the economic and social objectives will be key for combining pathways of care, e.g., linking social protection with child protection and social welfare services and embedding them in health and education (Davis, 2009).

The report is structured as follows: first, we describe the methodology used in this study. Second, we consider notions of child vulnerability across the region and establish a common understanding to serve as frame of reference within this report. Next, the concepts of referral mechanism and case management are discussed and a basic framework of case management, relevant and appropriate for ESAR, is put forward. We consequently consider a number of key questions with respect to making case management work for vulnerable children in the region. These questions in chapter 5 pertain to political commitment and resources, identification of children and their needs, roles and responsibilities, the role of the primary caregiver and household dynamics and issues around monitoring. Finally, we summarise the main points from this report and suggest next steps.

2. Methodology

This stocktaking report is guided by a number of questions that were formulated at the outset of the research process and uses a number of methods to seek answers to those questions. Questions pertain to gaining an understanding of child vulnerability, referral mechanisms and case management and the meaning and practical application of those terms in ESAR. Against the backdrop of these considerations, this report further seeks to investigate the potential of referral mechanisms and case management in ESAR based on experiences across the region. Issues under consideration include the division of roles and responsibilities across different actors and stakeholders, the need for resource mobilisation and mandate and leadership.

Different tools were used to inform this regional study. A desk review focused on current systems and practice in ESAR and referred to wider literature and documentation to place the regional situation within a wider context of case management and referral systems. The literature was identified through internet-based searches and discussions with key informants for case management and referral systems in Africa and literature on OVC and social protection responses in the region that specifically referred to case management and referral systems.

Long-distance interviews were undertaken with three different groups of respondents:

1) Key informants from the global and regional policy sphere;

2) UNICEF Country Office child protection specialists from 8 CARI countries and Zimbabwe;

3) Key informants at the country level.

Interviews with the first two groups of respondents informed the identification and selection of the third group of respondents. Interview guides were used for all interviews, albeit at a different degree of specificity. They were developed in such a way to guide the semi-structured and qualitative interviews rather than formalise or restrict discussions. A list of respondents and full interview guides can be found in Annex 1 and Annex 2.

3. Child vulnerability in ESAR

This section describes current understandings of child vulnerability and reviews regional literature to summarise how child vulnerability is being defined within the region and how this is impacting on the ability for the most vulnerable children to have their rights realised.

3.1 Definitions of child vulnerability in ESAR

Referral mechanisms and case management require an understanding of the types of vulnerabilities and risks indicating whether a child needs a referral and when, as understood in ESAR. More nuanced and wider understandings of child vulnerability ultimately means a widening of the remit of case management, with more needs and vulnerabilities to respond to and with more sectors and services involved to meet such needs and vulnerabilities.

In the early 2000s, debates in ESAR around vulnerable children, particularly OVC, pertained largely to children's individual vulnerabilities. Now, there is a move towards more nuanced understandings of child vulnerability, part of which may be attributed to the influence of the social protection debate with an increased focus on economic vulnerability, placing greater emphasis on structural vulnerabilities that affect larger groups of the population. National Plans of Action for OVC or MVC[4] have evolved from a simple definition of 'single or double orphan' to a more nuanced understanding of vulnerability, where HIV-related issues as household poverty or education levels are seen as equally important. NPAs have broader definitions of vulnerability or have more clearly articulated which children are to be reached. Internationally the trend towards a more nuanced understanding of vulnerability is reflected, most notably in PEPFAR II, in work with children who are directly and indirectly HIV-affected. In other words, the focus is shifting from an HIV-focused to an HIV-sensitive approach.

However, more needs to be done to clarify the specific needs of vulnerable children differentiated by age and sex. Specific groups of children, such as children living in institutions or on the street, children with disabilities, abused children and child soldiers are insufficiently included (Amoaten & Griffin, 2011). The same argument holds for children living in different

[4] Much debate has been had, especially in the Eastern and Southern Africa region on whether a vulnerable and HIV-affected child is an 'OVC', an 'MVC' or just a 'VC'. Given the connotations of 'OVC/MVC' that have come to imply HIV-specific targeting, this report uses the term vulnerable children. However, despite the semantics of this debate, what is consistently pointed out is that vulnerabilities are both economic and social.

geographical contexts (including urban, peri-urban and rural settings) and for children living in non-traditional households (including elderly-headed and child-headed households).

Box 1

Broadening the concept of vulnerability in national plans for vulnerable children

Namibia's proposed National Agenda for Children " *seeks to address the 'whole child' from the perspective of the individual child rather than that of government sectors." [...]* "*Two critical issues were identified […]: that Namibia needed to adopt a multi-sectoral approach to planning and implementation towards child-centred development, and that we needed to look more broadly at the concepts of vulnerability and inequity through the lens of a child's life cycle"* (Ministry of Gender Equality and Child Welfare, 2011b). Such an explicit notion of a wider sense of vulnerability, acknowledging that needs and vulnerabilities are different in different stages of childhood presents a clear shift away from a focus on narrowly defined vulnerable groups, such as OVC or orphans.

In addition to acknowledging the social and economic factors of vulnerability, stakeholders stressed the importance of considering the timing of shock or stress in relation to child vulnerability. They suggested that risk may provide a more constructive way to frame our thinking around vulnerable children as this requires thinking about the drivers of underlying vulnerability, thereby allowing for a preventive rather than reactive response. One respondent stated that:

> *"Obviously some groups are more vulnerable but the question is what are the causes of vulnerability and what are the risks that children are exposed to. Risks can pertain to macro-level events or household risks in combination with notion of resilience. I don't think of child vulnerability but rather what are children vulnerable to. When you do this analysis of what causes vulnerability, you may come up with particular vulnerable groups due to ethnicity or other reasons. Part of the problem when identifying vulnerable groups: 1) exclusion of vulnerable children as they don't fit particular groups, 2) disregard of causes of vulnerability, 3) conflating cause and effect of vulnerability."*

In general, the dynamic aspect of child vulnerability and the shifting nature of vulnerability over time need more deliberation. Children's needs and vulnerabilities are not only unique in the sense of being different from those of adults, but also diverse and shifting as children mature and grow older. This time-specific, or 'time-sensitive', aspect of children's vulnerabilities means that potential and actual crises for children need to be prevented, managed (in relation to the potentially multiple sources of risk and of support) and followed-up through on-going support and referral *over time* and varying according the age-specific situation of that child.

3.2 Child vulnerability in ESAR – from policy to practice

Although these broader understandings of child vulnerability are widely considered to improve the policy response, they have not yet translated into concrete changes in the way services are provided. The practical focus is still largely on 'standard' vulnerable groups such as double orphans, disabled children or children subject to violence or abuse. Several stakeholders described the challenge of translating a general definition into implementation.

"We have given our OVC focal points permission to think about vulnerability in a different way, which is good but has made it more complicated. The definition is broader but we are struggling to make the broader focus manageable in terms of results."

In the context of multiple needs and insufficient resources to meet this need, people often go for the most obvious 'groups'. In several countries, including Botswana, despite the recognition that vulnerability is multifaceted policies still tend to take the 'short cut' by focusing on orphans or by applying rigid socio-demographic data (e.g. double orphan, granny-headed household). Even where there have been different definitions of vulnerability, e.g. Most Vulnerable Children (MVC) in Tanzania, the application and the challenges remain the same. The MVC definition 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).

With respect to identification and coverage, the argument is sometimes made that, given the enormous levels of poverty in the region, it may be best to focus on lifting children out of poverty (Schubert, B. 2010, Child-Sensitive Social Protection in Zimbabwe: Study Commissioned by UNICEF, cited in Wyatt et al., 2010, p7). However, whilst there is a correlation between household wealth and many child welfare indicators, there are groups of children who need support and protection for reasons that are not necessarily related to poverty (Wyatt et al., 2010). Key informants also stressed the importance of poverty reduction in combating child vulnerability. At the same time, it was also clear that poverty reduction alone and social protection in and of itself cannot tackle the multitude of issues surrounding child protection (Roelen, 2011). This is slowly being recognised in more recent national plans of action for vulnerable children, which have greater linkage between economic and social vulnerabilities. Zimbabwe's National Action Plan for OVC 20011-15, for example, has a household-focused approach towards understanding and responding to children's needs. It includes a cash transfer scheme in order to reach the individual child through economic support to the whole household, complemented by other, individually focused, services to respond to a child's individual needs. Child vulnerability is considered to have elements at the level of the household as well as the individual child (Ministry of Labour and Social Services, 2011). Although encouraging, such examples are new and as yet untested. Many social protection frameworks and strategies remain unlinked to national child protection systems which, in turn, are insufficiently linked to OVC plans and policies.

3.3 Key points

- Child vulnerability is multi-layered and complex and it changes over time. Children can be vulnerable because of their young age or individual characteristics or because of external structural factors relating to economic poverty and exclusion from social services.

- Risks may be a more useful way of understanding children's needs rather than the concept 'vulnerable'. Talking of 'risk' may facilitate consideration of levels of need and therefore prioritisation of which children to support. If this is done in a way that enables a 'triaging' of response, it may streamline the referral process and identify which children and families require a complex case management system and which can receive support through a community-managed response or through access to a universal service.

- Whatever the definition, the concept of 'vulnerable child' is "*not used much for programming"* because of pressure of time and lack of resources. In reality, the 'easiest' children tend to be the ones that receive the most referrals.
- There remains some pressure to focus on reducing household poverty – as a means to reach the most children at scale. However, the most vulnerable children are not at risk only because of poverty. Child protection remains a huge challenge that cannot be met through economic responses alone.
- There are emerging examples of policies that have broader definitions of vulnerability and that are backed up by implementation plans and regulations that will make it easier for application.

4. Case management in ESAR

In this chapter, definitions of referrals mechanisms and case management are discussed in detail. Key definitions are provided in Box 2 and serve as guidance for discussions in this chapter, as well as the remainder of the report.

Box 2

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 professional social workers.

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 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.

4.1 Definitions of referral mechanisms for vulnerable children in ESAR

Referral implies having a system and structure – having a prescribed pathway of actions that can be taken. Wulczyn et al. (2010) highlight the following issues: having a common purpose or goal

that *"provides the glue that holds the system together";* recognition of the fact that "children are embedded in families or kin, which live in communities, which exist within a wider societal system" which requires that *"specific attention needs to be paid to coordinating the interaction of these subsystems such that the work of each system is mutually reinforcing to the purpose, goals, and boundaries of related systems";* and inclusion of "issues of accountability, where all stakeholders *"are held accountable for both their individual performance as well as the performance of the overall system"* (pp. 2-3). Save the Children (2011) suggests that a referral mechanism should be accompanied by a referral pathway, outlining *"the roles and responsibilities of the participating agencies, including which agency/authorities is responsible for providing which service to whom and where"* (p. 11). Services may sometimes be provided by the same agency or actor that is making the referral but in many cases, they will be different.

In interviews with stakeholders, referrals were widely considered to be more short-term and an obligation at all levels. They may be spontaneous and 'one-off' without any follow-up attached to consider whether the child has actually received a service. Informants largely describe referrals as "passive", although one respondent offered a useful distinction between two types of referrals: 1) the 'information' referral where someone is referred by mentioning a service or person to go to without any further support and 2) 'hand-holding' referral where someone is taken by the hand and guided to a service and possibly followed up on until the service has actually been provided. The first type of referral is obviously more passive and can be considered less effective in ensuring an adequate response to children's needs.

National Plans of Action for OVC, the main multi-sectoral response to vulnerable children, refer regularly to the need for referrals. Several plans refer to: *"enhanced referral system for seamless provision of critical services to OVCs and their families"*, *"all eligible orphans and vulnerable children are being referred and documented at appropriate service points by 2016"*. However, few plans developed prior to the last year or so provide details on how this is to be done and one plan makes no reference at all to a referral mechanism. In a few instances the detail is further spelled out. For example, Swaziland's NPA specifies monitoring referrals of vulnerable children to different services but also includes indicators to show how these referrals will be tracked. Malawi and Zimbabwe go further in their most recent plans and spell out mechanisms for developing and implementing case management.

4.2 Definitions of case management for vulnerable children in ESAR

Case management is generally considered to denote a system that follows an individual child across referrals, either within a particular sector or across sectors, thereby encompassing referral mechanisms. In the literature, case management in relation to children in developing countries most frequently refers to two main sectors; health and child protection, and to case management within those sectors.

In the case of health, initiatives such as the Integrated Management of Childhood Illnesses, core practices on maternal and child health and community initiatives for HIV treatment have developed strong and formalised referral mechanisms that train community health workers, provide clear guidance on what they must do and when they must refer, and what action to take at each stage (UNICEF 2008; WHO, 2010 & 2010a). Whilst there remain a large number of challenges, there are clear lessons to be learned about training and clarity of purpose. However, in this review few examples from the health sector were cited as successes related to vulnerable

children, indicating a lack of alignment between health sector-specific and more multisectoral responses.

In terms of case management for child protection, a recent review conducted by Save the Children defines case management as: *"[...] the process of assisting an individual child (and their family) through direct support and referral to other needed services, and the activities that case workers, social workers or other project staff carry out in working with children and families in addressing their protection concerns"* (McCormick 2011, p1). These principles of identifying a need and following that need through are not only pertinent within child protection sector specifically, but are relevant across and within other sectors. The key elements required for case management for child protection are summarised in Table 1.

Table 1 Elements of a case management system for child protection (*Source: McCormick, 2011*)

Identification & assessment of children	• Must have clear referral mechanism between agencies, stating clear roles & responsibilities • These referral pathways should be written down and should indicate *who* is responsible for *what* and *by when*. • Child protection agencies should have a mandate and a skilled workforce to respond in a way that supports the protection of a child in a timely manner. • At first point of referral, child should be registered and assessed, within context of family and environment, including the child's own perspectives.
Individual support plan	• One overall focal point ('case worker') for the child / family, who is responsible for overall coordination, as well as who is responsible for each recommended task • Clearly defined result of support for the child and and what actions are required to achieve this result, including details of the precise assistance, where this assistance is to take place, who is responsible for providing it and a clear time frame. • The child must be involved in the plan • Where the child is living within a family, the primary caregiver and possibly other family members should be aware of the plan and involved in the plan were appropriate
Support and referral services	• Referral mechanism must indicate roles and responsibilities of participating agencies, • Should indicate referral pathway (how the referral should be conducted, e.g. who talks to whom, what is written and by whom etc) • Even if a child is receiving support from another service provider, the case worker should be continuing to provide support to child / family.
Monitoring and review	• Case conferences (regularly planned meetings with all service providers who have significant responsibility within the support plan) • Follow up and monitoring to ensure that the case plan remains on track; adaptation where required to ensure additional action or enhance implementation • Case closure – there should be an agreed point at which the child stops receiving specialist 'case management' assistance.

Although relevant for framing our understanding of case management, this overview lacks reference to and understanding of case management outside the specific statutory social work and child protection sector – certainly not in the context of referrals across different sectors or from non-formal through to formal services.

Case management applies along a full continuum of care, ranging from intensive family-based preventive interventions (for example parenting support or family-focused HIV counselling and treatment), short-term support needed to enable a child or family to benefit from a service (for example, providing additional support for a disabled child to benefit fully from school by increasing access or providing additional educational support) to long-term care and support (e.g. home-based care, psychosocial support or treatment adherence care for families with members taking HIV treatment). It also includes emergency post-crisis interventions, such as providing alternative care for a child who has to leave his or her family by respondents to key informant interviews.

Respondents' reflections below indicate the diversity of views on the value of case management:

> *"The words of referral and case management are used often - in case of abuse and police response, the words are used interchangeably, meaning including linkages, referrals, operational procedures for service delivery [...]"* (but there is no capacity to actually implement).
>
> *"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."*
>
> *"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."*

These responses indicate the great interest in the potential of case management as a way of addressing a wide range of outcomes for children. At the same time, they illustrate a sense of confusion as to what case management really entails and how it can be implemented in practice. Case management was generally considered to be a more comprehensive and "active" approach to responding to children's needs, but with insufficient clarity about what such an approach actually entails.

Several respondents expressed the concern that the term 'case management' implied a 'Western, social work model' and felt that the debate in ESAR was dominated by the implementation of such an individual-focused model without critical thinking as to whether this is the most appropriate model. As postulated by one respondent: *"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".*

Given the lack of clarity about what case management or referrals actually mean in the ESAR context, coupled with the unease of adopting a Western social work model, the interviews made it clear that there is a growing interest in new concepts, such as 'community case management', with such concepts being more culturally appropriate and realistic. In particular, respondents stressed the importance of recognising that a response to the needs of individual children must

be coupled with a response to the wider family's needs. In this context, 'referral' or 'case management' does not necessarily mean only working with an individual child but could consider the issues of the whole family, where appropriate. As well as moving beyond the individual child (for example, managing the whole family's HIV treatment, whilst ensuring that each family members' diverse complementary needs are met), being family sensitive could also involve a more community-focused response, for example group support on parenting.

A recent series of articles on the response to vulnerable children demonstrate a range of family-focused responses, all of which recognise the differential needs of different children. This has been done in response to the weaknesses of the current HIV focus: *"Despite a wide variety of model approaches, interventions, whether medical or psychosocial, still tend to target individuals rather than families. The almost exclusive focus on orphans, defined initially as a child who had lost one or both parents to AIDS, has occluded appreciation of the broader impact on children exposed to risk in other ways and the impact of the epidemic on families, communities and services for children. In addition, it led to narrowly focused, small-scale social welfare and case management approaches with little impact on government action, global and national policy, integration with health and education interventions, and increased funding."* This same article argues for a more coordinated response of services that *"acknowledge a broad view of a "family system" and ideally include comprehensive treatment and care, community agencies and coordinated case management"* (Richter, 2010).

4.3 Current practice on case management in ESAR

Whilst referrals receive limited attention in most NPAs, case management receives even less. And whilst there are strong systems for referral into the health sector, there seems to be less focus on taking this into a more formal 'case management' response for children or families with the most complex challenges – seeing how a multisectoral response could enhance outcomes for children if all players shared information about referrals and outcomes.

Protocols and mandates spelling out roles and responsibilities within the so-called "referral pathway" are largely missing, according to key informants across the region, more broadly but also specifically within child protection. That said, a number of countries have started developing protocols and memoranda of understanding to articulate cross-sectoral cooperation and to establish accountability mechanisms. The health sector demonstrates the value for such protocols, yet no health-focused referrals could be identified that explicitly linked children or families to external, non-health sectors to assist in managing a complex health problem.

In terms of social protection, the review found no examples of where emerging social protection schemes had a protocol for referral to child protection or health schemes, other than where there was a conditionality attached to a cash transfer for school or health care.

Box 3

Developing protocols for case management

Several countries are developing case management protocols in the child protection context. Malawi, Namibia and Tanzania, for example, are complementing the development of national regulations for new Children's Acts with a set of referral protocols that specifically promote a case management approach. Whilst in their infancy, these tools will enable a qualified case management worker, assumed to be a qualified social worker, to ensure that a strong protection response is provided in case of reported abuse. The required response will build on input from multiple sectors.

This lack of protocol does not mean that referrals are not happening, but rather that they don't take place within a structured or well-defined mechanism. For example, it was explained that in Lesotho, whilst the elements of a coherent response to sexual abuse may be available, the lack of a protocol linking up the various services impedes a coherent response. Although it was clear that Child Helpline and the Child and Gender Protection Unit of the Police and Department of Social Welfare were key actors, guidance is missing as to their particular roles and how they follow up on each other. This lack of coherence between different formal sectors was one of the challenges most frequently mentioned during key informant interviews .

Unavailability of appropriate services was mentioned as another important barrier. The referral pathway may be well established with clearly defined roles and responsibilities but if there are no viable services in place, referral mechanisms will still not be able to adequately respond to and address children's needs. This is endorsed in the literature (McCormick, 2011) and by key informants: *"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 4

Community case management in Mozambique

Mozambique is currently in the process of rolling out its model of Community Case Management (CCM) under the auspices of the Ministry of Women and Social Action (MMAS). The community case management model recognizes the importance of communities as front-line actors in the response to vulnerable children, against a backdrop of limited government capacity and resources. The current model supports the establishment, training and support of Child Protection Community Committees (CPCCs), which are tasked with the identification of children facing a wide range of different needs and vulnerabilities, to provide support when possible, make referrals to other services when available and to provide follow-up to ensure continued support. Although initial experiences are promising, many challenges are to be addressed. The level of awareness of child protection issues differs considerably from one CPCC to the other, the identification of and response to non-material needs is limited, and linkages to other services (such as health and education) are weak. Initiatives are underway to improve training, strengthen cross-sectoral links and to increase the support from district-level social welfare offices by increasing and building their capacity.

4.4 Key points

- Referral implies having a system and structure – having a prescribed pathway of actions that can be taken.
- Referral mechanisms are regularly referred to in OVC NPAs but there definitions are not spelled out and there is little mention of how these are to be implemented or tracked.
- Case management remains a term that is primarily in use in the child protection sector. It often implies an individualistic response to children largely implemented by statutory sector workers alone. There are emerging attempts to consider community case management, which would imply the rigour of following individual children's concerns through, whilst retaining a family and community focus.
- There are few protocols or guidelines that guide referrals or case management function in practice in ESAR, with the exception of dealing with violence against children.
- Where protocols exist, there are few links between different actors (the 'case' is not being managed as a team). This holds true across the board, including child protection, health and social protection sectors.
- Even if protocols exist, the availability of viable services is often an important impediment to the provision of an adequate response to children in need.
- More critical thinking about appropriate models for case management in ESAR is required. In various countries in the region, new case management systems are at a design stage. These also include new ways of considering community-based case management. Strengths and constraints of the emerging models need to be assessed in the near future.

5. The case for greater attention on referral mechanisms and case management in ESAR

Against the backdrop of the established notions of child vulnerability and case management in ESAR, a number of questions are pertinent to further investigate the potential role of case management in scaling-up and improving the response to vulnerable children. We discuss the importance of policy commitment and resources, issues around identification of vulnerable children and the assessment of their needs, appropriate roles and responsibilities in referral processes and case managements, the importance of the family-context, and issues around tracking and monitoring.

5.1 Policy commitment and resources

As section 1.2 outlines, there has been a substantial policy shift over the previous five years, with a growth in commitments to social protection, broader conceptions of child vulnerability and a growing – albeit small – investment in social welfare and child protection systems strengthening. Despite these paradigm shifts, policy commitment and the mobilisation of resources remain a challenge in pushing for coherent systems for vulnerable children.

Referral mechanisms and case management require a system, to ensure that the right children are being identified, that their needs are being correctly assessed and that the most appropriate responses for the child in his or her immediate context are identified and delivered. Without a system (including a policy framework, clear roles and responsibilities and implementation plan),

there is unlikely to be an effective response, nor sufficient resourcing (of finances and human resources). One key informant described the importance of an integrated and multi-sectoral response for policy commitment as follows:

> *"The lack of an idea of a child protection 'system' is partly why there are weak referrals, because no system means no case management... There are three emerging models coming out of the region... One is media driven, with people talking about the need for prevention in the community but not a lot of services to respond, once prevention brings out a problem. The second is an organic sectoral approach where links are not really happening but sectors are individually strong... The third is where there is an integrated multisectoral approach which is the ideal to move towards."*

It is this need to think systemically which is explored further in this section, both at a national level and then at local level where there needs to be systemic coordination and leadership.

National Plans of Action for children have not sufficiently mobilised institutional resources for action (Amoaten & Griffin, 2011). Although NPAs have increased verbal commitment and stakeholder engagement, less than one-third of the countries in Africa with laws to protect children from violence, abuse and all forms of exploitation had the resources to enforce them (Davis, 2009). Against the backdrop of the weaknesses of NPAs, Children's Acts have been introduced across the region in order to update outdated and colonial laws or develop a legal framework for children for the first time. The development of these Acts, and accompanying regulations, are one way of putting statutory mandates into law and framing the state's responsibilities and national obligations with respect to vulnerable children.

Box 5

Moving from an international framework to national obligations – Children's Acts across the region

In several countries in Southern Africa, new legislation has been introduced that translate international legal frameworks into national obligations. The following countries have introduced Children's Acts, or equivalent, that broadly adhere to the Convention of the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC): Botswana (Children's Act, 2009), Lesotho (Child Protection and Welfare Act, 2011), Malawi (Child Care, Protection and Justice Bill, 2010), Mozambique (Children's Act, 2009), Namibia (Child Care and Protection Bill, 2011, South Africa (Children's Act, 2010), Swaziland (Child Protection and Welfare Bill, 2010) and Tanzania (Law of the Child, 2009).

All of the laws imply a state obligation to protect children from violence, injury, abuse, neglect or exploitation by putting in place effective procedures, programmes and follow-up of cases. The regulations should create obligations for the state, frontline workers, carers and guardians and community members. For example, in Tanzania, whilst social welfare officers hold the obligation to carry out investigations in case of abuse, community members have the obligation to report such abuse (UNICEF Tanzania, 2011).

These new **Children's Acts may prove important in creating an enabling environment for referral mechanisms and case management**, but few have yet developed roles and regulations. There are a number of challenges in relation to their formulation and implementation, particularly pertaining to overall leadership and coordination obligations and to maximising

resources through an effective multi-sectoral response to child vulnerability. Such a response requires linkages across a wide range of sectors and actors the establishment of which requires substantial political will. Depending on where the national mandate of the overall response to vulnerable children lies, the formulation of Children's Acts or other laws or policy frameworks may support such a systems approach.

The fact that the responsibility for children's issues in ESAR generally sits with bodies that are weak and under-resourced poses a real constraint. In most cases, this body is a ministry with responsibility for Gender and Children (e.g. Malawi, Mozambique, Namibia), for Social Development (e.g. Lesotho, South Africa) but rarely for children alone, although in Swaziland, all children's issues are convened in a unit under the Deputy Prime Minister's office. In several countries, the responsible body is a department within a particular ministry; i.e. the highest social welfare official is below the level of a minister, rather than a ministry in and of itself. The limited capacity of the responsible ministries (or departments) to lead, coordinate and implement national responses for children affected by HIV and other vulnerable children is cited in nearly every piece of literature reviewed for this study. With few exceptions, the social welfare and children's sector is consistently under-funded, understaffed and politically weak. As Jones and Sumner (2011) point out "*Many developing countries lack a dedicated children's ministry [...]*" and in case they do exist *"[...] they are typically amongst the least influential and under-resourced [...]"* (p. 67). This poses a significant challenge in developing and implementing a consistent and holistic response to children, given that national responses for orphans and vulnerable children are intended to coordinate activities in at least the HIV, health, education, justice and social welfare sectors.

Consultative processes can be helpful in bringing stakeholders at the policy level together. Although significant emphasis is being placed on the importance of convening at policy level (e.g. UNICEF, 2011), feedback from across the region points towards the difficulty of doing this – especially where social welfare is a subsection of the health ministry. Cases where coordination and leadership have been successful are often those based on an enhanced evidence base around a key child protection issue, most notably violence against children. In the early 2000s, for example, advocates managed to mobilise for HIV-affected children, given the urgency of the issue. Informants from Tanzania, Swaziland and the Regional Office report that the emerging Violence Against Children (VAC) studies conducted with national partners, UNICEF and the US Centers for Disease Control and Prevention (CDC) provide a clear evidence base that enables all to rally around a particular issue. Informants reported that in Tanzania the launch of the VAC study has leveraged substantial national commitments from every sectoral ministry with a child protection responsibility. This was in part because of the strong consultative process of designing the research and developing a sense of ownership. It is also an issue that people do feel strongly about. Informants in Namibia and South Africa also referred to the strongly consultative process around the development of these Children's Acts/Bills and how they facilitated a popular discussion on some of the issues that many feel strongly about. This investment in bringing together a broad range of stakeholders, including children, linked to proven evidence of the value of a multisectoral response, appears key to raising the issues on the agenda. However, there are few examples of where this has been successful.

Despite the formulation of NPAs and Children's Acts and consultative processes, links between formal and informal interventions are largely missing. Although the fact that 'systems' need to interact between the formal and the non formal is paramount and almost self-

evident, the literature on vulnerable children's access to care and support consistently identifies lack of coordination and networking as being one of the priority challenges. Recent comprehensive situation analyses of vulnerable children in South Africa and Uganda, for example, lack of alignment between protection services, judicial services including birth registration and community actions are consistently highlighted (Kalibala & Elson, 2010; Martin, 2010). Children's Acts, NPAs and other policy documents do sometimes indicate responsibilities for different stakeholders but clear guidance documents for the formal/non-formal linkage are missing. The establishment of such guidelines may be crucial in leveraging commitment both across the formal and informal sector.

Effective referral mechanisms and case management require resources. Funding for vulnerable children is insufficient (Davis, 2009; UNICEF, 2011) but without a clearer sense of the 'added value' of an effective referral and case management system, it remains hard to build the business case for investing in stronger referral systems. The move toward systems strengthening implies a greater level of state budgeting and financial accountability. However, the key informant interviews refer to the lack of information about where resources are coming from for vulnerable children and what impact they have. Some countries have undertaken budget analysis to see where child protection resources come from and what is needed (South Africa completed, Malawi and Tanzania in process, for example); this would appear to be an essential step but one which is rarely undertaken.

It appears crucial to build up an evidence base and an investment case for referral mechanisms and case management. Leverage for more resources would be more effectual if one was able to demonstrate that it is more effective to respond through a system than through individually funded, small-scale component parts. Whilst there is considerable information available on the cost benefits of HIV treatment (WHO, 2010a) or universal education (UNICEF, 2009a), there has been a far less successful case in arguing for investment in a systems response to vulnerability that is holistic and benefits 'systems-strengthening' across child protection as well as other sectors. The HIV sector, currently the sector that is the largest donor of vulnerable child-specific funding (although substantially decreased since the global financial crisis), has seen significant shifts towards 'systems financing' for vulnerable children. PEPFAR has moved from HIV-specific to HIV-sensitive responses, with its earmarked OVC funds being able to be used for a wider range of children and commitments to social welfare systems strengthening. The Global Fund on AIDS, TB and Malaria has pushed for 'community systems strengthening' within its overall focus on system strengthening and this has been used for supporting OVC-related initiatives at community level or through local government systems, although there remains limited information about how such child care workers can be funded through core government budgets.

> *"Recognition of the potential for synergies between systems can help make the case for funding comprehensive multi-sectoral responses with a significant systems strengthening component*." (UNICEF 2011, p56)

There is also substantial potential for increased funds through the social protection agenda, where there are new funding flows. Recognition is growing that developments within social protection should go hand-in-hand with wider social welfare initiatives for them to be effective. *"Proposals to combine pathways of care, e.g., linking social protection (cash transfers) with social welfare services and embedding them in health and education* (Pinkerton, 2008;

Greenberg, 2008)*, will necessitate careful balancing of the economic and social objectives and identifying contact opportunities. Otherwise child welfare services will be further marginalised* (Maritz & Coughlan, 2004; Davies & McGregor, 2009)." (in Davis, USAID, 2009, pp 3-4). The ability to tap into available resources within the growing sector of social protection could be an important avenue for scaling up case management efforts for children.

Key points

- Referrals and case management require a 'systems' approach, not just within one sector but across all sectors. This requires substantial political will.
- Political will and policy commitment may be leveraged by strong national mandate for the response to vulnerable children, through consultative processes and by a stronger evidence base on the benefits of a coherent response.
- The responsibility for a consistent and holistic response to vulnerable children and their needs often sits with weak and under-resourced ministries, or departments within in such ministries, posing a real constraint to the development, implementation and enforcement of legal frameworks, policies, guidelines and protocols.
- The link from informal/community into formal is not clear in national policy responses, with lack of alignment as clear guidance documents for this formal/non-formal linkage are missing.
- In terms of resource mobilisation, there is a need to demonstrate impact for the money invested. This is becoming more prudent with the squeeze on HIV-related funding and reduced donor funding.
- The growing interest in social protection interventions across the region provides interesting opportunities for accessing a new source of resources. To be able to tap into those resources, it will be crucial to stress the non-economic advantages of social protection and the benefit of linking social protection with wider responses for vulnerable children.

5.2 Identification and assessment of vulnerable children

Understandings of 'what makes a vulnerable child' in both policy and practice lay the foundation for identifying those children in need of referrals to services and case management and form the impetus for children to enter such systems. This section explores what is currently happening on the ground in terms of identification of vulnerable children, the assessment of this complex myriad of needs and vulnerabilities, to what extent this can then translate into an effective response for vulnerable children.

Box 6

Definitions of identification and assessment

Identification of a vulnerable child or a child in need pertains to the first 'flagging' of a problem, indicating that there is an issue that requires further attention.

Assessment establishes the particular need(s), whether the identified need(s) require a particular response and if so, what type of response. This process has the function of not only identifying and assessing which children and families are in need of support, but also of understanding the vulnerabilities and potential risks faced.

The majority of vulnerable children are identified through community-based identification. 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 and tools or criteria to guide the process of identification. It is not surprising to see that such community-based identification is widespread across the region; communities are at the forefront in terms of identifying vulnerable households, very good at organising themselves and committed to assisting each other. Identification at community level can be sectoral (for example with community health workers who provide health-specific preventive advice and refer directly to local clinics or volunteers identifying potential social transfer beneficiaries) or less sector-specific. Community-based interventions, to support identification of vulnerable children and assess their multiple needs are being implemented across the region. Community committees, notably OVC/MVC community committees, have potential to undertake more inclusive identification and referrals.

There is little information available about whether sector-specific systems are able to refer children into other sectors. There was little mention by key informants of sector-based mechanisms within the region that are effectively referring children to other sectors. A range of efforts within the education sector ensure that non-pedagogic needs of school children are being identified and met, although primarily limited just to that sector (UNICEF, 2009a). There were few examples of referral for non-health-specific needs from within the health sector. In Mozambique it was suggested that although community health workers and home-based carers may identify needs and vulnerabilities beyond health, they rarely refer to other services. This was commented on by several informants, who felt that the health sector, in particular, could do more to ensure basic protection mechanisms are in place, especially the relatively simple task of providing information about how to access birth certificates when a child has been born. The health sector was described as being the least open to multi-sectoral working by some informants, although an example from cooperation between Neighbourhood Care Points (NCPs) and mobile clinics in Swaziland provides a positive example (see box below).

Box 7

Linking a child protection and health response - Swaziland's NCPs

A partnership between the Ministry of Health and Swaziland Positive Living (SWAPOL), a national NGO for people living with HIV, aims to increase access to excluded households by providing family-based health care. Children living in households with an HIV-positive or sick parent tended to have less access to health care. SWAPOL and the Ministry of Health conduct monthly outreach mobile clinics at a Neighbourhood Care Point (NCP) in remote or hard to reach areas. They visit one NCP to which children from 'feeder' NCPs in the surrounding area are referred by NCP staff. Caregivers in the main and feeder NCPs have been trained on health-related assessments in preparation for monthly outreach. They screen children before the visit 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; other care providers are present to complement HIV treatment and health care with counselling as well as other non-health referrals. There are now 20 centralised and 67 feeder NCPs participating in the initiative. (Verbal report, UNICEF Swaziland)

Community identification of vulnerable children can prove an important tool in reaching out to the most vulnerable and ensure inclusion of those with more complex needs or that are less specific to a single sector. World Vision International (WVI), for example, works with

community groups to identify and support vulnerable children. Community members who are responsible for supporting vulnerable children and families are taken through exercises designed to invoke empathy with vulnerable households, rather than providing a checklist of 'vulnerabilities'. WVI is finding that this has helped build a greater sense of empathy with children, greater ability to consider the most appropriate types of referral and reflection about which children and families are the most excluded, and why (feedback from WVI informant).

Children themselves, or their family members, can also identify a need and ask for support or services. Review of evidence across the region suggests that such self-referral is limited. One respondent pointed out that *"Self-referral by children will be very unlikely as children (in big families) learn from a very early age to deal with issues and keep quiet."* Many family members and caregivers are unlikely to refer their child to appropriate services. Experiences with Child Helplines, however, suggest more positive experiences and illustrate the importance of self referral in terms of identifying children subject to violence and abuse.

Box 8

Listening to children – self referral through Child Helplines

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. Child Helplines worldwide receive an average of ten contacts per day, about violence and abuse. *"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).

Identification criteria and assessment tools are being revised or developed across the region to ensure a systematic and transparent process of identification and assessment of vulnerable children,. Community-based targeting is a common mechanism used in social protection programmes across the region and many use a particular checklist or other tool to standardise the needs assessment and to ensure multiple needs are being assessed. With respect to assessment of child-specific needs, the Child Status Index and Child Support Index are currently being piloted in respectively Mozambique and Ethiopia to assess child protection needs.

Box 9

Assessing the needs of children and their family members – the Child Support Index in Ethiopia

PACT Ethiopia (USAID funded) is implementing a country-wide, community-based response to vulnerable children. It explicitly takes into account the needs of children and their family members. Identification of vulnerable children is a two-step process, whereby children in 'obvious categories of vulnerability' (e.g. disability, orphanhood, living with elderly caregiver) are identified and the needs of these children are consequently assessed using a Child Support Index. 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.

If they are to be effective, **mechanisms for identification of vulnerable children need to take into account his or her wider living context, including the family situation.** Various respondents expressed their concern that current case management practice in ESAR is too biased towards the 'Western' individualised model of case management. As one respondent questioned: *"Why has case management become the flavour of the month in many of these countries* [in the region*]? It is a very North Western concept with a very individual take on social work - when I look at ESAR and community work in, for example, Tanzania and Ethiopia where it's more about community development work, why should we talk about case management from an individual perspective?"* Emerging initiatives on the ground, such as the work with community volunteers in Ethiopia, suggest a move away from such an individual approach to a more family-based perspective. However, in practice there were few examples where the whole family need was assessed and followed through using a 'case file' that would identify particular sets of support for diverse family members. This is discussed further in section 5.4.

Despite the ongoing developments in terms of community-based identification, evidence suggests that many vulnerable children, and particularly the most vulnerable children, are not being identified. The extent of inclusion and exclusion varies according to local programme design, attitudes and overall governance and may be due to the following reasons:

1) Exclusion because needs (of particular groups of children) are not identified or considered to be problems – sexual abuse within the household or early marriage, for example, may not be considered an issue that needs a response outside of the household;
2) Exclusion because the children themselves, or the risks they face, are being 'hidden' - children with disabilities are often hidden in the household or exclusion because of those doing the identifying feel that the child or family is not 'deserving', for example if parents drink or the mother is a sex worker; and
3) Exclusion because services may not be available to respond to problems, which gives rise to the question of why identify in the first place.

Traditional beliefs or attitudes may play an important role in the first two reasons for exclusion, i.e. not being identified as such or considered to require a response, or needs being hidden. In Botswana, the emerging possibility of magistrates to act as child welfare officers was mentioned but *"All this is difficult in a society that has changed so drastically in terms of cultural beliefs. There are examples where one does not believe in reporting cases even in case of incest; lots of confusion goes on with traditional laws being more tolerant of such abuses."* Similar issues were

raised with respect to child marriage. *"In traditional settings, cases are not pursued or punished."* Similarly, in Namibia the xenophobia of some Home Affairs officials limited information about accessibility to a birth certificate for children born of non-national fathers.

An issue mentioned in the literature and by many respondents in reference to the second reason for exclusion (problems being 'hidden') is the absence of consultation of children in decisions about referrals. Across the region children are expected in general to be submissive to adults' decisions. In Uganda *"[…] children reported that parents were too busy to talk to them, that children cannot sit and discuss with parents, that parents dictate what children must do, and that parents think children are too young to be consulted."* (Kalibala & Elson, 2010, p33). In this case, children cited education as an area where they were not consulted. Other reports that have explicitly invited children's views find that children place significantly greater emphasis on the need for support to address abuse, disempowerment and emotional deprivation. Responses to these issues were seen by children to be critical to open pathways to meeting material needs (Loewenson et al, 2009; The Cradle, 2007; Columbia Group for Children in Adversity, 2011).

Equally important for making needs for children visible and supporting self-referral by children and their family members 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 a clear idea often of what the main caregiving challenges are. Male caregivers report wishing to be able to do more but not having traditionally played a 'female' caring role and therefore struggling at times to give support (Long, 2010; Hosegood & Madhavan, 2010). Child caregivers report that their caregiving roles are not listened to (Save the Children UK, 2010). Overall, this review calls for stronger caregiver involvement in the referral procedures.

Finally, **identification of vulnerable children appears to depend heavily on age, but lack appropriate sensitivity to age and development stage-specific risks.** Emerging evidence suggests that younger children (pre-school) and adolescents are less likely to be beneficiaries of vulnerable child care programmes. A review of OVC support programs in Kenya, Namibia, Zambia and Uganda found that only 3% of the children reached were aged 0-2 years and only 8% were aged 2-4 years. 45% were of primary school age (5-11 years) and 44% were aged 12-17 years (PEPFAR, 2008). There appears to be relatively limited focus on 'packages' of care appropriate for children in different age groups. More consideration of this age sensitivity is required in terms of identification of vulnerable children and assessment of their needs.

Key points

- Identification of vulnerable children, and the assessment of their needs, can be done by different actors in different ways. It can be primarily sector-based, focusing on a particular set of needs; community-based, with the community at the forefront of identification; or be based on self-referral, with children or family members themselves identifying and acting upon one or multiple needs.
- Community-based identification is common across the region, in spontaneous forms, but increasingly so in more systematic ways through committees. Criteria and tools are becoming increasingly available to support a structured and more transparent needs assessment.
- Sector-specific referrals rarely serve as an entry-point into other sectors, despite the fact that opportunities have been identified to link across sectors. More efforts are required to do so in the future.

- Experiences with self-referral by or for children across the region are still rather thin but initiatives are growing. The provision of space for children and caregivers to speak out about needs and solutions is imperative in making self-referral work.
- Exclusion can arise from needs not being identified as actual problems, needs being '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 contribute to incomplete or failed identification and assessment processes. There is not enough focus in the existing identification and referral tools on the importance of listening to both children and caregivers.

5.3 Roles and responsibilities

Whilst there is a substantial amount of investment at community level on identification of children, **this is rarely translated into protocols, clearly spelling out when a problem needs referral and to whom**. Whilst many countries have had guidelines for community or district identification and support of 'OVC or MVC', in practice the roles and responsibilities that have been outlined have not translated into a clear set of criteria and guidelines.

Box 10

Definitions of formal and non-formal mechanisms and systems

In this report, 'formal' refers to the statutory, government-mandated sector. Delivery of services within the formal sector has government oversight, and conforms to national rules and regulations. 'Non-formal' refers to non-statutory mechanisms or processes and to family and community structures.

'Traditional' or 'customary' mechanisms and systems are not usually formally recognised in law but are generally recognised officially and have a rigid and usually commonly agreed set of practices.

When referring to 'social work workforce', we mean *"all types of people who work in the public and nongovernmental sectors on behalf of highly vulnerable children, such as professional and paraprofessional frontline workers, child protection officers, child welfare supervisors, managers and program planners, local and national advocates, policy makers, and teachers and trainers of social workers"* (Davis, 2009).

Several key challenges arose in relation to this absence of clarity about roles and responsibilities: linkages between different sectors, linkages between the non-formal (often community focused) sector into the statutory sector and the relationship of paid service providers vis-a-vis unpaid community workers.

Linkages across sectors

Referrals between statutory sectors and case management across those sector, present one of the biggest challenges in relation to effective response to vulnerable children, according to respondents.

> *"Raising the child is a team effort". You can't do it where one section is functional and another is dysfunctional. Although it is one of the easiest things in the world to ask for a*

birth certificate, and community groups do so, it would make a big difference to have stronger links. It would be simple to include a birth certificate box on a health chart but it's not there, health doesn't require it, and so the question doesn't get asked. Yet this is the first place that a child often goes into the system. Nurses think that it's not required in their job, so why should they ask about it. Similarly, community forum members whose role is to identify vulnerable children do not know what a child's immunisation schedule should be and they don't ask about it 'because it's health's job". (key-informant feedback)

There were few reported examples of enhanced inter-sectoral working. **Where referral protocols exist that spell out roles and responsibilities, it is generally for and within a single sector.** As a result, police and social workers, for example, end up with a different understanding of roles and responsibilities. Feedback from a respondent in Lesotho suggested that:

"A lot of work to be done on roles and responsibilities and mandates. The Trafficking Act has been passed this year and says that there is a role for social welfare, police etc. but at the moment there are no guidelines to make people accountable."

The health sector is usually a sector that offers most guidance in terms of referrals. There has been a growth in linkage between community-based health workers, home based care providers and trained health sector staff, particularly in the context of HIV but increasingly in relation to maternal, newborn and child health.[5] However, this remains primarily specific to within the health sector itself.

One element that appears to feed the challenge of cross-sectoral cooperation is the perceived difference in human and financial resourcing, mandate and overall professional status between different sectors, especially the child protection sector. Social workers are often expected to play a leadership and coordination role yet lack the mandate and resources to do so. *"Some officers complain that the Department is a laughing-stock in their locale because they have to beg or borrow not only transportation but stationery, typing facilities or the use of a telephone line or a printer. It is clearly difficult for an organisation to continue to present itself as playing an active, necessary and authoritative part in the local criminal justice and social protection systems if it does not have the means to carry out the most basic functions unaided"* (Wyatt et al, 2010, p33). Social workers continue to have unclear mandates for their core business and have relatively low status. The emerging focus on social welfare workforce strengthening (AIDSTAR-Two, 2011) is essential but has not yet been translated into tangible change on the ground in relation to linkages between sectors.

Regular opportunities for meeting and sharing with colleagues from different sectors do appear to make a positive difference to inter-sectoral cooperation. This is happening in some places formally, as in the development of formal memoranda of agreement that are being developed in Namibia (see box below). Elsewhere, regular opportunities for meeting and sharing are created more informally, as reported by a number of key informants. For example, in Tanzania the district child protection systems strengthening initiative has brought together representatives from all sectors at district level for a monthly child protection team meeting.

[5] The health sector has, for example, developed a set of clear guidelines setting out referral pathways, treatment protocols and accountability mechanisms for maternal, newborn and child health (WHO, 2010)

Members comment on the way that meeting others has enhanced their own ability to identify child protection risks: *"In our health sector, we do not talk much of children's rights. I am always coming up since being in the DCPT with different thinking, for example about a child with a burn injury. In medical school we would learn to treat the burn. Now I think about whether maybe the stepmother was harming the child."* (Doctor and member of a District Child Protection Team). Whilst attempts at formal multi-sectoral working groups have mixed success, the factors that enable shared working appear to be where people get results from working together. As one member of a district team in Tanzania said, *"We have reduced distances between us and the work is now easier. We can pick up the phone."* In Namibia, the same point was made – that at inter-sectoral meetings, people for the first time exchanged phone numbers and started to share information and tasks. In Namibia, they found that one of the problems of inter-sectoral linkages was that workers did not always understand their own responsibilities, some of which might include referral to others. Regular meetings and information sharing opportunities can help to clarify roles and responsibilities and support greater accountability towards those. In Tanzania, statutory sector workers meet together monthly at district level and report that the process of meeting regularly ensures mutual accountability. As 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."*

Box 11

Memoranda of agreement for improving referrals between ministries in Namibia

In Namibia, there is very low coverage of birth certificates – something that was not required of Namibians prior to independence in 1990. The Ministry of Home Affairs and Immigration (MHAI) has developed its own programme for expanding birth registration, including mobile programmes to remote areas and upgrading its own facilities. However, progress has been achieved more rapidly with 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) in order to identify and refer children from marginalised households more rapidly. The establishment of hospital-based facilities, in a country where the majority of children are born in hospital, has rapidly improved early birth registration. However, the MOU has been essential to demonstrate to staff working in the three ministries that they 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)

Linkages between non-formal and statutory sector

As has already been stated in section 5.2, community-based mechanisms are vital to identifying and meeting the needs of vulnerable children, yet their efforts need to be coordinated with those of statutory sectors such as health, education, economic and child protection.

> "*Community-based Child Protection Mechanisms CBCPMs are potentially significant elements because they have the opportunity to touch the lives of large numbers of vulnerable children and families. CBCPMs are also highly important in building national systems of child protection. If CBCPMs connect with and support the national system, then the national system of child protection may stand a greater chance of being effective and of improving the lives of children and families. However, if there is a*

disconnect between CBCPMs and the wider child protection system, the ability of the national system to actually reach grassroots people and improve the lives of children and families may be limited" (Wessels, 2011, p1).

Despite the importance and potential of community-based mechanisms, there is limited evidence base about the effectiveness of CBCPMs and other community-based or informal interventions, in child protection (Wessels, 2009). The available evidence also does not provide guidance about appropriate linkages between the formal and informal initiatives.

On the ground, there were few examples of referral mechanisms being clarified between formal and traditional processes. In West Africa, there are some emerging discussions about developing MOUs between traditional chiefs and the statutory sector in relation to GBV. In Eastern and Southern Africa, there was far less mention of this important link. There has been limited, but notable, progress in the context of child protection. In Swaziland and Tanzania, for example, there have been attempts to translate this challenge into simple and clear messages, backed up by laws that clearly state everyone's responsibility in relation to abuse. At community level, the new laws in Swaziland have been translated into 'the 10 things that everybody should know about sexual violence' which has made it possible to provide clear messages about everyone's responsibility to report suspected child protection violations.

A further challenge at community level is moving from passive referral to case management; not only knowing when and where to make the initial referral but following up when services are not available or when the referral does not work. Community workers are expected to refer children into services that are, very largely, absent or inaccessible. Whilst there are examples of success, for example the linkage between community activists and the health sector for HIV treatment adherence, this study did not find substantial evidence of similar approaches in other areas. In addition, as cited in several countries, whilst referral into the education system happens frequently, community workers *and* statutory workers based in the community find it much more difficult to know what to do when children drop out of school.

The role of the social worker vis-à-vis volunteer

Effective case management requires a certain minimum level of staffing, both across formal and informal sectors. There has been very little debate or documented information across the region about the challenges of volunteerism at the community level, or the appropriate balance of tasks between community volunteers and social workers in the statutory sector.

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,** including Botswana, Mozambique, Tanzania and Zimbabwe. For social workers, there should be a clearly outlined mandate to act as a case worker within the remit of their tasks as a civil servant. Yet what a social worker should do in the ESAR context, as opposed to a highly resourced 'Western' setting, remains unresolved. **The roles and responsibilities of social workers and social welfare staff are often diffused and unclear.** Social workers are often 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). There is the need for much more clarity about their role in processing applications for transfers or social protection and welfare programmes.

Various respondents have indicated that there are not enough social workers, and too few will be trained in the near future. In Mozambique it was evident that the pool of social workers within the country is too small: *"At district level, it is DSMAS* [district social welfare office] *that discusses cases and agrees on action. But there is limited capacity, especially since the department is often a sub-sector within the district health department. Currently there are only 23 social workers in 23 districts out of a total of 128 districts"* (respondent interview). This pattern of chronic understaffing is repeated across the region (Davis, 2009). One mechanism for reducing social work case load is to shift much of the administrative burden of managing social cash transfers, largely foster care grants, away from social workers to other district level administrative staff. Namibia's kinship care system, introduced in the 2010 Child Protection and Welfare Bill, is expected to reduce case burden on social workers, providing a stronger role for family and community involvement in decisions about placements, whilst retaining some oversight function to monitor child wellbeing.

Box 12

Social workers in Botswana – juggling multiple roles and responsibilities

Botswana's response to vulnerable children relies heavily on social workers as front line staff. A study by Roelen et al. (2011) revealed that social workers are over-stretched, with too little capacity for the wide variety of tasks that they are currently performing.

The range of tasks includes community mobilisation, grants case assessment, psychosocial support, child protection and case work, probation work, mediation and referrals. Social workers struggle to juggle all these tasks as it entails (i) too broad a range of responsibilities, (ii) too heavy area and case-loads with little means of transport, (iii) insufficient training and supervisory support for the tasks, (iv) inadequate resources for the work at hand and (v) insufficient support from higher levels, with no effective route of recourse for complaints. In reference to the broad array of tasks, social workers noted that "*there's no specialisation, but there should be*", or "*if you are doing orphan work, you have to meet everything – education, health, food security, counselling.* The way in which social workers were assessed on the basis of tangible and countable outcomes was another source of frustration: *"In case work and PSS, it will look like you are not working and you get negative feed-back on your targets".* The quote "*All hopes are anchored on social workers and yet they are drowning*." clearly suggests the need for more feasible and appropriate expectations from social workers in their response to vulnerable children.

Despite efforts to decrease the workload of social workers, **providing fully qualified social workers with similar statutory responsibility to social workers in high-income countries is not tenable for most countries in ESAR, given both the scale and types of vulnerabilities faced by children in the region.** Several informants referred to South Africa as one of the most extreme examples of reliance on a 'Western' model of social work. The new Children's Act in South Africa spells out what provincial social development departments "must" and "may" do. A review of the costs needed to fulfil the minimum scale up of existing services showed that the amount currently allocated by provincial departments (2010/2011 financial year) was equivalent to about 45 percent of the lowest estimate for implementing currently provided minimum services

and only 5 percent of the estimate of what it would cost to provide full services to all eligible vulnerable children (Budlender et al, 2011).

The concurrent reliance on volunteers gives rise to major challenges in the informal provision of services, particularly at community level – both in terms of capacity to deliver effective referrals and in relation to impact on community workers. Whilst the use of volunteers in the health sector for home and community based HIV care has been discussed extensively (GEMSA, 2010), this is less the case for community volunteers working on child protection or responding to the needs of vulnerable children. Across the region it is largely community members who provide the first line of response to children and they are heavily overburdened. Training is often minimal and there is a high emotional impact on volunteer carers. 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).

As an intermediary solution between community volunteers and social workers**, several countries are discussing a new cadre of para-social workers or agents at community level.** The advantage of such a cadre is that it provides an official link between formal and informal structures; suggesting a 'para' level of those responsible at community level, not volunteers, who are paid, have formal training and are supervised. Current examples include Child Care Workers in Namibia, Child Protection Workers in Malawi and para social workers in Tanzania. There are unresolved tensions between their relatively high level of education (at least high school completion) and resultant career expectations and the grass roots work that they are expected to undertake (reported as a conflict from informants discussing Kenya and Tanzania). Anecdotal feedback referred to the lack of empathy and experience in some educated but relatively young auxiliary staff. Ability to put onto the national pay roll is also a huge challenge. That said, it is an important move away from the unrealistic expectation of highly trained social workers common to the region and a sign of recognition of the importance of staff with child protection training.

An additional attempt to fill the capacity gap in terms of social workers includes countries' increased flexibility in terms of who is allowed to carry out social work, including civil society organisations. The lack of a mandate for civil society to make referrals or provide services to children in need proves a real impediment for NGOs or CBOs. In Lesotho, although NGOs such as World Vision are active in providing legal aid and following up on cases sent to court, they have no mandate to do so and thus courts may not provide the required information or provide the necessary assistance. In a bid to allow NGOs to pursue social work, Zimbabwe has seen a move towards registering qualified NGOs so that they can perform social work under statutory regulations. South Africa similarly contracts out functions to service providers, although funding is a huge constraint because donors are less likely to cover full NGO running costs.

Such models can come with problems. A Zimbabwe study noted the sometimes tense relationship between government functionaries responsible for coordinating the identification, assessment and case management of vulnerable children and civil society initiatives ranging from community-based organisations to, often well resourced, NGOs. *"Lack of resources undermines DSS's professional relationships with other government bodies and NGOs; it cannot*

credibly present itself as playing an active, necessary and authoritative part in the local criminal justice and social protection systems if it does not have the means to carry out the most basic functions unaided" (Wyatt et al., 2010, p60). Government social service employees reported having varied relationships ranging from a sense of partnership between themselves and private voluntary organisation providing services to feeling resentment about available resources within NGOs and seeking to constrain through bureaucratic control. Similar sentiments were reported in a case study on child and HIV-sensitive social protection in Botswana where tight governmental control of the provision of services of NGOs was perceived by such NGOs as limiting their freedom and encroaching on their integrity (Roelen et al., 2011). Such tension has been alluded to, or sometimes explicitly acknowledged, in NGO literature. INGOs with child protection programmes sometimes use a parallel approach, conducting a direct case management scheme of individual children *"while supporting and building the capacity of governments to develop a longer term statutory system."* (McCormick, 2011, p.1).

Key points

- There are few countries that have spelled out inter-sectoral roles and responsibilities that respond to the multi-sectoral nature of childhood vulnerability. Protocols and guidelines that support a cross-sectoral response are largely absent. Lack of clearly defined expectations between different sectors, a lack of knowledge within the own sector of core responsibilities for children and (perceived) differential levels of financial and human resources across sectors compound challenges of cross-sectoral cooperation.
- Regular meetings and a sense of mutual accountability can contribute positively to cross-sectoral working. Examples indicate that meeting regularly and developing an individual sense of team commitment can support the clarification of roles and responsibilities and the mechanisms to hold each one accountable.
- Despite the current importance and potential of community-based mechanisms, there is a limited evidence base about the effectiveness of CBCPMs and other community-based or informal interventions and few guidelines of how these should link into formal/ statutory services. As a result, it is unclear how community-based interventions can move from being reactive to providing comprehensive 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, although their roles and responsibilit*i*es are often diffuse and unclear. Social workers are generally overstretched, have low status and are under-resourced. The 'Western model' of social work was considered untenable in ESAR given the large range of tasks and responsibility in a context of deep and widespread vulnerability.
- The reliance on community structures means that volunteers are often over-burdened with minimal remuneration and unrealistic expectations about their responsibility in promoting child well-being. Volunteers often lack the training and statutory mandate to appropriately assess needs and/or make adequate referrals.
- Options to fill the capacity gap include the introduction of para social workers and an extension of the mandate to civil society.

5.4 Understanding the role of the primary caregiver and other household members

Particular characteristics of a household, head of the household or main caregiver may positively or negatively affect a child's identification of need, the referral to services, or access to and uptake of services in case of referral. **Household composition and decision making will affect whether a child's material and protection needs can be met, either because of factors external to the household (e.g. greater poverty levels amongst particular types of household, service provider attitudes about particular types of household or primary caregiver) or because of intra-household dynamics (for example, caregiver or household decision makers' beliefs about early marriage, child labour or disability).** Overall, there is limited information on this issue in the literature as well as from key informants, despite the fact that it was felt significant. It clearly points to a knowledge gap and need for further enquiry and investigation, especially given the expressed need by key informants for a more family-based or community-focused case management approach. Nevertheless, we pull together a number of issues as identified from the information base available.

With respect to characteristics of the household head, there is indication that **when initial identification is done through community associations, women-headed households are preferred** (Nshakira & Taylor, 2010). This is likely to be the case because there are more female-headed houses in the beneficiary population. It may, however, also be based on an assumption that a female-headed household is inherently more vulnerable. Male caregivers are generally excluded from 'child care' related interventions. Whilst the majority of primary caregivers are women, there is a substantial amount of literature showing that men have an important role to play in parenting and they are often excluded by service providers (Hosegood & Madhavan, 2010). This includes not only biological fathers, but also 'social fathers' and male family members who are often excluded from awareness campaigns about HIV, child protection and child health, to name but a few.

Household poverty linked to high dependency ratios will generally make it harder for some households to access services or act on proposed referrals, because of lack of time, money and other resources to access services. As older caregivers and youth often lack the means to travel from one service to the other, they are often excluded from services (HelpAge, 2011; Holmes & Jones, 2010; Hosegood & Madhavan, 2010). In addition, children living with older caregivers often struggle to access health care, because of both household poverty and because treatment information and other relevant information is not targeted at older caregivers (Samuels & Wells, 2009). A review of South Africa's Child Support Grant found that children of elderly caregivers were less likely to have birth certificates, not only because of the administrative challenge because the mother and father's documents were not available but also because public information about birth registration was not targeted at older people (Martin, 2010).

Exclusion from social networks is a key challenge – **children who do not have access to social networks are more invisible and their social isolation makes it difficult for them to self refer for support.** Reasons for social exclusion vary across Eastern and Southern Africa, but include very high levels of adolescent marriage (Population Council, 2009), high levels of domestic labour and assumptions that girls must be available for caring and domestic housework, even if this means missing school (Bruce, 2007; Levine et al., 2008). A review of Zimbabwe's Programme

of Support to vulnerable children found that children in urban areas are less likely to identify other community members as being caregivers for them (Shepp, 2010). Children in residential care, including institutional care or 'care villages' are likely to be socially isolated (Delap, 2010). Young mothers in particular face social isolation which has profound implications for reaching adolescent girls (Temin et al., 2009). It is also likely that children aged seven years and under are less likely to have their needs identified and met through community-based 'OVC programmes' than older children, since they are less visible and their developmental needs are often insufficiently recognised (Engle, 2008; Martin, 2010). Older caregivers, especially in skip generation households (where there is no younger adult present in the household) are reported to have less family and community support. Several studies have found that when families faced with stigma are supported to be more open about the cause of stigma (very often this is HIV), there has been greater social support – families are more willing to ask for support from others. A family-focused model of care and proactive consideration of stigma and discrimination would appear to increase the confidence of family members to be able to make use of referrals (and consequently case management) (Bhana et al, 2010; Cluver, 2010).

Another group who may have significant greater difficulty in benefiting from referrals are children who are the primary caregivers, either child heads of household or children whose primary caregiver is too sick to provide sufficient care. Their needs for support are profound – child carers *"[…] are performing a physically, mentally and emotionally demanding set of tasks during a period in which their own lives are undergoing profound change"* (Save the Children UK, 2010, p4) and children who are taking on significant caring responsibilities are likely to be living in a household under severe economic stress and with limited or no access to social networks, which in turn has serious implications for identification and support to that family (Save the Children UK, 2010). One respondent pointed towards the particularly difficult situation of older siblings as primary caregivers. *"Older sibling caregivers are among the most excluded - they don't know where to go and have low confidence levels".*

A common understanding between all household members about the importance of particular interventions for children and others appears crucial in ensuring access and take-up of services. In the context of HIV treatment, for example, fathers are often the last to become involved in treatment and grandmothers are often the strictest custodians of traditional infant feeding practices in contrast to new guidance on breastfeeding for HIV-positive mothers (Leeper et al, 2010). Whilst the issue of lack of common understanding as in impediment in making referrals work was acknowledged by the large majority of respondents, the review did not find examples of the importance of working with the whole family to enhance that such understandings. However, it is very likely that in the ECD literature and in much of the HIV literature, there are importance lessons learned about promoting family commitment to enhance referrals and family involvement in services.

Although the family is widely recognised as the preferred option of care for children, it is also important to emphasise that **the family is not always the best environment for children in terms of safety or quality of care**. In a Namibian review of formal and informal child protection systems, many children reported feeling unsafe at home, largely adolescent boys and girls, with girls in particular expressing problems at home (unpublished report, UNICEF Namibia). Tanzania and Swaziland's Violence Against Children studies indicate that home is not always a place of safety for children (Reza et al, 2007, UNICEF Tanzania et al, 2011) – confirming global evidence on violence against children (Pinheiro, 2006). An assessment of Zimbabwe's OVC programme

found that many orphaned children (both boys and girls) felt that their needs were less considered than those of other children in the household (Sheff, 2010). A particular vulnerability seems to be when there is a stepmother or stepfather in the house, with children in many studies talking about discrimination or violence (Long, 2010).

Box 13

Understanding the household to be able to help the child

In Rwanda, the 1994 genocide and HIV have contributed to high numbers of youth-headed households. In response to the particular needs faced by these households, the NGO Bampareze Association established the "Community Child Mentorship Model" in 2001. The model involves the whole community, volunteer mentors, local authorities, service providers and the children themselves. Child headed households identify mentors who are approved by the community members and act as a teacher, advocate, counsellors, friends and 'bridges' to government services. Children are supported through training to help to re-establish relationships with adults in a caregiving role, given that many children have been heads of households for a long time and are not accustomed to having adult care, support or supervision. Mentors, in turn, are trained to communicate with the children and enable them to understand and talk about problems. The programme is finding that children with mentors benefit from improved use of services such as school and health facilities, but are also actively participating in community and group activities more (Muhongayire, 2010).

Mentoring is also a focus of the Isibindi model in South Africa which often gets cited as a model that leverages resources and makes connections between service providers. *"Children and youth are the focus of services in the context of the family, extended family, neighbourhood and community with a service provider and/or the state acting as a protective mechanism... Any risk experienced at the first level (of family), will be compensated for by a focused intervention which, while promoting interconnectedness of the family to the extended family, neighbourhood and community will empower children and youth with life skills"* (National Association of Child and Community Workers, n.d.).

Despite the acknowledgement that primary caregivers have a crucial role in terms of forming an enabling or impeding factor in the access to referrals and services, there were also critical voices emphasising the external pressures faced by families. As one respondent pointed out: *"There is so much focus on what happens within the family, such as sexual abuse of girls, for example. So the notion of children's rights and how they are abused within the family comes across strongly. But in terms of child protection, too much focus is on that and we don't focus enough on all the other factors that make a family vulnerable e.g. economic vulnerability, ethnic exclusion etc. In most cases, parents and caregivers do try to act in parent's best interest. We need to pay attention to that."*

Key points

- There is little information available about the role of primary caregivers and household members in children's access to and uptake of referrals and services, both in terms of their links to external and intra-household factors. This topic requires more attention.
- Household composition, such as those headed by elderly, living in extreme poverty or with high dependency ratios, may affect ability to access services. Challenges include lack of information, time, energy and resources. As a result, children in these households are less likely to benefit from referral mechanisms and case management.

- Social networks are crucial for households to act upon referrals for their children. Children living in institutions, or households headed by elderly or children themselves are more likely to be excluded from such support structures. Stigma and discrimination also play a role and appear particularly pertinent for households affected by HIV and male caregivers.
- Not enough is known about which children within households are more or less likely to be supported by referrals and case management. Research indicates that adolescents are less likely to be reached because of cultural and family attitudes towards adolescent children. This may hold true particularly when caregivers are elderly. More information is needed to gain insight into intra-household dynamics.
- Evidence shows that there must be a common understanding amongst all household members of the importance of interventions to address particular needs if any family member, including a child, is able to access and take up of services.
- Although the family is widely recognised to be the preferred care option for children, it is important not to romanticise the family; it may not always be the safest and most caring environment for children.

5.5 Monitoring and tracking systems

Accurate data and information is recognised to be crucial in providing a coherent and long-term response to children. Despite this recognition, **experiences with monitoring and tracking systems for vulnerable children are thin and often point towards challenges in setting up and maintaining such systems**, notably the capacity required to work with tracking and monitoring systems, both in terms of the data that needs to be feeded into the system and the technology used to run the system. This means that cases are either not entered into the system, or not appropriately, are not shared with other stakeholders, or are not revised and updated.

Good practice in case management requires clear documentation – a 'case file'. *"This case file must hold a written record of all the information on the child and family that is relevant to how their protection concerns are to be addressed. Documentation is vital to record and monitor all the services that are required and provided. Poor and incomplete documentation can lead to inappropriate assistance and services being provided that may not be in the best interest of the child or their family"* (McCormick 2011, p10). The creation of a 'case file' can be contested for two reasons. First, issues of confidentiality come into play. Second, and maybe more importantly, there are ethical concerns. In situations where written reports are not routinely shared between relevant stakeholders, for example from a social worker to a police officer to a nurse or doctor doing a medical exam to a judge or magistrate, a child will have to repeat his or her experiences to multiple different stakeholders, thus possibly increasing the emotional trauma already experienced. **A strong information management system, resourced and with strong links across sectors, allows for processing documentation about 'cases' without breach of confidentiality and repetitive provision of information**.

Examples of functioning monitoring and tracking systems for vulnerable children are few. Swaziland is trying to simplify their current child protection data management system to enhance cross-sectoral linkages, by introducing a unified file number wherever a case protection case is reported. The intention is that the different sectoral data collection systems remain specific to the sector, but that the uniform number will enable tracking across sectors. There has also been considerable investment in the child protection in emergencies sector, with the Inter-Agency Child Protection Information Management System (CP IMS) database that is able to

track children. A recent global evaluation shows that the CP IMS system works well primarily in emergency contexts where there is significant INGO investment, but is labour intensive (McCormick, 2010). There are some emerging examples of using this database for tracking children outside of a rapid onset emergency, with migrant child workers in South Asia, for example, but the examples remain small-scale and not across the broad range of vulnerability that is typical of most settings in ESAR. This review also sought to find examples of mobile phone technology for monitoring and tracking vulnerable children. This is being used in a range of other referral mechanisms, particularly in the health sector (Berg, Wariero and Modie, 2009; USAID, 2011). The primary focus appears to be one-way i.e. reminding people to return for follow up care rather than tracking across different formal and non-formal systems, but this is definitely an area for further exploration.[6]

Low levels of literacy and experience with technology are important challenges data collection and monitoring efforts, particularly at the community level (see a review of community-based data collection systems for vulnerable children in Mozambique by Blackett-Dibinga and Sussman, 2008). Although literacy is a problem, the system requires community volunteers to document cases in writing. They often preferred not to write down primary needs of most children *"because it will raise expectations"* in terms of response and follow-up. There was little evidence that home visitors updated their registers, either because follow-up did not take place, services were not provided or there was no capacity to update registers. The consequent under-reporting of the actual support provided, undermined linkages with community-based services. For example, many children were referred to community-based child centres, where records were also kept, but there was no linkage between the OVC committee's records and the centre records.. In general, data collection was found to be more rigorous where the service provided at community level was pre-determined by the sector, such as in the health sector following home based care activities (Blackett-Dibinga and Sussman, 2008).

The lack of capacity to manage cases was mentioned by many as an enormous problem across the region. In Tanzania, volunteers have very diverse types of education and experience, leading to a lack of consistency and errors finding their way into the data. Also, because they are volunteers, 'motivation' is a real barrier and major obstacle. Finally, the system faces major issues around the capacity to analyse and use the information (Robertson, 2011). In response to this critique, a new and simpler system is being developed in Tanzania (see box below).

Box 14

Referral tools for data and monitoring in Tanzania

Tanzania is piloting a multisectoral district child protection team. They have developed a referral and case management tool that will provide a practical case file system for individual children or families as well as data for monitoring programme implementation and for influencing national policy. The intention behind the design of the tool is to motivate staff, volunteers and community members and to empower all stakeholders to be able to act or advocate more effectively.

[6] Uganda is reportedly piloting mobile text message systems for child protection referrals; Malawi is currently designing a mobile phone system for the child protection referral and case management system that is being designed. It was not possible to follow up on these systems for this review. In Senegal, there is also a mobile phone system that links NGOs to the formal sector for child care, but it was not possible to find more during this review.

The tool contains a short "Notification Form" that can be used by any partner to inform the District Social Welfare Officer about a case to which they are responding, a more detailed attachment if the person making the referral has already undertaken action and a "Referral Form" used by all partners to manage their own actions within the case, with one section completed by the person who first responds to a report and the second one by the 'respondent' providing details of any actions they have taken. A "Consolidated Case Record" integrates data from all the partners for each individual case. All records are kept by every partner in the referral pathway and both DSWO and others involved in the case have a checklist to manage his or her case load and ensure tracking. The tools are accompanied by guidelines explaining how the tools are to be used and how they should be implemented and a list of options available for each of the tools that provides detailed data definitions to ensure consistent implementation within the district and across the three districts who have started piloting the tools. Currently the tools are only used by government and civil society staff at district level. A simpler tool is to be introduced for ward and village or street level community groups.

In addition to capacity issues, the technology is reported as not always appropriate, causing the tracking and monitoring system to break down. In Botswana and Namibia, both middle-income countries with relatively high infrastructure, computers have been provided for the police but are not fully used - many people do not know how to or have the confidence to use them and they are not maintained. In Lesotho, the Child and Gender Protection Unit implemented a computerised database for cases of assault. At district level, it appears that there is not enough police staff to actually do such entries and often no computers are available. Furthermore, the database does not allow migration or merging of information across districts and to national level. Management at district level itself is another problem as cases need to be followed up and updated with new information, for which capacity is often not available. In Botswana, electronic systems have been put in place within the policy system but have not been operative. In 2007/8, computers were provided to all districts but were never used.

Beyond those capacity constraints and technological barriers, **the most fundamental challenge is that of data analysis and consequent use to follow-up individual cases and improve the system as a whole.** Before embarking on any information collection and management system, it should be clear what data is to be collected for what purpose. This review suggests that these issues have been given too little thought and attention.

Key points

- Accurate and timely data is crucial for tracking children across different sectors over time to support a functioning case management system and to improve the system following findings from that data.
- Given the important role of community-based responses to vulnerable children, one of the biggest challenges and priorities, is an information system that can be used by community-based workers. 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 many pilot initiatives are underway across the region.
- 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).
- A crucial priority in monitoring and tracking case management is a deeper consideration of the use of information coming from the system and how it can support case management for all those involved.

6 Summary of findings and conclusions

In this report, we set out to identify lessons learned from and for referral mechanisms and case management for vulnerable children in ESAR. This is timely, given developments in the fields of child protection and social protection. It is encouraging that children's issues, the response to their needs and the requirement for a cross-sectoral and holistic approach are moving higher up on the agenda of governments across the region. Children's Acts, regulatory frameworks and policy documents clearly point towards states' responsibilities in providing such a response to vulnerable children and an increasing number of governments aim to exercise their responsibility. In addition, such frameworks and documents are increasingly recognisant of the complex and multi-faceted nature of child vulnerability, suggesting a comprehensive and cross-sectoral approach. Nevertheless, a number of challenges are apparent and need to be overcome to ensure a holistic and integrated response to vulnerable children.

Child vulnerability is now widely recognised as being multi-dimensional, complex and dynamic. The important question with respect to this study is the extent to which the recognition of social and economic risks, and thereby structural and individual vulnerabilities, has implications for the response to vulnerable children and particularly for the role of referral mechanisms and case management. A broadening of understandings of child vulnerability may lead to more nuanced thinking about potential entry points into referral mechanisms and case management but also increase expectations with respect to feedback from those systems into different services. Although Children's Acts and other policy frameworks do adopt wider concepts of vulnerability, and who vulnerable children are, the majority of policies and programmes continue to focus on easily identifiable groups of vulnerable children. As a result, entry points into, and responses by, referral mechanisms and case management systems remain insufficient and not tuned to the particular risks that children, and families, face.

It is now widely acknowledged that children need a comprehensive, and thereby cross-sectoral, systematic response. Referral mechanisms and case management are key vehicles through which to link different sectors and services for children. This study identified an interest in taking on case management across the region. The regional definition has a stronger focus on community case management and a greater focus on the family context (in its broadest sense), as opposed to the largely statutory and individual response in the 'Western' model. Nevertheless, this has not yet translated into a concrete set of guidance on how to identify vulnerable children and assess their needs, the appropriate roles for statutory versus non-statutory services and between sectors in providing support and follow-up and for monitoring and tracking systems.

A first issue important in scaling up case management initiatives is that of *policy commitment and the mobilisation of resources*. A comprehensive and systematic response implies cross-sectoral linkages, requiring strong policy coordination. Currently, responsibility for vulnerable children in the majority of countries in the region is mandated to relatively weak ministries or government bodies, resulting in limited capacity to coordinate cross-sectorally and leverage resources. Placing the responsibility within a stronger body may lead to a stronger formulation of a coherent policy response and also strengthen the coordination, implementation and resourcing of that policy. More information about costs associated with setting up and implementing case management systems and more profound insights into the potential benefits of such systems is also required in order to to argue for more resources.

A second challenge relates to *identification of vulnerable children and an assessment of their needs*, and how to ensure that sector-specific referral link to other sectors and how community-based identification leads to appropriate action. Community-based identification is common across the region, often spontaneously but increasingly so in more systematic ways through committees. Despite long-standing sector-specific identification and assessment, referrals made in this way rarely serve as an entry-point into other services to address children's needs beyond that of a particular sector. Experiences with self-referral by or for children across the region are also rather thin, although initiatives are growing. The provision of space for children and caregivers to speak out about needs and solutions is imperative in making self-referral work.

Despite the different mechanisms in place to identify children and their needs, it is likely that large groups of children fail to be captured by such mechanisms. Exclusion can arise from needs not being identified as actual problems, needs being '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 contribute to incomplete or failed identification and assessment processes. There is not enough focus in the existing identification and referral tools on the importance of listening to both children and caregivers. New identification and needs assessment tools may help to overcome barriers to identification, thereby improving coverage of all children in need, and are currently being tested in different countries.

A third challenge is the weak formulation of at *roles and responsibilities for referral and case management*. There are few countries that have spelled out roles and responsibilities that are inter-sectoral and respond to the multi-sectoral nature of childhood vulnerability. A lack of clearly defined expectations between different sectors, a lack of knowledge of one's own core sectoral responsibilities for children and differential (perceived) levels of financial and human resources across sectors make a cross-sectoral response harder to implement and coordinate. The positive examples of cross-sectoral cooperation suggest the importance of regular meetings to clarify roles and responsibilities and to promote a sense of mutual accountability. Given the strong community involvement in the provision of and referral to services for children, it will also be crucial to provide better guidance to such community efforts. A translation of those efforts in mandates, protocols and guidelines to guide implementation on the ground is largely missing, representing an important gap in current practice on referral and case management. This holds for referrals into, and case management across, the formal and informal sector and between different sectors.

The lack of clarity and guidance on roles and responsibilities also has implications for considerations of who should be *frontline staff* to respond to vulnerable children. Social workers were by and large considered to be 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. However, such a 'Western model' of social work was also considered largely untenable in most of the countries in ESAR. Community volunteers acting as first entry point into case management system may present a more viable option in ensuring community involvement and bottom-up referral. That said, challenges are numerous; volunteers are often over-burdened, receive minimal remuneration, face unrealistic expectations about their responsibilities and lack appropriate training and statutory. Various options to fill this capacity gap were suggested during the course of this review, such as the employment of para social

workers, extension of civil society and task shifting of administrative work away from social workers but need more thought and enquiry within their particular contexts.

The *role of the primary caregiver, and the household as a whole*, in the potential effectiveness of referrals and case management of children requires more consideration as their characteristics may form an impediment in the identification of a child's need, the provision of referral and access to or take-up of services following that referral. Elderly caregivers, for example, may be less able to access services due to lack of energy or resources, lack of information, but also limited access to social networks and social support structures. Heads of poor households and children or youth as heads of household are likely to experience similar constraints. The role of male caregivers is often not duly recognised – both within communities and by service providers - leading to barriers in the access of services. Internal dynamics within the household were also recognised as important in that they may impede the access to referrals for individual children within households, although little evidence is available about the actual impact of such dynamics. Although the preferred care option for children, the family setting may not always present a safe or quality care environment.

Finally, the review found that *tracking and monitoring systems* of referrals and case management for vulnerable children are largely underdeveloped in ESAR. Capacity constraints in terms of literacy, ability to work with and maintain technology, lack of motivation and limited understandings of the need to keep data up-to-date are some of the main challenges in getting such systems off the ground. In addition, confidentiality concerns, ethical considerations and the need to link systems across sectors need to taken into account in monitoring and tracking a cross-sectoral response to vulnerable children. Most importantly, more thinking is required about the actual purposes that data collection, monitoring and tracking systems are supposed to serve – thereby making sure that the data that is being collected can actually be used to support follow-up of individual cases and serve as a feedback loop to support improvements of the response to vulnerable children as a whole.

In sum, it is clear that there is strong willingness and commitment across the region to strengthen the response to vulnerable children by making it more comprehensive, consistent and responsive to children's needs. This commitment was found at all levels, from the formal to informal sector, across sectors and with international and national partners. Translation into practice on the ground so far has been limited, although new initiatives are taking shape in a growing number of countries. Preliminary lessons learned from those initiatives, in conjunction with those from experiences in other sectors and other regions, are encouraging but also point towards a range of challenges. In extending referral mechanisms and case management as part of a comprehensive response for vulnerable children, these challenges should be given due consideration. A discussion paper following this stocktaking report will put forward key recommendations following this extensive review and outline a number of options in taking referral mechanisms and case management for children in ESAR forward.

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Annex 1 Overview of respondents

Name	Organisation	Function
Nadia Balete	Lifeline/Childline Namibia	National Counselling Manager and Child Protection Programme Manager
Lidia Borba	UNICEF Angola	Child Protection Specialist
Connie Botma	UNICEF Namibia	Chief of Special Protection for Vulnerable Children
Annalisa Brusati	International Rescue Committee	Coordinator, CP IMS
Matthew Dalling	UNICEF Namibia	OVC/Children and AIDS Specialist
Brigette Delay	UNICEF WCARO	Child Protection Officer
Joshua Emmanuel	UNICEF Botswana	Chief Child/Adolescent Protection and Participation
Bill Forbes	World Vision International	Senior Advisor for Child Protection and Children in Crisis
Kendra Gregson	UNICEF – New York, HQ	Child Protection Officer
Pedro Guerra	UNICEF Angola	Child Protection Specialist
Dianne Hubbard	Legal Aid Centre, Namibia	Coordinator, Gender Research & Advocacy Project
Mayke Huijbregts	UNICEF Mozambique	Chief Social Policy
Phenny Kakama	UNICEF Tanzania	Child Protection Specialist
Stuart Kean	World Vision International	Senior HIV and AIDS Policy Advisor

Edina Kozma	UNICEF Angola	Chief of Child Protection
Patricia Lim Ah Ken	UNICEF – New York, HA	Adviser, HIV/AIDS protection, care and support
Lila Machaieie	UNICEF Mozambique	Child Protection Specialist
Alice Mapenzi Kubo	Child HelpLine International	Programme manager for Africa
Sarah Lilley	Save the Children UK	Child Protection Learning & Impact Assessment Advisor
Heidi Loening-Voysey	UNICEF South Africa	Child Protection Specialist
Catherine Maternowska	UNICEF ESARO	Violence Against Children consultant
Maury Mendenhall	USAID	Orphans and Vulnerable Children Advisor
Tanja Miller	ChildLine Zimbabwe	Director
Lynette Mudekunye	REPSSI	Deputy Executive Director
Leon Muwoni	Ministry of Labour and Social Services, Zimbabwe	National Coordinator - NAP II
Farida Noureddine	UNICEF Lesotho	Child Protection Specialist
Elayn Sammon	UNICEF Zimbabwe	Child Protection Specialist
Julia Sloth-Nielsen	University of Western Cape	Senior Professor and Dean of Faculty of Law (Child Rights Specialist)
Lucy Steinitz	PACT, USAID – Addis Ababa, Ethiopia	Senior Technical Advisor
Sefora Tsiu	UNICEF Lesotho	Social Policy Officer
Jennifer Yablonski	UNICEF – New York, HQ	Social Protection Specialist
Rachel Yates	UNICEF – New York, HQ	Senior Adviser, HIV/AIDS protection, care and support

Annex 2 Interview guide

1. Child vulnerability

a. What is your definition of child vulnerability? Which child needs support, care or protection?

b. Are there particular groups of children that have been prioritised nationally with local or sub-national differences?

2. Understanding of concept of referral / referral mechanisms / case management

a. In the national response to vulnerable children in your country, are referrals defined through national protocols/guidelines and if so, how?

b. To what extent are referral mechanisms designed (or expected) to link between different service sectors?

c. Is the notion of "case management" a current concern in national 'OVC responses' or child protection responses? Is the phrase typically mentioned in current debates?
d. Are referrals through and across services tracked and monitored? If so, can you say how?

3. Mechanisms and criteria for identifying children in need of referral

a. In existing referral mechanisms, or arrangements, who are the most likely persons or bodies to initiate the identification of children in need (or at risk) and make referrals?
b. What criteria are currently being used for identification of vulnerable children at both community- and facility-level? How effective is this identification at the different levels?
c. Are current referral systems failing some children because they are not being identified or not being accepted within a service? If so, which children and why might this be?

4. Roles and responsibilities

a. How do you see the appropriate division of roles between state and non-state actors in terms of the identification of children in need, assessing their need, referring to services and providing such services?
b. What are the main enabling factors that ensure that a child is referred into/across a system?
c. What are the main barriers that prevent a child being referred into/across a system?

5. Role of primary caregiver and household composition

a. To what extent does the effectiveness of referrals mechanisms depend on whom the child's primary caregiver is and the access of caregivers to services?
b. To what extent does the effectiveness of referrals mechanisms depend on whom the child's primary caregiver is and the *role* of the primary caregiver within the family?

6. Practical and implementation issues of referrals

a. How is data and information being generated and used for tracking and monitoring?
b. What are the practicalities in the system, which make this work or not?
c. Have you come across any examples that support management of data/information?